

Master Document Commands

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www.podiatryriskgroup.com/speakeasy

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Insert Abscess Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals a warm, indurated, and fluctuant area consistent with a soft tissue abscess. Specific Location: [Location] Open Ulceration: [No, Yes] Drainage: [No, Yes] Signs of Proximal Infection: [No, Yes] Lymphadenopathy: [No, Yes] Lymphangitis: [No, Yes] Subjective (NRS Scale) Pain Level: [0-10] Additional Findings: [N/A]

Insert Achilles Tendon Exam

Examination of the Achilles tendon reveals pain with palpation on the [RIGHT, LEFT, BILATERAL] extremity(s) consistent with Achilles tendinitis. Location of Pathology: [Insertional, Watershed] Defects Observed: [No, Yes] Clinical Tendinosis: [No, Yes] Haglund's Deformity: [No, Yes] Ability to Single Heel Rise: [Yes, No] Simmonds-Thompson Squeeze Test: [Positive, Negative] Ankle Joint Equinus: [No, Yes] Subjective Pain Level (NRS Scale) RIGHT: [0-10] Subjective Pain Level (NRS Scale) LEFT: [0-10] Additional Findings: [N/A]

Insert Achilles Tendonitis Plan

A lengthy discussion with respect to the etiology and proposed treatment plan took place this office visit. The patient had ample opportunity to ask any questions about their diagnoses and expected prognosis. I explained to the patient the function of their Achilles tendon at length. I explained to the patient that the contracture of their Achilles places an increased load on the tendon during their gait cycle. Furthermore, their contracture (Ankle Joint Equinus) results in significant pronation at the subtalar joint (STJ) as compensation. I explained to the patient the importance of using night splints to keep the Achilles tendon stretched to an optimal length. I advised the patient to wait one week before using their night splints. This will allow some of the acute inflammation to reduce prior to starting. A heel lift was placed in the shoe of the affected extremity to offload some of the increased tension. The concept of RICE was explained to the patient. The patient was instructed to ice and elevate the extremity 20 minutes on, then 20 minutes off at least 3 times per day to control the inflammation. An Ace bandage was placed on the involved extremity for compression and edema control. I examined the patients shoe gear which was noted to be excessively worn and ill-fitting. Shoe recommendations were given to the patient during today´s office visit. I recommend the patient purchase new shoes. I advised and educated the patient on modification of their physical activity to promote tendon healing. Shoe gear changes, functional orthotic devices, strappings, cast immobilization, night splints, cortisone injections, physical therapy, anti-inflammatories, surgical correction, and ESWT was discussed. The three clinical objectives are: (1) Reduce the inflammatory process and expedite repair of the Achilles tendon. (2) Reestablish biomechanical function of the foot: the Achilles tendon and the "windlass" mechanism in relationship to the plantar fascia. (3) Reestablish appropriate strength, range of motion, and tolerance to eccentric loads and forces typical of standing, walking, and running. Our initial goal of treatment is not to allow their Achilles pathology to develop chronicity or become recalcitrant. The abnormal biomechanics of the foot was reviewed as it relates to their conditions and symptoms. We did discuss the use of custom made functional orthotic devices to reduce the stress strain along the Achilles tendon and plantar fascia at its insertion into the calcaneus. This will slow further progression of the posterior calcaneal exostosis and help rebalance intrinsic and extrinsic musculature throughout the lower extremity.

Insert Air Heel BILATERAL

This patient has BILATERAL plantar fasciitis with bilateral pes planus deformity. This pes planus deformity is resulting in an abnormal flattening of the longitudinal arches of bilateral feet and causing strain on the plantar soft tissue structures of both feet, including the plantar fascia. This is causing inflammation and pain and affecting the patient´s ability to ambulate. The patient is ambulatory but this deformity should be addressed and stabilized. There are multiple potential medical complications of pes planus deformity. It can cause pain, instability, gait disturbances, and other pathology to joints of the foot as well as the ankle joint. It is for these reasons that stabilization is required in the form of Ankle Orthoses (AFO) that can address pes planus. This can result in a significant improvement in function. As described above, the patient´s foot function is being negatively impacted by the patient´s pes planus deformity. Addressing this with AFO´s should improve function both short term and long term. The patient´s need for these braces did not begin during a hospitalization or a SNF stay. To address the pes planus deformity and provide stabilization, two ankle orthosis, ankle gauntlets were dispensed today, one for the right and one for the left. The patient will wear these while ambulating. The rigidity of these braces is sufficient to address the pes planus deformity and improve the function of the lower extremity bilateral. These braces extend above the ankle and are fastened around the lower leg. Upon gait analysis, the device appeared to be fitting well and the patient states that the device is comfortable at this time. At the time the device was dispensed, it was in suitable condition and not substandard. An acknowledgment form was signed indicating that they received the product. Written instructions, warranty information, and the list of 26 DME Supplier Guidelines were dispensed. The braces were assembled in accordance with the manufacturer's instructions and adjusted to fit the patient. The patient was examined while wearing the braces and ambulating in the braces and after the fitting was complete, the fit was appropriate for both left and right. The patient stated they were both comfortable. The goals and function of these devices were explained in detail to the patient. The patient was shown how to properly apply, remove, wear and care for the devices. The patient was able to apply and remove the devices properly without assistance when we were done. The braces were suitable for the condition and not substandard. No guarantees regarding resolution of symptoms were given and precautions were reviewed. The patient signed a written proof of delivery. All questions were answered to their satisfaction.

Insert Air Heel LEFT

This patient has LEFT plantar fasciitis with pes planus deformity. This pes planus deformity is resulting in an abnormal flattening of the longitudinal arch of the left foot and causing strain on the plantar soft tissue structures, including the plantar fascia. This is causing inflammation and pain and affecting the patient´s ability to ambulate. The patient is ambulatory but this deformity should be addressed and stabilized. There are multiple potential medical complications of pes planus deformity. It can cause pain, instability, gait disturbances, and other pathology to joints of the foot as well as the ankle joint. It is for these reasons that stabilization is required in the form of Ankle Orthoses (AFO) that can address pes planus. This can result in a significant improvement in function. As described above, the patient´s foot function is being negatively impacted by the patient´s pes planus deformity. Addressing this with AFO´s should improve function both short term and long term. The patient´s need for these braces did not begin during a hospitalization or a SNF stay. To address the pes planus deformity and provide stabilization, two ankle orthosis, ankle gauntlet was dispensed today, one for the left. The patient will wear these while ambulating. The rigidity of this brace is sufficient to address the pes planus deformity and improve the function of the lower extremity. This brace extends above the ankle and is fastened around the lower leg. Upon gait analysis, the device appeared to be fitting well and the patient states that the device is comfortable at this time. At the time the device was dispensed, it was in suitable condition and not substandard. An acknowledgment form was signed indicating that they received the product. Written instructions, warranty information, and the list of 26 DME Supplier Guidelines were dispensed. The brace was assembled in accordance with the manufacturer's instructions and adjusted to fit the patient. The patient was examined while wearing the brace and ambulating in the brace and after the fitting was complete, the fit was appropriate. The patient stated it was comfortable. The goals and function of this device was explained in detail to the patient. The patient was shown how to properly apply, remove, wear and care for the device. The patient was able to apply and remove the devices properly without assistance when we were done. The brace is suitable for the condition and not substandard. No guarantees regarding resolution of symptoms were given and precautions were reviewed. The patient signed a written proof of delivery. All questions were answered to their satisfaction.

Insert Air Heel RIGHT

This patient has RIGHT plantar fasciitis with pes planus deformity. This pes planus deformity is resulting in an abnormal flattening of the longitudinal arch of right foot and causing strain on the plantar soft tissue structures, including the plantar fascia. This is causing inflammation and pain and affecting the patient´s ability to ambulate. The patient is ambulatory but this deformity should be addressed and stabilized. There are multiple potential medical complications of pes planus deformity. It can cause pain, instability, gait disturbances, and other pathology to joints of the foot as well as the ankle joint. It is for these reasons that stabilization is required in the form of Ankle Orthoses (AFO) that can address pes planus. This can result in a significant improvement in function. As described above, the patient´s foot function is being negatively impacted by the patient´s pes planus deformity. Addressing this with AFO´s should improve function both short term and long term. The patient´s need for these braces did not begin during a hospitalization or a SNF stay. To address the pes planus deformity and provide stabilization, two ankle orthosis, ankle gauntlet was dispensed today, one for the right. The patient will wear these while ambulating. The rigidity of this brace is sufficient to address the pes planus deformity and improve the function of the lower extremity. This brace extends above the ankle and is fastened around the lower leg. Upon gait analysis, the device appeared to be fitting well and the patient states that the device is comfortable at this time. At the time the device was dispensed, it was in suitable condition and not substandard. An acknowledgment form was signed indicating that they received the product. Written instructions, warranty information, and the list of 26 DME Supplier Guidelines were dispensed. The brace was assembled in accordance with the manufacturer's instructions and adjusted to fit the patient. The patient was examined while wearing the brace and ambulating in the brace and after the fitting was complete, the fit was appropriate. The patient stated it was comfortable. The goals and function of this device was explained in detail to the patient. The patient was shown how to properly apply, remove, wear and care for the device. The patient was able to apply and remove the devices properly without assistance when we were done. The brace is suitable for the condition and not substandard. No guarantees regarding resolution of symptoms were given and precautions were reviewed. The patient signed a written proof of delivery. All questions were answered to their satisfaction.

Insert Ankle Sprain Exam

Examination of the lateral collateral ligaments on the [RIGHT, LEFT, BILATERAL] ankle(s) are painful consistent with an acute ankle sprain. Presence of Edema: [No, Yes] Anterior Talofibular Ligament (ATFL) Pain: [No, Yes] Calcaneofibular Ligament (CFL) Pain: [No, Yes] Posterior Talofibular Ligament (PTFL) Pain: [No, Yes] Pain Over Syndesmosis: [No, Yes] Pain Over Ankle Joint: [No, Yes] Peroneal Subluxation: [No, Yes] Pain Over Peroneal Tendons: [No, Yes] Pain Over Deltoid Ligaments: [No, Yes] Pain Over Anterior Calcaneal Process: [No, Yes] Anterior Drawer: [No, Yes] Chronic Lateral Ankle Instability: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Ankle Sprain Plan

Explained and advised that RICE post ankle sprain is critical to control the acute inflammation and promote proper healing. Advised the patient to use cold compresses on the affected extremity at least four times per day. This should be done in a manner which allows for 20 minutes on and 20 minutes off. Advised and demonstrated to the patient that elevation should be above the level of their heart to control the acute inflammation. Explained the etiology, proposed treatment protocol, and expected prognosis of acute ankle sprains to the patient. I explained that injured ankle ligaments, depending on severity, take between 3-6 weeks on average to fully heal. I explained the possibility of long-term complications such as: lateral ankle instability, generalized weakness, and/or chronic pain syndromes (RSD) may occur after an ankle sprain.

Insert Arthritis Plan

The diagnosis and etiology of arthritis was explained to the patient at length during today´s office visit. Conservative treatment options including: RICE, cortisone injections into the affected joint(s), physical therapy, NSAIDs, analgesics, topical compounds, and HEP range of motion & stretching exercises were discussed with the patient. The importance of no barefoot walking and the use of quality supportive shoe gear was discussed. Increased physical activity with exercise as tolerated will help joint lubrication, stretching, and pain reduction.

Insert At Risk

At Risk Foot Care Was Performed: Patient Qualifier: [Q7, Q8, Q9] Class A: (Non-Traumatic Amputation of Foot) Class B: (Absent DP, PT Pulses, Advanced Trophic Changes, Decreased and/or Absence of Hair Growth, Nail Changes, Skin Pigment Changes, Thin and/or Shiny Skin Texture, Rubor and/or Skin Redness) Class C: (Claudication, Temperature Changes, Edema, Paresthesia, Burning) Additional info: (presence of neuropathy) Q7 = One Class A, Q8 = two class B, Q9 = One Class B and Two Class C. Location of Mycotic Toenails: [Enter] Thick, painful, yellow mycotic nails are evident. There is pain upon palpation to each nail. Procedure: Extensive nail debridement was performed on each mycotic nail utilizing an electric grinder to reduce the nail bulk and girth of the diseased nail plate to the level of reasonably expected toenail thickness. The purpose of this procedure is to reduce patient pain and discomfort and prevent secondary bacterial infections. Any remaining elongated toenails were trimmed to an appropriate length in conjunction with patient tolerance and the medical standard of care. Location of Hyperkeratotic Lesions: [Enter] Procedure: Utilization of sharp instrumentation the lesions were addressed (sharply pared) to an appropriate skin level in conjunction with patient tolerance and the medical standard of care. Patient Education: This patient has a systemic disease resulting in severe circulatory embarrassment and/or compromise that performance of these procedures by an unskilled and/or nonprofessional individual would be hazardous to this particular patient increasing the danger of infection and injury putting the patient at risk. Educated the patient to avoid self-care to preclude the risks associated with peripheral vascular disease. Debridement procedures were performed to remove all of the abnormal and/or diseased nail plate and debris of the infected mycotic nail beds. Sharp paring of the hyperkeratotic lesions are intended to reduce points of pressure (stress risers) and prevent ulceration. The patient had marked limitation of ambulation and pain from these pathologies. Educated the patient on appropriate and preventative foot care measures to further reduce risk. Continued at risk podiatric follow-up was emphasized to mitigate risks long-term.

Insert Blister Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot there appears to be a fluid-filled collection consistent with a blistering formation. Signs of Secondary Infection: [No, Yes] Description of Exudate: [Serous, Purulent, Hematogenous, Seropurulent] Volume of Exudate: [ ] cc Subjective Pain Level (NRS Scale): [0-10] Additional findings: [N/A]

Insert Blister Plan

The etiology of the blister was discussed with the patient. Discussed different treatment options, including the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. After reviewing these options, I explained my recommendation to perform an aspiration of the blister at length. The potential risks, potential benefits, and possible complications of the proposed procedure were explained. Patient understood and asked to have this performed. An informed consent was signed by the patient. Patient was already properly positioned in the chair for ideal access to the site. The blister site was prepped with a betadine scrub. Local anesthesia was not necessarily given lack of sensation at the site. Utilizing a large bore needle, Serosanguinous material was immediately encountered. All serosanguinous material was expressed and removed. The blister roof was left intact to act as a protective barrier. It was dressed with a dry sterile dressing. Patient was instructed to keep this clean, dry, and intact until tomorrow. Patient was asked to change this dressing daily by applying a dry sterile dressing. All questions were answered, and patient was told to contact us right away with any other questions. The patient was given a follow up appointment.

Insert Bunion Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot the first metatarsal was deviated medially with the hallux deviated laterally. A prominent medial eminence was present consistent with a hallux abductovalgus deformity. Evidence of Bursitis: [No, Yes] Associated Sesamoid Pain: [No, Yes] Structural Hallux Limitus Deformity: [No, Yes] Functional Hallux Limitus Deformity: [No, Yes] Evidence of Hypermobility: [No, Yes] Evidence of Crepitation: [No, Yes] Hallux Interphalangeus: [No, Yes] Joint Tracking: [No, Yes] Subjective Pain Level (NRS Scale) RIGHT: [0-10] Subjective Pain Level (NRS Scale) LEFT: [0-10] Additional Findings: [N/A]

Insert Bunion Measurements

Intermetatarsal angle (IMA): [Less Than 9 Degrees] Hallux Abductus Angle (HAA): [Less Than15 Degrees] Proximal Articular Set Angle (PASA): [Less Than 15 Degrees] Distal Articular Set Ankle (DASA): [Less Than 7.5 Degrees] Hallux Interphalangeal Angle (HIA): [Less Than 10 Degrees] Tibial Sesamoid Position (TSP): [Position 1] Metatarsus Adductus Angle (MAA): [Approximately 22 Degrees]

Insert Bunion Plan

The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms with discussion of the use of custom made functional orthotic devices to control their biomechanical abnormalities, reduce stress and strain throughout the 1st MPJ, slow the progression of the HAV deformity, and help prevent surgical intervention. The surgical options were briefly discussed with the patient. Explanation that the orthotic devices will help to rebalance the abnormal forces across all planes of the 1st MPJ causing the progressive misalignment as well as help to rebalance intrinsic and extrinsic musculature throughout the lower extremity. Proper shoe gear was reviewed with the patient. A series of 1st MPJ range of motion exercises were reviewed and demonstrated to prevent long term joint stiffness and arthritis.

Insert Bursitis Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals pain with palpation directly over the anatomic bursa consistent with acute bursitis. Location of Bursitis: [Location] Presence of Edema: [No, Yes] Presence of Warmth: [No, Yes] Signs of Infection: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Bursitis Plan

I discussed the etiology of bursitis and the proposed treatment plan. I explained that bursitis is an extremely common condition that usually affects patients with their given foot type. The abnormal stresses around the affected joint causes inflammation and associated pain. I explained that bursitis is usually caused by overuse, repetitive movements, or long periods of pressure to the affected area during their daily activity. Naturally, we discussed temporary modification of their daily activities to reduce the discomfort and promote healing. The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities, reduce stress and strain on the joints and intrinsic musculature of the foot. I discussed the conservative treatment options with the patient including: RICE, use of anti-inflammatories, modification of current activity and wearing supportive shoe gear.

Insert Left Pneumatic CAM Walker

A LEFT prefabricated Pneumatic Ankle-Foot Orthosis, (Aircast Foam Walker) (L4361) was dispensed and applied at this visit. Due to the patient's diagnosis and related symptoms this is medically necessary for treatment. The function of this device: (1) to restrict and limit motion, (2) provide stabilization, (3) immobilization, and (4) compression to the affected area. There is also edema of the lower extremity present. The presence of edema can delay healing and contribute to pain. The goals and function of this device were explained to the patient at length. Upon examination, the device appeared to be fitting well. The patient was shown how to properly apply, wear, and care for the device. The patient will wear this while ambulating. The rigidity of this brace is sufficient to provide the stabilization needed for healing. This brace extends above the ankle and is fastened around the lower leg. The patient demonstrated their ability to properly apply the device without difficulty. The pneumatic function of the brace was inflated to proper level to address the edema that was present. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information were dispensed along with the 26 Durable Medical Equipment Supplier Guidelines.

Insert CAM Walker RIGHT

A RIGHT prefabricated Pneumatic Ankle-Foot Orthosis, (Aircast Foam Walker) (L4361) was dispensed and applied at this visit. Due to the patient's diagnosis and related symptoms this is medically necessary for treatment. The function of this device: (1) to restrict and limit motion, (2) provide stabilization, (3) immobilization, and (4) compression to the affected area. There is also edema of the lower extremity present. The presence of edema can delay healing and contribute to pain. The goals and function of this device were explained to the patient at length. Upon examination, the device appeared to be fitting well. The patient was shown how to properly apply, wear, and care for the device. The patient will wear this while ambulating. The rigidity of this brace is sufficient to provide the stabilization needed for healing. This brace extends above the ankle and is fastened around the lower leg. The patient demonstrated their ability to properly apply the device without difficulty. The pneumatic function of the brace was inflated to proper level to address the edema that was present. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information were dispensed along with the 26 Durable Medical Equipment Supplier Guidelines.

Insert Cavus Foot Exam

Biomechanical examination of the patient in the standing position revealed oversupination and increased arch height noted on the [RIGHT, LEFT, BILATERAL] lower extremity consistent with a cavus foot deformity. Forefoot Abduction (Peek-A-Boo Sign): [No, Yes] Rigid Plantarflexed 1st Ray: [No, Yes] Flexible Plantarflexed 1st Ray: [No, Yes] Pseudo-Equinus: [No, Yes] Ankle Joint Equinus: [No, Yes] Evidence of Lateral Ankle Instability: [No, Yes] Subtalar Joint Pain: [No, Yes] Plantar Fascia Pain: [No, Yes] Achilles Tendon Pain: [No, Yes] Various Ankle Deformities: [No, Yes] Coleman-Block Test: [Reducible, Nonreducible] Rearfoot Resting Calcaneal Stance Position (RCSP) RIGHT: [Value]° Resting Calcaneal Stance Position (RCSP) LEFT: [Value]° Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert CDFE

Right DP pulse \_\_\_\_\_\_\_\_. Left DP pulse \_\_\_\_\_\_\_\_\_. Right PT pulse \_\_\_\_\_\_\_\_. Left PT pulse \_\_\_\_\_\_\_\_\_. Capillary refill time is immediate to all toes bilateral. There is no edema bilateral lower extremity. Protective sensation at all 10 places tested bilateral intact as tested with 5.07 / 10g monofilament. Vibratory sensation intact bilateral as tested with tuning fork. Deep tendon reflexes intact bilateral. Sharp / dull sensation and differentiation intact bilateral. Hair growth is [normal, decreased] bilateral lower extremity. Skin texture is [normal, thin and shiny] bilateral lower extremity. Skin pigment is [normal, pale, dark] bilateral lower extremity. Skin color is [normal, reddish] bilateral lower extremity. Interdigital skin is [normal, macerated] bilateral lower extremity. Calluses are [not present, present at \_\_\_\_\_\_\_]. Skin temperature is [normal, cool, cold] bilateral lower extremity. Muscle strength bilateral ankle joint dorsiflexion is \_\_\_\_\_\_\_\_\_\_\_. Muscle strength bilateral ankle joint plantarflexion is \_\_\_\_\_\_\_\_\_\_\_. Lesser digital contracture is [absent, present] on the left. Lesser digital contracture is [absent, present] on the right. Boney prominence of the medial aspect of the first metatarsal head is [absent, present] on the left. Boney prominence of the medial aspect of the first metatarsal head is [absent, present] on the right.

Insert CDFE Plan

Reviewed diabetic foot care with the patient. Explained the role that diabetes can play in foot pathology. Discussed the importance of glycemic control and nutrition and the roles they play in preventing diabetic foot pathology, infection, and amputation. Reviewed the importance of never walking barefoot. Discussed steps in keeping feet clean and dry and nightly foot exams. Explained to the patient that if they ever see anything abnormal, discolored, or concerning to let us know right away.

Insert Chief Complaint Abscess

The patient presents to the office today complaining of redness and swelling on the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Achilles Tendon

The patient presents to the office today complaining of pain at the back of the [RIGHT, LEFT, BILATERAL] heel. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Ankle Sprain

This patient presents with a chief complaint of pain in their ankle following a sprain. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Arthritis

This patient presents with a chief complaint of joint pain. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint At Risk Foot Care

The patient presents today for at risk foot care. Having this performed by an unskilled professional places this patient at risk. The patient is in need of professional care. This patient is [negative, positive] for diabetes. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Blister

The patient presents to the office today complaining of a painful blister on the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Bunion

The patient presents to the office today complaining of a bunion deformity on the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Diabetes

The patient presents for a comprehensive diabetic foot exam and at risk foot care. This patient is diabetic. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint EPAT

The patient presents to the office today for EPAT therapy. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Flat Foot

The patient presents to the office today complaining of flat feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Foreign Body

The patient presents to the office today complaining of a painful foreign body on the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Fracture

The patient presents to the office today complaining of an extremely painful area on the [RIGHT, LEFT, BILATERAL] foot concerned about a possible fracture. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Ganglion

The patient presents to the office today complaining of a lump on the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Gout

The patient presents to the office today complaining of a red, warm, and extremely painful joint on the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Hallux Limitus

The patient presents to the office today complaining of a painful big toe joint on the [RIGHT, LEFT, BILATERAL] foot/feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Hammertoe

The patient presents to the office complaining of a painful contracted toe on the [RIGHT, LEFT, BILATERAL] foot/feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Hematoma

This patient presents with a chief complaint of pain and swelling of the [RIGHT, LEFT, BILATERAL] foot/feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Hyperhidrosis

The patient presents to the office complaining of sweaty feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Ingrown

This patient presents with a chief complaint of pain and swelling from an ingrown nail. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Ingrown Chronic

This patient presents with a chief complaint of pain and swelling from a recurrent ingrown nail. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Ingrown Follow Up

This patient presents for follow up of an ingrown nail Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Ingrown Wedge

This patient presents with a chief complaint of pain and swelling from an ingrown nail. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L One Nine Zero Two Bilateral

This patient presents today for dispensation of an ankle brace for both ankles. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L One Nine Zero Two LEFT

This patient presents today for dispensation of an ankle brace for the left ankle Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L One Nine Zero Two RIGHT

This patient presents today for dispensation of an ankle brace for the right ankle. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L One Nine Zero Six Bilateral

This patient presents today for dispensation of an ankle brace for both ankles. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L One Nine Zero Six Left

This patient presents today for dispensation of an ankle brace for the left ankle. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L One Nine Zero Six right

This patient presents today for dispensation of an ankle brace for the right ankle. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L Four Three Six One Left

This patient presents today for dispensation of Pneumatic Ankle-Foot Orthosis left. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L Four Three Six One Right

This patient presents today for dispensation of Pneumatic Ankle-Foot Orthosis right. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L Four Three Nine Seven Bilateral

This patient presents today for dispensation of a plantar night splint for both feet and legs. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L Four Three Nine Seven Left

This patient presents today for dispensation of a plantar night splint for left foot and leg. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint L Four Three Nine Seven Right

This patient presents today for dispensation of a plantar night splint for right foot and leg. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Metatarsalgia

The patient presents to the office today complaining of pain in the ball of the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.]

Insert Chief Complaint Multiple Skin Lesion

This patient presents with a chief complaint of multiple skin lesions. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Mycotic Nails

The patient presents with a chief complaint of toenails that are thick, painful, discolored, brittle, and difficult to manage on the [RIGHT, LEFT, BILATERAL] foot/feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Neuroma

The patient presents to the office complaining of pain on the ball of the [RIGHT, LEFT, BILATERAL] foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Neuropathy

The patient presents to the office complaining of numbness [RIGHT, LEFT, BILATERAL] foot/feet. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Peroneal Tendonitis

This patient presents with chief complaint of pain in the outer side of the foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Sesamoiditis

The patient presents with pain underthe ball of their foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Sinus Tarsitis

The patient presents with pain on the outer side of their foot. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Skin Lesion

This patient presents with a chief complaint of a skin lesion. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Skin Substitute

The patient presents for application of skin substitute to their wound. Factors complicating wound healing and what is being done to address each of them: [ ]. Complications of the ulcer that have been addressed and resolved prior to today: [ ] Treatments attempted to date that have failed [ ]. I suspect the reason the ulcer has not responded to attempted treatments to date is [ ]. Etiology of the wound [ ]. Nutritional status [ ]. Tobacco use [ ]

Insert Chief Complaint Ulcer

This patient presents with a chief complaint of a wound. Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Chief Complaint Wart

This patient presents with a chief complaint of plantar wart(s). Nature of Pain: [Describe: Throbbing, Achy, Numb, Burning, etc.] Location: [Location] Duration: The pain has been present for [Duration] Onset: The onset was [Acute, Insidious, Traumatic] Course: The course has been [Worsening, Improving, Unchanged] Aggravating Factors: [Ambulating, Sports, Shoes, Cold Weather, etc.] Severity: The patient rates the pain [0-10] on the NRS Scale. Previous Treatments: [Ice, NSAIDs, Rest, OTC Orthotics, etc.] Additional HPI: [N/A]

Insert Class Findings Exam

The patient has the following class findings:[Class A: non-traumatic amputation of foot] [Class B:] [Absent PT pulse] [Absent DP pulse] [Advanced trophic changes with] [decrease or absence of hair growth, nail changes, skin pigment changes, thin or shiny skin texture, rubor or redness of the skin] [Class C:] [Claudication, Temp changes-cold feet, edema, paresthesia, burning] (Q7= one Class A, Q8= two class B, Q9=once class B and two class C)

Insert Complicated Abscess Plan

The suspected etiology of the abscess was with discussed the patient. Discussed different treatment options, including the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. After reviewing these options, I explained my recommendation to perform an incision and drainage (I&D) of the complicated abscess {CPT 10061} at length. The potential risks, potential benefits, and possible complications of the proposed procedure were explained. Patient understood and asked to have this performed. The abscess area was marked and an informed consent was signed by the patient. Patient was already properly positioned in the chair for ideal access to the site. The integument overlying the abscess was first prepped with a betadine scrub. The area was then draped. The area for anticipated incision had been previously marked. Local anesthesia was not necessarily given lack of sensation at the site. Utilizing a #15 scalpel blade an incision was made through the abscess parallel to the neurovascular structures. Drainage and purulent material was immediately encountered. All purulent material was expressed. A sample was obtained at that time and sent for both culture and sensitivity. All necrotic and nonviable tissue was removed. The area was then copiously irrigated with multiple saline flushes. Hemostasis was achieved with pressure, a drain was placed, and the site was packed open. Patient was asked to change this dressing daily by applying a dry sterile dressing. Instructions regarding how to handle the drain were given. All questions were answered, and patient was told to contact us right away with any other questions. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Diabetes Plan

A lengthy discussion about their diabetes took place in the office during today´s visit. I explained the diagnosis, etiology, pathophysiology, and management. I explained that diabetes is a long-term metabolic disorder characterized by high blood sugar and insulin resistance. I educated the patient on the long-term complications from high blood sugar including: heart disease, stroke, diabetic retinopathy (which can result in blindness), kidney failure, and peripheral neuropathy leading to ulceration and subsequent amputations. I explained how high blood glucose can affect the vascular system and peripheral nerves. General lifestyle recommendations were made including: low glycemic index and low carbohydrate diet, regular optometrist appointments, tight regulation of their glucose, never walk around barefoot, perform daily inspections of their feet either directly or with an extension mirror, regular exercise, do not attempt to cut their own toenails or trim their own calluses, and the use of a daily moisturizing lotion to keep their skin hydrated. This will prevent cracking of the skin which can lead to secondary bacterial infections

Insert Dystrophic Nail Exam

Toenails [1L, 2L, 3L, 4L, 5L, 1R, 2R, 3R, 4R, 5R] are thickened consistent with nail dystrophy

Insert EPAT Plan

An EPAT treatment was performed today after the painful area was first identified by clinical exam. Conductive gel was placed over the area of maximal tenderness and a unique set of pressure waves was delivered in the appropriate frequency & duration per protocol. Treatment intensity was titrated to produce a consistent 6-7/10 pain level during the treatment. I explained to the patient that mild erythema, ecchymosis, and edema are possible side effects of EPAT. I explained that maximal therapeutic effects of EPAT may take up to 2 months. RTO 1 week.

Insert Erythasma Exam

In the [first, second, third, fourth] interspace of the right foot and the [first, second, third, fourth] interspace of the left foot there are well defined pink/brown patches of skin with mild scaling and superficial fissures. A Wood´s lamp examination reveals fluorescence of a pinkish/red color in these areas.

Insert Erythasma Plan

Reviewed erythasma diagnosis with the patient and explained exactly what it is. Discussed potential etiologies and treatment options. We discussed the options of topical antimicrobial, oral antimicrobial, and red light photodynamic therapy. We reviewed each of these options. We discussed potential advantages and disadvantages of these different treatment options. We also discussed potential risks and complications of both the diagnosis and these different treatment options. The patient had some questions regarding this discussion and I answered all of them. After this discussion, I explained the importance of keeping this area clean with antimicrobial soap and drying well after cleaning. We will start with topical erythromycin. See instructions in below e-Rx. Patient was advised to follow these instructions and that they should expect to start to see improvement after using this for a couple days. Asked them to let us know if this does not start to improve after a couple days of treatment or if it gets worse in any way or if they notice any similar discoloration elsewhere on their body. Also asked them to let us know right away if they begin to feel ill or experience any nausea, vomiting, fever, or chills. Follow up one week.

Insert Excisional Biopsy Plan

Operative Report: Surgeon: [Provider], DPM Assistants: None Preoperative Diagnosis: Soft Tissue Neoplasm [RIGHT, LEFT] Foot Postoperative Diagnosis: Soft Tissue Neoplasm [RIGHT, LEFT] Foot Procedure: Excision of Skin Neoplasm [RIGHT, LEFT] Foot Anesthesia: 6cc of 1% Lidocaine (With Epinephrine) Hemostasis: Local Anesthetic With Epinephrine Estimated Blood Loss: [ ]cc Materials: [ ] Pathology: Soft Tissue Complications: None After a very lengthy discussion with the patient apprising them of the risks, benefits, alternative treatment options, and possible complications of the proposed procedure an appropriate informed consent was signed. The patient demonstrated full understanding of the procedure and the possible complications that could result. These complications were explained to the patient at length. All questions were answered to the patient´s full satisfaction prior to starting the procedure. Informed consent was obtained. This patient was brought into the procedure room and placed on the treatment chair in the supine position. Local anesthesia was obtained utilizing a total of 6cc of 1% lidocaine with epinephrine in a local infiltration block fashion. The surgical site was then prepped, scrubbed, and draped in the usual sterile fashion. Attention was then directed to the aforementioned soft tissue lesion. Utilizing a #15 blade scalpel, the keratotic covering was sharply debrided from the area overlying the lesion. A hyfrecator was then utilized to ablate the lesion. The #15 blade scalpel and a sterile curette was then utilized to clear the base. The hyfrecator was used once again to cauterize the base. Close inspection of the wound area shows no further abnormal tissue. Antibiotic ointment was placed over the operative site followed by a multilayer bandage. Excellent capillary refill time and palpable pedal pulses were noted upon completion of the procedure. Condition: The patient tolerated the procedure well without any complications. The patient was instructed to keep the dressing clean, dry, and intact. I explained the importance of not getting the dressing wet. Sponge bathing was recommended. The patient was scheduled a follow up appointment but was instructed to call the office with any questions or concerns they have.

Insert Flat Foot Exam

Biomechanical examination of the patient in the standing position revealed overpronation [RIGHT, LEFT, BILATERAL] with collapse of the medial arch and calcaneal valgus. Single Heel Rise Ability: [No, Yes] Mobile Rear Foot: [No, Yes] Subtalar Joint Pain: [No, Yes] Ankle Joint Pain: [No, Yes] Posterior Tibial Tendon Pain: [No, Yes] Peroneal Tendon Pain: [No, Yes] Plantar Fascia Pain: [No, Yes] Too-Many-Toe Sign: [No, Yes] Resting Calcaneal Stance Position (RCSP) RIGHT: [Value]° Resting Calcaneal Stance Position (RCSP) LEFT: [Value]° Ankle Joint Equinus: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Johnson & Strom Stage: [1-4] Additional Findings: [N/A]

Insert Flat Foot Plan

I explained the diagnosis, etiology, and proposed treatment plan with the patient at great length. Explained that their presenting pain is being caused by faulty foot mechanics during their gait. A gait examination took place during today´s office visit which confirms this. There is abnormal STJ pronation noted B/L. The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce stress and strain on the feet. The conservative treatment options were discussed with the patient which include: custom functional foot orthotics, ankle joint strengthening and range of motion exercises, physical therapy (focusing on strengthening and reducing inflammation), RICE, immobilization, anti-inflammatories, compression, and proper shoe modification.

Insert Flexor Tenotomy Plan

Operative Report: Surgeon: [Provider], DPM Assistants: None Preoperative Diagnosis: Reducible Hammertoe Deformity [LOCATION] Postoperative Diagnosis: Reducible Hammertoe Deformity [LOCATION] Procedure: Percutaneous Flexor Tenotomy [LOCATION] Hemostasis: Digital Ring Tourniquet Injectables: Digital Block Consisting of 3cc Lidocaine 1% Estimated Blood Loss: [ ]cc Materials: None Pathology: None Complications: None This patient was brought into the room and placed in the treatment chair in the supine position. Informed consent was obtained. As noted above, a digital block was given at the level of the metatarsal neck proximal to the surgical sites. A sterile ring tourniquet was then utilized to exsanguinate the surgical site. The foot was scrubbed, prepped, and draped in the usual sterile fashion. Confirmation of anesthesia was performed at this time. A small stab incision was made parallel to the long axis of the digit at the level of the PIPJ. The associated flexor tendon was transected (28010). Once the flexor tendon was completely transected the digit was extended. The area was then irrigated with sterile saline and the corresponding skin was repaired utilizing 4-0 Nylon suture. The tourniquet was then released and excellent capillary refill time was noted to the digit. The surgical digit was noted to be pink and warm to the touch. A multilayer sterile foot and ankle dressing was then applied. Oral and written instructions were dispensed to the patient. These instructions included: (1) Keep the dressing clean, dry, and intact at all times. (2) Do not to remove the dressing. (3) Do not get the dressing wet. Sponge bathing was recommended. The patient was scheduled a return appointment and was instructed to call the office with any questions or concerns.

Insert Foreign Body Plan

The area of suspected foreign body was scrubbed, prepped, and draped in the usual sterile fashion. The suspected area was first anesthetized utilizing 3cc of 1% lidocaine plain in a local infiltration block fashion. Utilizing a #15 blade scalpel and sterile pickups, deep exploration of the tissues beyond the level of the deep fascia was performed. Vital neurovascular structures were avoided to prevent further soft tissue trauma. After removal of the foreign body, close inspection of the surrounding soft tissue was carried out. No additional foreign substance(s) were noted. There was no evidence of deep space infection or abscess noted. The site was then copiously irrigated utilizing sterile saline. Antibiotic ointment was placed over the site and the foot was wrapped in a multilayer dressing. The patient was instructed to keep the dressing clean, dry, and intact. Instructed the patient to ensure the dressing does not get wet. Sponge bathing was recommended until the area heals. The patient was scheduled a follow up appointment but was given specific instructions to call the office with any questions or concerns they may have.

Insert Foreign Body Ultrasound Exam

Ultrasound examination of [Right foot, Left foot] reveals: A foreign body measuring [ ] cm located \_\_\_\_\_\_\_\_\_. [Negative, Positive] hypoechoic abscess formation surrounding the foreign body.

Insert Four Plus Callous Plan

At risk foot care with trimming of skin lesion greater than 4, utilization of a sharp instrumentation, the lesions were trimmed to level appropriate in conjunction with patient tolerance and medical standard of care. Each location of the lesions were referenced in the examination.

Insert Fracture Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals severe pain [LOCATION] concerning for underlying fracture. Obvious Deformity: [No, Yes] Evidence of Ecchymosis: [No, Yes] Evidence of Erythema: [No, Yes] Soft Tissue Edema: [No, Yes] Evidence of Compartment Syndrome: [No, Yes] Neurovascular Status Intact: [Yes, No] Ability to Ambulate: [No, Yes] Antalgic Gait: [No, Yes] Vibratory Pain: [No, Yes] Additional Findings: [ ]

Insert Fracture Plan

I reviewed the patient´s diagnosis and expected prognosis at length during today´s office visit. I personally reviewed the radiographs with the patient and pointed out the area of fractured bone. The basic tenants of fracture care were discussed with the patient at length. I have determined that RICE and immobilization are essential to reduce the acute inflammation and heal the involved area. I explained to the patient that bone usually takes (on average) 6-8 weeks to heal. Varying healing times are based on many factors such as: poor bone quality, systemic disease, and noncompliance with the immobilization protocol. All patient questions were answered at length.

Insert Full Thickness Ulcer Plan

The noted ulceration and the surrounding skin was first prepped with betadine. Utilizing a #15 blade scalpel and scissors, a sharp nonselective debridement of nonviable tissue was performed (11042) to remove necrotic tissue, devitalized tissue and fibrotic tissue from the wound bed. Debridement was carried out to the depth of the subcutaneous tissue. Hemostasis was obtained with pressure. The indication for this debridement was to attempt to remove all nonviable tissue to decrease risk of infection and promote healing. The goal is to achieve complete closure of the ulcer Bleeding was minimal and controlled by direct pressure. Procedural pain 0/10. Post-procedural pain 0/10. The ulceration was then covered with triple antibiotic ointment and a dry sterile dressing. There is an expectation that this treatment will substantially affect tissue healing and viability, reduce or control tissue infection, remove necrotic tissue, or prepare the tissue for surgical management. The ulcer is [stable] [improving] [worsening]. Anesthesia was [used, not used]. The expected frequency with which patient will need to be seen for this is [ ]

Insert Gait Exam

Gait Examination: Angle & Base of Gait: [Normal, Abnormal] Stride Length: [Equal, Unequal] Foot Drop: [No, Yes] Scoliosis: [No, Yes] Patellar Position: [Normal, Abnormal] Head Tilt: [Normal, Abnormal] Hip Level: [Normal, Abnormal] Shoulder Position: [Normal, Abnormal] Balance Difficulty: [No, Yes] Symmetrical Arm Swing: [No, Yes] Overpronation: [No, Yes] Early Heel Off: [No, Yes] Abductory Twist: [No, Yes] Additional Findings: [N/A]

Insert Ganglion Plan

The area of ganglion cyst was marked, and an informed consent was signed by the patient. The suspected etiology and proposed treatment plan for an aspiration of the ganglion cyst was explained to the patient at length. The risks, benefits, and possible complications of the proposed procedure was explained. The integument overlying the ganglion was first prepped with a betadine scrub. The area was then prepped and draped. The skin was first anesthetized by local infiltration of 6cc 1% lidocaine plain. Utilizing a large bore 18G needle the skin was punctured to release the contents of the ganglion cyst (20612). The high rates of recurrence following aspiration was explained to the patient at length. Antibiotic ointment and DSD were placed.

Insert Gout Exam

Examination of the [RIGHT, LEFT, BILATERAL] extremity reveals an extremely painful, edematous, and guarded joint with localized increased temperature and erythema consistent with acute gouty arthropathy. Pain 1st MPJ: [No, Yes] Pain Hallux IPJ: [No, Yes] Pain Retro-Achilles: [No, Yes] Pain Lateral TMTJ: [No, Yes] Pain Lesser Digits: [No, Yes] Signs of Infection: [No, Yes] Open Ulceration: [No, Yes] Tophaceous Discharge: [No, Yes] Subjective Pain Level (NRS Scale) RIGHT: [0-10] Subjective Pain Level (NRS Scale) LEFT: [0-10] Additional Findings: [N/A]

Insert Gout Plan

I discussed the diagnosis, etiology, and expected prognosis with the patient at length. I explained that acute gout is a form of inflammatory arthritis that results from a defective metabolism of uric acid in the blood. The excessive uric acid accumulates and creates swelling, tenderness, and painful range of motion. Treatment options include: anti-inflammatories (NSAIDs and Colchicine), injections, RICE, immobilization, and medications to control long-term levels of uric acid. I educated the patient on foods that are excessively high in purines (alcohol, hearts, herring, muscle, yeast, smelt, sardines, sweetbreads, liver, salmon, turkey, kidneys, and scallops) and recommended diet modification. I advised the patient to add vegetables, cherries, and strawberries into their daily diet as these foods have been shown to naturally lower uric acid.

Insert Graduate CAM Walker Plan

The patient appears to be doing very well clinically and I am recommending they start transitioning from the CAM Walker they have been wearing. They will be transitioned into an Active Ankle brace due to the residual yet improved discomfort they are still experiencing. Detailed instructions on proper transition from the CAM Walker into the Active Ankle brace were discussed. They were instructed to transition by approximately 1 hour per day over the next week. If they are not having any discomfort, they can wear the Active Ankle brace exclusively. If the pain persists with the transition, I have instructed them to return back into the CAM Walker until their next follow up.

Insert Hallux Limitus Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot there appears to be a decreased range of motion at the 1st metatarsophalangeal joint consistent with hallux limitus/rigidus deformity. Dorsiflexion 1st MPJ RIGHT: [ ] Degrees Dorsiflexion 1st MPJ RIGHT: [ ] Degrees Plantarflexion 1st MPJ LEFT: [ ] Degrees Plantarflexion 1st MPJ LEFT: [ ] Degrees Palpable Osteophyte Development: [No, Yes] Evidence of Crepitation: [No, Yes] Interphalangeal Joint Pain: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [ ]

Insert Hallux Limitus Plan

Reviewed hallux limitus diagnosis with the patient and explained exactly what it is. Discussed potential etiologies and treatment options. We discussed topical anti-inflammatory, steroid injection, oral NSAID, orthotic with a Morton extension, stiff-soled shoe, avoiding shoes with a higher heel, ice, physical therapy, and even surgery only if other options fail. We reviewed each of these options. We discussed potential advantages and disadvantages of these different treatment options. We also discussed potential risks and complications of both the diagnosis and these different treatment options. I discussed shoe gear recommendations.

Insert Hammertoe Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot revealed abnormal contractures at the [PIPJ, DIPJ, Both PIPJ & DIPJ] consistent with a hammertoe deformity. Digit(s) Observed: [1-5] Flexibility: [Flexible, Semi-Flexible, Rigid] Associated MPJ Contracture: [No, Yes] Adductovarus: [No, Yes] Lachman Exam: [Negative, Positive] Stressed ROM of MPJ: [Normal, Abnormal] Associated Plantar Metatarsal Head Pain: [No, Yes] Flexor Stabilization: [No, Yes] Flexor Substitution: [No, Yes] Extensor Substitution: [No, Yes] Associated Skin Pathology: [No, Yes] Additional Findings: [ ]

Insert Hammertoe Plan

The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities, reduce stress and strain on the intrinsic musculature of the foot. I discussed the various etiologies of hammertoes with the patient at great length. Conservative treatment options including: orthotic devices, cortisone injections, strapping and splinting of the digits, toe crests, and silicone toe caps were discussed with the patient at great length. Surgical corrective procedures including PIPJ arthroplasty vs. arthrodesis with internal fixation were discussed as potential options if conservative efforts are unsuccessful.

Insert Hematoma Plan

The suspected etiology of the hematoma was discussed with the patient. Discussed different treatment options, including the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. After reviewing these options, I explained my recommendation to perform an incision and drainage (I&D) of the hematoma {CPT 10140} at length. The potential risks, potential benefits, and possible complications of the proposed procedure were explained. Patient understood and asked to have this performed. The hematoma area was marked and an informed consent was signed by the patient. Patient was already properly positioned in the chair for ideal access to the site. The hematoma site was prepped with a betadine scrub. The area was then draped. The area for anticipated incision had been previously marked. Local anesthesia was not necessarily given lack of sensation at the site. Utilizing a #15 scalpel blade an incision was made through the hematoma parallel to the neurovascular structures. Serosanguinous material was immediately encountered. All serosanguinous material was expressed and removed. The area was then copiously irrigated with multiple saline flushes. Hemostasis was achieved with pressure, a drain was placed, and the site was packed open. It was dressed with a dry sterile dressing. Patient was instructed to keep this clean, dry, and intact until tomorrow. Patient was asked to change this dressing daily by applying a dry sterile dressing. Instructions regarding how to handle the drain were given. All questions were answered, and patient was told to contact us right away with any other questions. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Home Exercise Plan

Home physical therapy exercises, both oral and written were reviewed and demonstrated to re-establish foot function and improve tolerance to load during their gait cycle. Ankle joint range of motion exercises including the "alphabet" technique and the "full-circling" method was demonstrated and performed by the patient. It was advised that the patient should perform these exercises at least 3 times per day without interruption. Muscle group strengthening exercises for inverters, everters, dorsiflexors, and plantarflexors were demonstrated and performed by the patient. It was instructed that these exercises should also be performed at least 3 times per day. The patient should perform "wall & stirrup" stretches to lengthen the calf musculature and promote normalized gait. I recommend the patient roll their affected foot on a frozen water bottle to stretch and ice the plantar fascia. These exercises can be combined with "marble grabs" and "towel scrunches" to stretch the intrinsic foot musculature. The patient demonstrated their ability.

Insert HPI

Nature: the problem is described as [aching, burning, swollen, tender, throbbing, tingling, sharp, dull]. Location: the problem is located at [location]. Duration: the pain has been present for [unknown duration, yesterday, a few days, week, months]. Onset: the onset was [acute, insidious, non-traumatic, slow, sudden, traumatic] Course: the course has been [worsening, improving, unchanged, exacerbating and remitting] Aggravating Factors: [ambulating, climbing, cold weather, exercise, shoes, standing, working] Previous Treatments: [Ace wrap, ice, ankle support, orthotics, decreased activity, evaluation by another doctor]

Insert Hyperhidrosis Plan

The diagnosis, etiology, and expected prognosis of the patients presenting hyperhidrosis (& bromhidrosis) was discussed with the patient at length. Several therapeutic modalities including: proper hygiene and antibacterial agents, drying agents, diet modification, changing socks daily, rotating shoe gear, the use of foot powders and sprays, wearing sandals during the warm weather, and the use of disposable moisture-wicking insoles (Summer Soles) for the shoes.

Insert Ingrown Avulsion Plan

The suspected etiology of the ingrown toenail was discussed with the patient, including different treatment options, the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. Among the potential disadvantages of avulsion that were discussed included the possibility of the nail growing back dystrophic, thickened, or discolored and that this could be permanent. After reviewing these options, I explained my recommendation to perform a partial nail avulsion {CPT 11730} to remove the offending border at length. The potential risks, potential benefits, and possible complications of the proposed procedure were explained. Patient understood and asked to have this performed. The ingrown site was marked and an informed consent was signed by the patient. Patient was already properly positioned in the chair for ideal access to the site. The ingrown site was prepped with a betadine scrub. The area was then draped. The affected border had been previously marked. 6 cc of 1% lidocaine without epinephrine was infiltrated at the base of the toe in the standard H-block fashion. Verification of anesthesia was performed after which a tourniquet was applied to the base of the toe. A nail spatula was first used to free the border of the toe from the proximal nail fold, underlying nail bed, and the associated nail groove, including all surrounding soft tissue. A nail nipper was then used to separate the ingrown portion of the toenail from the rest of the nail plate. This border was then atraumatically removed utilizing a hemostat. All offending border was removed with no spicule left behind. There was purulence encountered. The area was then copiously irrigated with saline solution. The tourniquet was removed after verifying that all pathologic nail tissue was removed, and an antibiotic-impregnated non-stick compression dressing applied to the toe. Good capillary refill time was noted prior to completion. Patient was instructed to keep this clean, dry, and intact until tomorrow. Patient was asked to change this dressing daily with a dry sterile dressing. All questions were answered, and patient was told to contact the office right away with any other questions. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Ingrown Exam

Examination Reveals an Ingrown Toenail: Digit: [1,2,3,4,5] Foot: [RIGHT, LEFT, BILATERAL] Border: [Medial, Lateral, Bilateral] Incurvation: [No, Yes] Excessively Wide Nail Plate: [No, Yes] Evidence of Self Care: [No, Yes] Signs of Infection: [No, Yes] Drainage: [No, Yes] Signs of Edema: Yes Hypertrophy of Labial Fold: [No, Yes] Granuloma Formation: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Ingrown Follow Up Exam

Examination of Previous Surgical Site: Procedure Performed: [Avulsion, Matrixectomy, Labioplasty] Postoperative Bandage: [Clean, Dry, & Intact] Status: [Resvolved, Improved, Worsened, Status Quo] Drainage: [None, Mild, Moderate, Heavy] Signs of Infection: [No, Yes] Foreign Debris: [No, Yes] Residual Spicule: [No, Yes] Seroma Formation: [No, Yes] Hypergranulation: [No, Yes] Patient Compliance: [Satisfactory, Moderate, Poor] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Ingrown Follow Up Plan

I reexamined and evaluated the patient and the previous surgical site appears to be healing uneventfully without signs of complication.

Insert Injection Plan

The site was cleansed with betadine and an injection was performed consisting of 0.5cc of Kenalog-40 and 1cc of 1% Lidocaine Plain was administered into the affected area [site of injection] . Possible complications such as hypopigmentation, photosensitivity, increased blood sugars, rupture of ligaments and/or tendons, steroid flare, and infection were discussed. Instructed the patient to temporarily modify their activity level.

Insert Labiaplasty Plan

After a lengthy discussion with the patient advising them of the etiology and possible treatment options with respect to their painful ingrown toenail, a wedge-type resection (11765) was performed in the office today. The risks, benefits, and possible complications were discussed with the patient at length. Informed consent was obtained. The digit was first anesthetized utilizing a total of 6cc of 1% lidocaine plain in the standard digital block fashion. The involved digit was then prepped with betadine in the usual aseptic fashion. A digital toe tourniquet was placed on the involved digit. Utilizing a sterile English anvil, a wedge shaped portion of the offending incurvated nail was removed. The labial fold was then remodeled utilizing a sterile currette by pushing the hypertrophied tissue away and proximal from the offending nail border. Hyper-granulation tissue and remaining hypertrophied labial fold was removed with a sterile tissue nipper. The digital tourniquet was removed. The tourniquet was removed, and an antibiotic-impregnated non-stick compression dressing was applied to the toe. Good capillary refill time was noted prior to completion. The surgical site was cleansed with alcohol and covered with antibiotic ointment and DSD. The patient was instructed to keep the surgical site clean and dry for 2 weeks and watch for signs of infection. All questions were answered, and patient was told to contact the office right away with any other questions. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Lymphedema Pumps Plan

Despite exercise, elevation and class 1 compression being applied, Stage 2/3 lymphedema is still present. I suspect fibrosis & scar tissue formation present at this time. Without intervention, gradual thickening of the skin will ensue, and the limb will continue to increase in size. At this point in time, I am recommending and prescribing the patient lymphedema pump. The purpose of these lymphedema pumps is to halt progression of the disease and improve patient symptoms. Specifically, treatment focuses not only on the reduction of fluid volume but also on the softening of tissue fibrosis, reducing the risk of open ulceration and infection, and maintaining/enhancing the function of the overall limb. The patient had ample opportunity to ask questions.

Insert Matrixectomy Plan

I discussed the diagnosis, etiology, and possible treatment options during today´s office visit. Due to the chronic nature of this ingrowing nail, I am recommending permanent removal by means of matrixectomy. I discussed the risks, complications, and expected recovery course with the patient. The patient expressed full understanding that the nail margin, or spicules of it, may re-grow and may become symptomatic again in the future. I explained and educated the patient about the overall success rates of this procedure according to the most current literature. After appropriate informed consent and verifying the correct digit and border, the toe was anesthetized with 6 cc of 1% lidocaine plain without Epinephrine in the standard H-block fashion. The digit was cleansed with betadine, prepped and draped in the usual aseptic manner. Verification of anesthesia was performed after which a tourniquet was applied to the toe. Antibiotic ointment was placed proximal to the nail plate over the eponychium to protect the healthy skin from 89% phenol. The offending nail border was freed of the surrounding soft tissues utilizing a nail spatula. A sterile English Anvil was then utilized to cut and remove the offending nail border. Approximately 1/5th of the offending nail plate was removed. A sterile currette was utilized to ensure no remaining spicules remained prior to phenolization. The offending portion of the nail matrix was then permanently destroyed by performing a phenolization matrixectomy (11750). 3 applications of phenol (89% Carbolic Acid) was applied utilizing a cotton tipped applicator. This was performed in a fashion to ensure phenol did not violate surrounding healthy tissue. The area was then copiously irrigated with alcohol. The granuloma was cauterized with an application of silver nitrate. The tourniquet was removed after verifying that all pathologic nail tissue was removed, and an antibiotic-impregnated compression dressing applied to the toe itself. Good capillary refill time was noted prior to completion. Explicit oral and written postoperative instructions were dispensed to the patient. The patient was given specific instructions to call the office with any questions or concerns they may have. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Metatarsalgia Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot was painful with palpation to the plantar aspects of the metatarsal heads consistent with metatarsalgia. Metatarsal Heads Involved: [Location(s)] Forefoot Fat Pad Atrophy: [No, Yes] Ankle Joint Equinus: [No, Yes] Lachman Exam: [Negative, Positive] Associated Skin Lesions: [No, Yes] Evidence of Ulceration: [No, Yes] Subjective Pain Level (NRS Scale): [0-10]

Insert Metatarsalgia Plan

The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce the excessive pressure on the sub-metatarsal region. Additionally, I explained that night splints will stretch their Achilles tendon complex reducing excessive forefoot load during midstance. I explained to the patient that metatarsalgia is a generalized term used to describe a variety of conditions. I discussed temporary modification of physical activity to reduce the inflammation. I recommended icing 20 minutes on / 20 minutes off at least 3 times per day to reduce the acute inflammation over the next 24 hours. After 24 hours the patient can begin using their night splints and perform ankle joint range of motion exercises. A metatarsal offloading pad was placed on the affected extremity just proximal to the metatarsal heads. Customized-shaped moleskin was placed directly over the metatarsal heads to help reduce the friction in their shoe. All patient questions were answered.

Insert Mycotic Nail Exam

Each digital nail was examined and there was hypertrophy of the nail plate with yellow color, brittle texture, and malodorous subungual debris noted with nails [1L, 2L, 3L, 4L, 5L, 1R, 2R, 3R, 4R, 5R] consistent with onychomycosis and are each [painful, non painful] to palpation and ambulation. The patient's subjective pain level was a [1,2,3,4,5,6,7,8,9,10] on the NRS Scale.

Insert Nail Biopsy Plan

To confirm the presence of fungal elements, the affected nail and portion of nail bed was biopsied & cultured (11755) and sent to Pathology for KOH & PAS. The free edge of the affected nail was first debrided in length to prevent fungal colonization. A sterile currette was utilized to collect subungual debris in both the medial and lateral labial folds and free edge of the nail plate. RTO 2 weeks.

Insert Nail Debridement Greater Than Five Plan

Extensive nail debridement was performed using electric grinder to reduce the nail bulk and girth of the nail bulk to the level of expected reasonably normal nail thickness on each nail with mycotic pathology bilateral. There is greater than 5 nails noted with this pathology as noted in the exam, that were debrided extensively to reduce pain and discomfort along with secondary infections. This patient is at risk due to pathology evident and possible complications associated.

Insert Nail Debridement Less Than Five Plan

Extensive nail debridement was performed to reduce the nail bulk and girth of the nail bulk to the level of expected reasonably normal nail thickness on each nail with mycotic pathology bilateral. There is 5 or less nails as noted in the exam, with this pathology that were debrided extensively to reduce pain and discomfort along with secondary infections.

Insert Nail Debridement Plan

Extensive nail debridement was performed using electric grinder to reduce the nail bulk and girth of the nail bulk to the level of expected reasonably normal nail thickness on [1,2,3,4,5 R] [1,2,3,4,5 L] with mycotic pathology. The nails were debrided extensively [electrically, manually] to reduce the girth of each as well as reduce the risk of secondary infections. This patient has a systemic disease/condition [Diabetes, PVD, MS, etc] resulting in severe circulatory embarrassment with areas of diminished sensation in the patients legs of sufficient severity that the performance of that procedure by an unskilled or nonprofessional person would be hazardous to that patient. Debridement procedures were performed to remove all of the abnormal and/or diseased nail plate and debris of the infected nail beds. The appropriate foot care discussion with preventative care was explained to the patient. Follow up care was stressed.

Insert Nail Dystrophy Plan

Extensive nail debridement was performed to reduce the nail bulk and girth of the nail bulk to the level of expected reasonably normal nail thickness on each nail with dystrophic pathology bilateral. The pathology that was debrided extensively to reduce pain and discomfort along with secondary infections.

Insert Negative KOH Follow Up Plan

I reviewed the KOH report which was negative for obvious fungal elements. To prevent future fungal colonization of the reportedly traumatized toenail(s), provide adequate nail softening to facilitate reattachment, and attempt to restore a more normative cosmetic appearance I have recommended the patient start using topical antifungal BID. I discussed modification of the patient´s current shoe gear as this has been shown to contribute to the reported pathology.

Insert Nerve Biopsy Plan

An ENFD (Epidermal Nerve Fiber Density) biopsy (11104)(11105) was performed in the office today. Informed consent was obtained and the patient had the ability to ask questions prior to the procedure. An area 10cm above the lateral malleolus bilateral was anesthetized with 1cc Lidocaine 1%. Once anesthesia was obtained, each area was cleansed with betadine solution. A small punch biopsy (provided in the ENFD testing kit) was utilized to perform the biopsy. The tissue specimen was then placed in Zamboni's fixative. Pressure was temporarily held on each biopsy site. The area was then covered with antibiotic ointment and DSD. Postoperative instructions were explained to the patient at length. The patient will keep these areas covered until their scheduled follow up visit. They were instructed to call the office with any questions or concerns.

Insert Neuroma Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals radiating burning paresthesias with percussion of the forefoot consistent with a neuroma. Interspace Location: [LOCATION] Tinel Sign: [No, Yes] Valleix Phenomenon: [No, Yes] Mulder's Sign (Palpable Clicking): [No, Yes] Sullivan Sign: [No, Yes] Signs of Edema and/or Increased Warmth: [No, Yes] Signs of Ecchymosis: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Neuroma Plan

I explained the diagnosis, etiology, and proposed treatment plan with the patient at great length. Explained that their presenting pathology is being caused by a benign nerve tumor. The abnormal biomechanics of their feet (Excessive STJ pronation) and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce stress and strain on the nerve. The conservative treatment options were discussed with the patient which include: custom functional foot orthotics, cortisone injections, NSAIDS, RICE, immobilization, anti-inflammatories, and proper shoe modification.

Insert Neuroma Ultrasound exam

Ultrasound examination of [Right foot, Left foot, BILATERAL feet] reveals: a non-compressible hypoechoic mass of the [1,2,3,4] Interspace between the metatarsal head/neck. The ultrasound and physical exams are consistent with intermetatarsal neuroma. The neuroma measures [ ] mm.

Insert Neuropathy Plan

I reviewed the causes and effects of neuropathy with the patient at great length. I discussed with the patient the potential complications that include but are not limited to neuropathic ulcerations, chronic neurologic pain, burning symptoms, loss or diminished sensation to hands and feet, and the possible loss of balance from the disease process. A lengthy discussion with general recommendations about peripheral neuropathy ensued. Under no circumstances should the patient walk bare foot. The patient was instructed to perform daily foot and shoe checks to ensure the integrity of the skin and the absence of pre-ulcerative lesions. The patient was advised that under no circumstances should they cut their own toenails or trim any calluses.

Insert Night Splint BILATERAL

BILATERAL Static Ankle-Foot Orthosis, plastic, prefabricated (L4397), was dispensed and fitted at todays office visit. This patient has bilateral plantarflexion contracture of the ankle demonstrated by dorsiflexion on passive range of motion. These braces extend above the ankle joint, and in doing so, maintain dorsiflexion of the ankle. These braces control motion in the sagittal, frontal, and transverse planes to optimize dorsiflexion force on the ankle joint. The device will be utilized for the next six to eight weeks. I have determined that these night splints will decrease the patients presenting symptoms and that they are medically necessary. The function of this AFO is to serve as an anti-contracture device of the plantar fascia and Achilles tendon. Its purpose is to restrict and limit motion, reducing excessive stress and strain to the plantar fascia and Achilles tendon at its distal insertion. The goals of therapy are as followed: 1) To reduce the presenting pain and symptoms of post static dyskinesia. 2) Prevent non-weightbearing contracture of the Achilles tendon. Excessive contracture leads to increased forefoot pressure during the stance phase of gait which can lead to multiple pathologies. 3) Provide static stretch of the Achilles tendon. 4) Reduce and prevent plantar fascial symptoms. The goals and function of these devices were explained to the patient at great length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. the patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information along with DME standards were given to the patient with ample opportunity to ask any questions.

Insert Night Splint LEFT

LEFT Static Ankle-Foot Orthosis, plastic, prefabricated (L4397), was dispensed and fitted at todays office visit. This patient has bilateral plantarflexion contracture of the ankle demonstrated by dorsiflexion on passive range of motion. These braces extend above the ankle joint, and in doing so, maintain dorsiflexion of the ankle. These braces control motion in the sagittal, frontal, and transverse planes to optimize dorsiflexion force on the ankle joint. The device will be utilized for the next six to eight weeks. I have determined that these night splints will decrease the patients presenting symptoms and that they are medically necessary. The function of this AFO is to serve as an anti-contracture device of the plantar fascia and Achilles tendon. Its purpose is to restrict and limit motion, reducing excessive stress and strain to the plantar fascia and Achilles tendon at its distal insertion. The goals of therapy are as followed: 1) To reduce the presenting pain and symptoms of post static dyskinesia. 2) Prevent non-weightbearing contracture of the Achilles tendon. Excessive contracture leads to increased forefoot pressure during the stance phase of gait which can lead to multiple pathologies. 3) Provide static stretch of the Achilles tendon. 4) Reduce and prevent plantar fascial symptoms. The goals and function of these devices were explained to the patient at great length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. the patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information along with DME standards were given to the patient with ample opportunity to ask any questions.

Insert Night Splint RIGHT

RIGHT Static Ankle-Foot Orthosis, plastic, prefabricated (L4397), was dispensed and fitted at todays office visit. This patient has bilateral plantarflexion contracture of the ankle demonstrated by dorsiflexion on passive range of motion. These braces extend above the ankle joint, and in doing so, maintain dorsiflexion of the ankle. These braces control motion in the sagittal, frontal, and transverse planes to optimize dorsiflexion force on the ankle joint. The device will be utilized for the next six to eight weeks. I have determined that these night splints will decrease the patients presenting symptoms and that they are medically necessary. The function of this AFO is to serve as an anti-contracture device of the plantar fascia and Achilles tendon. Its purpose is to restrict and limit motion, reducing excessive stress and strain to the plantar fascia and Achilles tendon at its distal insertion. The goals of therapy are as followed: 1) To reduce the presenting pain and symptoms of post static dyskinesia. 2) Prevent non-weightbearing contracture of the Achilles tendon. Excessive contracture leads to increased forefoot pressure during the stance phase of gait which can lead to multiple pathologies. 3) Provide static stretch of the Achilles tendon. 4) Reduce and prevent plantar fascial symptoms. The goals and function of these devices were explained to the patient at great length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. the patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information along with DME standards were given to the patient with ample opportunity to ask any questions.

Insert Normal Nail Exam

Toenails [1L, 2L, 3L, 4L, 5L, 1R, 2R, 3R, 4R, 5R] are elongated

Insert One Callous Plan

At risk foot care with trimming of skin lesion x1, utilization of a sharp instrumentation, the lesion was trimmed to level appropriate in conjunction with patient tolerance and medical standard of care.

Insert Onychomycosis Plan

The etiology, proposed treatment plan, and the expected prognosis was discussed with the patient at length during today´s visit. It was explained to the patient that toenails on average grow approximately 1mm per month. It takes an entire toenail approximately one year to grow out completely. The affected nails were debrided in both length and thickness with an electric grinder. A lengthy discussion about the topical vs. oral treatment options for onychomycosis ensued. I educated the patient on the clinical success rates of topical therapy alone vs. topical and oral therapy combined. I explained that Lamisil would be the therapy of choice with confirmation of fungal elements in the nail plate. I explained that they would need to obtain blood work to evaluate the basic liver enzymes prior to being started on oral Lamisil. I explained the remote possibility of developing liver disease while on oral antifungal therapy. The oral treatment regimen consisting of Lamisil 250mg QD for 3 months followed by re-culture of the nail unit to ensure eradication of the infection. I explained that systemic antifungal therapies have success rates of 50-70%.

Insert Opioid Plan

I discussed at length with the patient why a Schedule II drug is being prescribed. The risks of 1. Developing a physical or psychological dependence on the controlled dangerous substance. 2. Risk of mixing opioid drugs with alcohol, benzodiazepines, other CNS depressants. 3. The risk of overdose. 4. The risk of driving or operating machinery. I have discussed the alternative therapies with the patient in great detail. The patient has no questions regarding its usage at this time.

Insert Orthotic Dispensing Plan

I reviewed the condition, etiology, and proposed treatment plan with the patient. I reeducated the patient on their abnormal biomechanics. We discussed the purpose of custom orthotics and their ability to control abnormal functioning biomechanics. The custom orthotic appliances were dispensed to the patient today after observing they properly and comfortably fitted in the patient's current shoe gear. Proper break-in instructions for the new orthotic appliances were discussed with the patient at length. The custom molded, fully functional orthoses fit the contour to each foot. They appear to fit in the patients presenting shoes. The calcaneus appears to be perpendicular to the weightbearing surface during stance. No overpronation. Follow-up three weeks for an official orthotic check.

Insert Orthotic Follow Up Plan

I reevaluated the patient's orthotics in both the weight-bearing and non-weight bearing position. They appear to be correcting the patient's biomechanical faults as anticipated. I have determined that no orthotic adjustments are necessary at this time. The orthotics appear to be controlling the patient's biomechanics & symptomatology and I have recommended that they continue to wear the devices on an indefinite basis with yearly orthotic checks to ensure functionality. The patient declines outpatient physical therapy, NSAIDs, or anti-inflammatories.

Insert Orthotic Plan

This device is fabricated from a three dimensional model of the patient´s own foot using [cast, foam impression, virtual true 3-D digital image]. These orthotics are a functional device, (reducing pathological forces) which has a molded deep heel cup (UCBL type) of 12mm and trim lines with substantial height to provide both medial and lateral directive forces to control the hind and fore foot. It also has intrinsic and extrinsic posts designed to control foot motion. This device will be made of a sufficiently rigid material to control function and reduce pathological forces. It´s intent is to reduce pain and disability as well as hopefully preclude the need for more aggressive treatments.

Insert Osteomyelitis Plan

Based on both clinical and/or radiographic evaluation, I have determined that the patient has acute osteomyelitis. I had an extensive discussion with the patient explaining both the conservative versus surgical treatment options for osteomyelitis. The option for an extended course of intravenous antibiotics which would be managed by infectious disease versus primary surgical resection of the bone was explained. I explained that an extended course of IV antibiotics offers no guarantee of permanent remission and discussed the possibility of future acute infection despite length of time post-treatment.

Insert Partial Thickness Ulcer Plan

The noted ulceration and the surrounding skin was first prepped with betadine. Utilizing a #15 blade scalpel and scissors, a sharp selective debridement of nonviable tissue was performed (97597) to remove hyperkeratotic rim, necrotic tissue, devitalized tissue and fibrotic tissue from the wound bed. Debridement was carried out to the depth of the dermis. Hemostasis was obtained with pressure. The indication for this debridement was to attempt to remove all nonviable tissue to decrease risk of infection and promote healing. The goal is to achieve complete closure of the ulcer Bleeding was minimal and controlled by direct pressure. Procedural pain 0/10. Post-procedural pain 0/10. The ulceration was then covered with triple antibiotic ointment and a dry sterile dressing. There is an expectation that this treatment will substantially affect tissue healing and viability, reduce or control tissue infection, remove necrotic tissue, or prepare the tissue for surgical management. The ulcer is [stable] [improving] [worsening]. A total of [ ] sq cm of dermis was removed. Anesthesia was [used, not used]. The expected frequency with which patient will need to be seen for this is [ ]

Insert Pediatric Exam

VASCULAR: Right DP pulse [ ] Left DP pulse [ ] Right PT pulse [ ] Left PT pulse [ ] Capillary refill time is [immediate, delayed] to all toes bilateral. There [is, is no] edema bilateral lower extremity. Hair growth is [normal, decreased] bilateral lower extremity. Skin temperature is [normal, cool, cold] bilateral lower extremity. NEUROLOGIC: Babinski sign [present, absent] BILATERAL. Deep tendon reflexes [intact, decrease] BILATERAL. DERMATOLOGIC: Skin texture is [normal, thin and shiny] bilateral lower extremity. Skin color is [normal, reddish] bilateral lower extremity. Interdigital skin is [normal, macerated] bilateral lower extremity. Calluses are [not present, present at \_\_\_\_\_\_\_]. ORTHOPEDIC: Muscle strength bilateral ankle joint dorsiflexion is [ ]. Muscle strength bilateral ankle joint plantarflexion is [ ] Muscle strength bilateral ankle joint inversion is \_\_\_\_\_\_\_\_\_\_\_. Muscle strength bilateral ankle joint eversion is [\_\_\_\_\_\_\_\_\_\_\_]. Lesser digital contracture is [absent, present] on the left. - Lesser digital contracture is [absent, present] on the right. - Boney prominence of the medial aspect of the first metatarsal head is [absent, present] on the left. - Boney prominence of the medial aspect of the first metatarsal head is [absent, present] on the right. - [positive, negative] forefoot adduction with Bleck classification [Normal heel bisector line through 2nd and 3rd toe webspace, Mild heel bisector line through 3rd toe, Moderate - heel bisector through 3rd and 4th toe webspace, Severe - heel bisector through 4th and 5th toe webspace] - Tibial torsion: [ ]° external rotation [Right, Left BILATERAL]. - Femoral anteversion: [ ]° internal rotation [Right, Left BILATERAL]. - Limb length: [ ] cm Right, [ ]cm Left - Genou[varum, varum, straight] BILATERAL - Resting Calcaneal stance position: [ ]° [inversion, eversion] on the right and [ ]° [inversion, eversion] on the left. - Dorsiflexion range of motion of the foot on the ankle is [increased, decreased, normal] [Right, Left, BILATERAL].

Insert Peroneal Tendon Exam

Examination of the peroneal tendons reveal pain on the [RIGHT, LEFT, BILATERAL] extremity(s) consistent with peroneal tendinitis. Peroneal Brevis Insertional Pain: [No, Yes] Retromalleolar Pain: [No, Yes] Peroneal Subluxation: [No, Yes] Peroneal Tubercle Pain: [No, Yes] 5th Metatarsal Shaft Pain: [No, Yes] Anterior Talofibular Ligament (ATFL) Pain: [No, Yes] Sinus Tarsi Pain: [No, Yes] Ankle Joint Pain: [No, Yes] Subjective Pain Level (NRS Scale) RIGHT: [0-10] Subjective Pain Level (NRS Scale) LEFT: [0-10] Additional Findings: [N/A]

Insert Peroneal Tendonitis Plan

I explained the diagnosis, etiology, and proposed treatment plan with the patient at great length. Explained that their presenting peroneal pathology is being exacerbated by faulty foot mechanics during their gait. A gait examination took place during today´s office visit which confirms this. The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce stress and strain on the peroneal tendons. The conservative treatment options were discussed with the patient which include: custom functional foot orthotics, cortisone injections, ankle joint strengthening and range of motion exercises, physical therapy, RICE, immobilization, anti-inflammatories, and shoe modification.

Insert Plantar Fascia Exam

Examination of the plantar fascia at the origin of the intrinsic musculature at the plantar medial calcaneal tubercle revealed pain with palpation [0] RIGHT & [0] LEFT. Examination along the medial band of the plantar fascia revealed pain with palpation [0] RIGHT & [0] LEFT. Defects and/or Fibromas Observed: [No, Yes] Edema and/or Increased Warmth: [No, Yes] Pain Medial-Lateral Compression of Calcaneus: [No, Yes] Ankle Joint Equinus: [No, Yes] Resting Calcaneal Stance Position (RCSP) RIGHT: [Value]° Resting Calcaneal Stance Position (RCSP) LEFT: [Value]° Additional Findings: [N/A]

Insert Plantar Fascia Ultrasound Exam

Ultrasound Examination of the [RIGHT, LEFT, BILATERAL] plantar fascia reveals: Plantar Fascia Appearance: [Normal, Abnormal] Plantar Fascia Thickness: RIGHT: [ ] mm LEFT: [ ] mm (Note: Normal ~less than 3.8 mm) Hypoechoic Changes: [No, Yes] Plantar Fascia Disruption/Tear: [No, Yes] Fusiform Nodular Thickening/Fibromatosis: [No, Yes] Additional Findings: [N/A]

Insert Plantar Fasciitis Plan

I reviewed in detail their conditions, etiologies, options for care, treatment plan and prognosis. Discussed both conservative and surgical care. A schedule for future care needs was explained. The patient verbalizes understanding of these instructions at this time. Explained to the patient that conservative therapies for plantar fasciitis tend to be successful about 85-90% of the time according to the most current literature. It was explained that failure to adhere to the entire treatment plan will decrease the overall success rate of conservative therapies. I recommended strict no barefoot. I explained that barefoot walking out of bed creates an excessive inflammation at the origin and within the plantar fascia due to its contracted nature during sleep. I have discussed modification of current activity and icing utilizing frozen water bottle stretches.

Insert Plantar Fasciitis Power Plan BILATERAL

I reviewed in detail their conditions, etiologies, options for care, treatment plan and prognosis. Discussed both conservative and surgical care. A schedule for future care needs was explained. The patient verbalizes understanding of these instructions at this time. Explained to the patient that conservative therapies for plantar fasciitis tend to be successful about 85-90% of the time according to the most current literature. It was explained that failure to adhere to the entire treatment plan will decrease the overall success rate of conservative therapies. I recommended strict no barefoot. I explained that barefoot walking out of bed creates an excessive inflammation at the origin and within the plantar fascia due to its contracted nature during sleep. I have discussed modification of current activity and icing utilizing frozen water bottle stretches. Two separate injections consisting of 0.5cc of Kenalog-40 and 1cc of 1% Lidocaine Plain was administered into the affected areas of the BILATERAL HEELS after appropriate cleansing. Possible complications such as hypopigmentation, photosensitivity, increased blood sugars, rupture of ligaments and/or tendons, steroid flare, and infection were discussed. Instructed the patient to temporarily modify their activity level. BILATERAL Ankle/Foot Strapping was applied to the lower extremity during today´s office visit (29540). The purpose of the strapping is to rapidly decrease the pain and inflammation present. Tape adhesive was first used on the affected limb(s). A series of 3-inch nylon tape was then applied around the posterior aspect of the calcaneus ensuring to plantarflex the first ray to recreate the medial longitudinal arch. A series of 3-inch strips were placed just distal to the calcaneal tubercles in the standard Campbell fashion to suspend the plantar fascia. The placement of the strapping was to provide restriction of movement of the feet, the longitudinal arch of the feet, and hold bilateral arches in their position of optimal function. The patient was sitting up with their legs hanging down and knees bent at a 90-degree angle. The subtalar joints were held in the neutral position. Upon completion, the neurovascular status of the distal feet and toes was checked and found to be normal. Instruction regarding how to care for these bilateral strappings were provided to the patient. BILATERAL Static Ankle-Foot Orthosis, plastic, prefabricated (L4397), was dispensed and fitted at todays office visit. This patient has bilateral plantarflexion contracture of the ankle demonstrated by dorsiflexion on passive range of motion. These braces extend above the ankle joint, and in doing so, maintain dorsiflexion of the ankle. These braces control motion in the sagittal, frontal, and transverse planes to optimize dorsiflexion force on the ankle joint. The device will be utilized for the next six to eight weeks. I have determined that these night splints will decrease the patients presenting symptoms and that they are medically necessary. The function of this AFO is to serve as an anti-contracture device of the plantar fascia and Achilles tendon. Its purpose is to restrict and limit motion, reducing excessive stress and strain to the plantar fascia and Achilles tendon at its distal insertion. The goals of therapy are as followed: 1) To reduce the presenting pain and symptoms of post static dyskinesia. 2) Prevent non-weightbearing contracture of the Achilles tendon. Excessive contracture leads to increased forefoot pressure during the stance phase of gait which can lead to multiple pathologies. 3) Provide static stretch of the Achilles tendon. 4) Reduce and prevent plantar fascial symptoms. The goals and function of these devices were explained to the patient at great length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. the patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information along with DME standards were given to the patient with ample opportunity to ask any questions. Based on today's examination I have recommended the patient be fitted for custom foot orthotics (CFO). These devices are medically necessary to alleviate the current pathology and prevent future foot ailments. These devices are fabricated from a three dimensional model of the patient´s own foot using [cast, foam impression, virtual true 3-D digital image]. These orthotics are a functional device, (reducing pathological forces) which has a molded deep heel cup (UCBL type) of 12mm and trim lines with substantial height to provide both medial and lateral directive forces to control the hind and fore foot. It also has intrinsic and extrinsic posts designed to control foot motion. This device will be made of a sufficiently rigid material to control function and reduce pathological forces. It´s intent is to reduce pain and disability as well as hopefully preclude the need for more aggressive treatments.

     

Insert Plantar Fasciitis Power Plan LEFT

I reviewed in detail their conditions, etiologies, options for care, treatment plan and prognosis. Discussed both conservative and surgical care. A schedule for future care needs was explained. The patient verbalizes understanding of these instructions at this time. Explained to the patient that conservative therapies for plantar fasciitis tend to be successful about 85-90% of the time according to the most current literature. It was explained that failure to adhere to the entire treatment plan will decrease the overall success rate of conservative therapies. I recommended strict no barefoot. I explained that barefoot walking out of bed creates an excessive inflammation at the origin and within the plantar fascia due to its contracted nature during sleep. I have discussed modification of current activity and icing utilizing frozen water bottle stretches. An injection consisting of 0.5cc of Kenalog-40 and 1cc of 1% Lidocaine Plain was administered into the affected area of the LEFT HEEL after appropriate cleansing. Possible complications such as hypopigmentation, photosensitivity, increased blood sugars, rupture of ligaments and/or tendons, steroid flare, and infection were discussed. Instructed the patient to temporarily modify their activity level. LEFT Ankle/Foot Strapping was applied to the lower extremity during today´s office visit (29540). The purpose of the strapping is to rapidly decrease the pain and inflammation present. Tape adhesive was first used on the affected limb(s). A series of 3-inch nylon tape was then applied around the posterior aspect of the calcaneus ensuring to plantarflex the first ray to recreate the medial longitudinal arch. A series of 3-inch strips were placed just distal to the calcaneal tubercles in the standard Campbell fashion to suspend the plantar fascia. The placement of the strapping was to provide restriction of movement of the feet, the longitudinal arch of the feet, and hold bilateral arches in their position of optimal function. The patient was sitting up with their legs hanging down and knees bent at a 90-degree angle. The subtalar joints were held in the neutral position. Upon completion, the neurovascular status of the distal feet and toes was checked and found to be normal. Instruction regarding how to care for these bilateral strappings were provided to the patient. LEFT Static Ankle-Foot Orthosis, plastic, prefabricated (L4397), was dispensed and fitted at todays office visit. This patient has bilateral plantarflexion contracture of the ankle demonstrated by dorsiflexion on passive range of motion. These braces extend above the ankle joint, and in doing so, maintain dorsiflexion of the ankle. These braces control motion in the sagittal, frontal, and transverse planes to optimize dorsiflexion force on the ankle joint. The device will be utilized for the next six to eight weeks. I have determined that these night splints will decrease the patients presenting symptoms and that they are medically necessary. The function of this AFO is to serve as an anti-contracture device of the plantar fascia and Achilles tendon. Its purpose is to restrict and limit motion, reducing excessive stress and strain to the plantar fascia and Achilles tendon at its distal insertion. The goals of therapy are as followed: 1) To reduce the presenting pain and symptoms of post static dyskinesia. 2) Prevent non-weightbearing contracture of the Achilles tendon. Excessive contracture leads to increased forefoot pressure during the stance phase of gait which can lead to multiple pathologies. 3) Provide static stretch of the Achilles tendon. 4) Reduce and prevent plantar fascial symptoms. The goals and function of these devices were explained to the patient at great length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. the patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information along with DME standards were given to the patient with ample opportunity to ask any questions. Based on today's examination I have recommended the patient be fitted for custom foot orthotics (CFO). These devices are medically necessary to alleviate the current pathology and prevent future foot ailments. These devices are fabricated from a three dimensional model of the patient´s own foot using [cast, foam impression, virtual true 3-D digital image]. These orthotics are a functional device, (reducing pathological forces) which has a molded deep heel cup (UCBL type) of 12mm and trim lines with substantial height to provide both medial and lateral directive forces to control the hind and fore foot. It also has intrinsic and extrinsic posts designed to control foot motion. This device will be made of a sufficiently rigid material to control function and reduce pathological forces. It´s intent is to reduce pain and disability as well as hopefully preclude the need for more aggressive treatments.

Insert Plantar Fasciitis Power Plan RIGHT

I reviewed in detail their conditions, etiologies, options for care, treatment plan and prognosis. Discussed both conservative and surgical care. A schedule for future care needs was explained. The patient verbalizes understanding of these instructions at this time. Explained to the patient that conservative therapies for plantar fasciitis tend to be successful about 85-90% of the time according to the most current literature. It was explained that failure to adhere to the entire treatment plan will decrease the overall success rate of conservative therapies. I recommended strict no barefoot. I explained that barefoot walking out of bed creates an excessive inflammation at the origin and within the plantar fascia due to its contracted nature during sleep. I have discussed modification of current activity and icing utilizing frozen water bottle stretches. An injection consisting of 0.5cc of Kenalog-40 and 1cc of 1% Lidocaine Plain was administered into the affected area of the RIGHT HEEL after appropriate cleansing was performed. Possible complications such as hypopigmentation, photosensitivity, increased blood sugars, rupture of ligaments and/or tendons, steroid flare, and infection were discussed. Instructed the patient to temporarily modify their activity level. RIGHT Ankle/Foot Strapping was applied to the lower extremity during today´s office visit (29540). The purpose of the strapping is to rapidly decrease the pain and inflammation present. Tape adhesive was first used on the affected limb(s). A series of 3-inch nylon tape was then applied around the posterior aspect of the calcaneus ensuring to plantarflex the first ray to recreate the medial longitudinal arch. A series of 3-inch strips were placed just distal to the calcaneal tubercles in the standard Campbell fashion to suspend the plantar fascia. The placement of the strapping was to provide restriction of movement of the feet, the longitudinal arch of the feet, and hold bilateral arches in their position of optimal function. The patient was sitting up with their legs hanging down and knees bent at a 90-degree angle. The subtalar joints were held in the neutral position. Upon completion, the neurovascular status of the distal feet and toes was checked and found to be normal. Instruction regarding how to care for these bilateral strappings were provided to the patient. RIGHT Static Ankle-Foot Orthosis, plastic, prefabricated (L4397), was dispensed and fitted at todays office visit. This patient has bilateral plantarflexion contracture of the ankle demonstrated by dorsiflexion on passive range of motion. These braces extend above the ankle joint, and in doing so, maintain dorsiflexion of the ankle. These braces control motion in the sagittal, frontal, and transverse planes to optimize dorsiflexion force on the ankle joint. The device will be utilized for the next six to eight weeks. I have determined that these night splints will decrease the patients presenting symptoms and that they are medically necessary. The function of this AFO is to serve as an anti-contracture device of the plantar fascia and Achilles tendon. Its purpose is to restrict and limit motion, reducing excessive stress and strain to the plantar fascia and Achilles tendon at its distal insertion. The goals of therapy are as followed: 1) To reduce the presenting pain and symptoms of post static dyskinesia. 2) Prevent non-weightbearing contracture of the Achilles tendon. Excessive contracture leads to increased forefoot pressure during the stance phase of gait which can lead to multiple pathologies. 3) Provide static stretch of the Achilles tendon. 4) Reduce and prevent plantar fascial symptoms. The goals and function of these devices were explained to the patient at great length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. the patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information along with DME standards were given to the patient with ample opportunity to ask any questions. Based on today's examination I have recommended the patient be fitted for custom foot orthotics (CFO). These devices are medically necessary to alleviate the current pathology and prevent future foot ailments. These devices are fabricated from a three dimensional model of the patient´s own foot using [cast, foam impression, virtual true 3-D digital image]. These orthotics are a functional device, (reducing pathological forces) which has a molded deep heel cup (UCBL type) of 12mm and trim lines with substantial height to provide both medial and lateral directive forces to control the hind and fore foot. It also has intrinsic and extrinsic posts designed to control foot motion. This device will be made of a sufficiently rigid material to control function and reduce pathological forces. It´s intent is to reduce pain and disability as well as hopefully preclude the need for more aggressive treatments.

Insert Porokeratosis E and M Plan

Discussed potential etiologies of this porokeratosis with the patient. Discussed different treatment options, mostly focusing on debridement and padding versus attempt at permanent removal. We discussed the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. I explained that potential disadvantages of an attempt at permanent removal include recurrence, scarring, worse pain than is present now, numbness, and infection. Explained the advantage of attempt at permanent removal is the potential for this to be eradicated forever. [We also discussed the underlying, causative biomechanical pathology and what needs to be done to address this.] We also discussed that just shaving this down and using padding would likely only provide temporary relief. We reviewed aperture padding, how this can help, and I showed the patient some examples of pads that may be helpful. We even discussed the possibility of a custom orthotic with this type of aperture padding built into it. This discussion and education constitutes the Evaluation and Management. After reviewing these options, the patient did not want to attempt permanent removal. Patient asked to just have this shaved down. After a sterile prep, the lesion was debrided and we were able to get out some of the deeper tissue, but, without injected local anesthetic a full excision was not possible. The area was dressed with triple antibiotic ointment and an adhesive fabric bandage and the patient was asked to apply this same dressing daily for the next 3 days in addition to keeping this area clean and dry. The patient stated the area was immediately more comfortable, but they understand this is likely only a temporary fix. We again reviewed padding options and the option to attempt a permanent excision.

Insert Porokeratosis Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals a painful area of thick hyperkeratotic tissue with a nucleated core consistent with a porokeratoma. Lesion Location: [Location] Lesion Size: [ ] mm x [ ] mm Interrupted Skin Lines: No Pinpoint Bleeding Upon Debridement: No Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Porokeratosis Excise Plan

Discussed potential etiologies of this porokeratosis with the patient. Discussed different treatment options, mostly focusing on debridement and padding versus attempt at permanent removal. We discussed the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. I explained that potential disadvantages of an attempt at permanent removal include recurrence, scarring, worse pain than is present now, numbness, infection and others. Explained the advantage of attempt at permanent removal is the potential for this to be eradicated forever. [We also discussed the underlying, causative biomechanical pathology and what needs to be done to address this.] We also discussed that just shaving this down and using padding would likely only provide temporary relief. After reviewing these options, patient asked to attempt a permanent removal of this lesion. The potential risks, potential benefits, and possible complications of the proposed procedure were explained again. Patient understood and asked to have this performed. The porokeratosis site was marked and an informed consent was signed by the patient. The patient was already properly positioned in the chair for ideal access to the site. The porokeratosis site was prepped with a betadine scrub. The area was then draped. 3 cc of 1% lidocaine with epinephrine was infiltrated directly under the lesion. Verification of anesthesia was performed. A scalpel was used to circumscribe the entire lesion, incising through the full thickness of skin into the subcutaneous tissue layer. A curette was then used to excise the entire lesion in toto, removing all aspects of it, including a thin layer of subcutaneous tissue. The excised lesion was sent for pathological evaluation. Phenol solution was then applied to the base of surgical site. There was no bleeding encountered. Triple antibiotic ointment was applied to the surgical site. A sterile, non-adherent covering was applied to the site. A dry bandage was then applied over that. The patient was instructed to keep this clean, dry, and intact until tomorrow. Patient was asked to wash the site daily with soap and water and then cover it with antibiotic ointment and a dry dressing. All questions were answered and patient was told to contact us right away with any other questions. Told patient if they experience nausea, vomiting, fever, or chills to contact us right away. Also asked them to contact us if they see any redness at the area of experience any heat to the area. Follow up in 7 days.

Insert Porokeratosis Plan

I discussed the diagnosis, etiology, and possible treatment options with the patient. Partial thickness debridement of the skin through the stratum corneum was performed. A deep keratin plug was observed underlying the area of hyperkeratosis which was enucleated utilizing a #15 blade scalpel. Accommodative pads were applied to the patient´s current shoe gear. Immediate relief was obtained as evidenced by pain-free ambulation. Follow-up P.R.N.

Insert Posterior Tibial Tendon Exam

Examination of the posterior tibial tendon reveals pain [0-10] RIGHT & [0-10] LEFT extremity(s) consistent with posterior tibial tendinitis. Enlarged Navicular Tuberosity: [No, Yes] Ankle Joint Equinus: [No, Yes] Soft Tissue Edema: [No, Yes] Resting Calcaneal Stance Position (RCSP) RIGHT: [Value]° Resting Calcaneal Stance Position (RCSP) LEFT: [Value]° Single Heel Rise RIGHT: [Yes, No] Single Heel Rise LEFT: [Yes, No] Mobile Rearfoot RIGHT: [Yes, No] Mobile Rearfoot LEFT: [Yes, No] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Posterior Tibial Tendonitis Plan

I explained the diagnosis, etiology, and proposed treatment plan with the patient at great length. Explained that their presenting posterior tibial tendon pathology is being exacerbated by faulty foot mechanics during their gait. A gait examination took place during today´s office visit which confirms this. The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce stress and strain on the posterior tibial tendon. The conservative treatment options were discussed with the patient which include: custom functional foot orthotics, cortisone injections, ankle joint strengthening and range of motion exercises, physical therapy (focusing on strengthening and reducing inflammation), RICE, immobilization, anti-inflammatories, compression, and proper shoe modification.

Insert Postop Exam

Examination of the Surgical Site: Surgical Location: [Describe] Postoperative Bandage: [Clean, Dry & Intact] Sutures Intact: [Yes, No] Signs of Dehiscence: [No, Yes] Edema & Erythema: [Normal, Abnormal] Signs of Postoperative Infection: [No, Yes] Ambulation Status: [Non, Partial, Full] Postoperative Modalities: [CAM Walker, Surgical Shoe, Crutches] Patient Compliance: [Satisfactory, Moderate, Poor] Signs of Complication: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Preop Plan

Anticipated Procedure: [Procedure] Anticipated Surgery Date: [Date] Anticipated Surgery Location: [Location] I reviewed in detail the procedure to be performed, disability to be expected, and long-term prognosis. No guarantee or warranty was given or implied as to the results of the surgery. Possible postoperative complications and postoperative course of treatment were reviewed at length. I did advise the patient to write down or call the office with any questions they may have prior to their surgery. The informed consent was reviewed and signed by the patient after reviewing each component at length. The possible risks of the procedure were reviewed, and the patient initialed each of these risks on the informed consent accordingly. Instructions for pre-operative clearance and labs were discussed with the patient. Post-operative instructions and prescriptions were dispensed to the patient. Instructions to be NPO past midnight the evening before the procedure was discussed. Failure to comply could result in the delay or cancellation of the procedure.

Insert Prescribe NSAID

As noted in the below eRx section, an NSAID was prescribed. This was done in an effort to decrease inflammation and pain. The potential side effects of this medication were discussed with the patient. I explained that potential side effects include stomach pain, heartburn/indigestion, gastrointestinal ulcers, bleeding more easily, headache, cardiac issues, renal disease and some others that are less common. In this situation, I think the potential advantages outweigh the potential disadvantages and that was explained to the patient and they agree and would like to try the medication. The patient was asked to take the medication with food and water.

Insert Punch Biopsy Plan

A 2mm punch biopsy was performed in the office today. The area to be biopsied was first anesthetized with 2cc Lidocaine 1%. Once anesthesia was obtained, the area was cleansed with betadine solution. A small punch was utilized to perform the biopsy. The tissue specimen was then placed in Formalin and sent to pathology. Pressure was temporarily held at the biopsy site. Bleeding was controlled with light pressure. The area was then covered with antibiotic ointment and DSD. Postoperative instructions were explained to the patient at length. The patient will keep the site covered until their scheduled follow up visit. Advised the patient to use bacitracin and keep the area dry. Educated the patient on the signs and symptoms of infection and instructed them to call the office with any questions or concerns they may have. RTO 2 weeks for follow up evaluation.

Insert Raynaud Syndrome Plan

I explained the diagnosis, etiology, and proposed treatment plan with the patient at great length. Explained that their presenting Raynaud syndrome is a vasospastic condition that causes episodes of reduced blood flow secondary to cold exposure. I explained the characteristic color changes that occur. Various methods of management were discussed including: avoidance of cold exposure, use of wool (Smart Socks), and possible use of medication when needed.

Insert Sesamoiditis Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot demonstrates pain with direct palpation overlying the sesamoid apparatus consistent with sesamoiditis. Sesamoid Involvement: [Tibial, Fibular, Both] Evidence of Edema: [No, Yes] Radiographic Evaluation: [Normal, Fractured, Bipartite] Painful ROM of 1st MPJ: [No, Yes] Fixed Structural Deformities: [None, Rigid Plantarflexed 1st Ray] Ankle Joint Equinus: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Sesamoiditis Plan

The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce the excessive pressure over the area of the sesamoid bones. Additionally, I explained that night splints will stretch their Achilles tendon complex reducing excessive forefoot load during midstance. I explained to the patient that sesamoiditis is an inflammatory condition involving the sesamoid bones. I discussed temporary modification of physical activity to reduce the inflammation. I recommended icing 20 minutes on / 20 minutes off at least 3 times per day to reduce the acute inflammation over the next 24 hours. After 24 hours the patient can begin using their night splints and perform ankle joint range of motion exercises. A dancer offloading pad was placed on the affected extremity to adequately offload the first metatarsal head and sesamoid apparatus. Customized-shaped moleskin was placed directly over the lateral metatarsal heads to help reduce the friction in their shoe.

Insert Severs Disease Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals pain with direct palpation over the calcaneal apophysis consistent with Sever's disease. Edema and/or Erythema: [No, Yes] Signs of Overpronation: [No, Yes] Ankle Joint Equinus: [No, Yes] Resting Calcaneal Stance Position (RCSP) RIGHT: [Value]° Resting Calcaneal Stance Position (RCSP) LEFT: [Value]° Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Severs Disease Plan

I did review the abnormal biomechanics of their feet and lower extremity and how it relates to their presenting diagnosis. I did advise custom-made functional orthotic devices to control the biomechanical abnormalities and reduce the stress and strain at the insertion of the plantar fascia and Achilles tendon. This will reduce tensile forces on the painful calcaneal apophysis. Additionally, it was explained that custom orthotics will rebalance intrinsic and extrinsic musculature throughout the lower extremity. I had a lengthy discussion about the etiology, prognosis, and prevention of Sever's disease. I did explain that Sever's is an overuse injury to the growth plate of the heel. I assured the patient that this is a self-limiting condition, and with the proper treatment the symptoms usually resolve in about 2-8 weeks. Tight calf musculature has been shown to prolong the period of inflammation. Based on the physical examination, I have determined that the patient would benefit from bilateral night splints. I have advised the patient to ice and elevate the area of the calcaneal apophysis, wear open-backed shoes to prevent irritation, and wear bilateral Tuli heel cups for shock absorption in closed shoe gear. Modification of physical activity was discussed at length to properly rest the apophysis until resolution of symptoms.

Insert Simple Abscess Plan

The suspected etiology of the abscess was discussed with the patient. Discussed different treatment options, including the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. After reviewing these options, I explained my recommendation to perform an incision and drainage (I&D) of the abscess {CPT 10060} at length. The potential risks, potential benefits, and possible complications of the proposed procedure were explained. Patient understood and asked to have this performed. The abscess area was marked and an informed consent was signed by the patient. Patient was already properly positioned in the chair for ideal access to the site. The integument overlying the abscess was first prepped with a betadine scrub. The area was then draped. The area for anticipated incision had been previously marked. Local anesthesia was not necessary given lack of sensation at the site. Utilizing a #15 scalpel blade an incision was made through the abscess parallel to the neurovascular structures. Drainage and purulent material was immediately encountered. All purulent material was expressed. The area was then copiously irrigated with multiple saline flushes. Hemostasis was achieved with pressure and the site was packed open. It was dressed with a dry sterile dressing. Patient was instructed to keep this clean, dry, and intact until tomorrow. All questions were answered, and patient was told to contact the office right away with any other questions. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Sinus Tarsitis Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot reveals pain with deep palpation into the sinus tarsi consistent with acute sinus tarsitis. Pain Exacerbated on Dorsiflexion & Eversion: [No, Yes] Anterior Talofibular Ligament (ATFL) Pain: [No, Yes] Anterior Calcaneal Process Pain: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Sinus Tarsitis Plan

I explained the diagnosis, etiology, and proposed treatment plan with the patient at great length. Explained that their presenting sinus tarsitis is being exacerbated by faulty foot mechanics during their gait. A gait examination took place during today´s office visit which confirms this. The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms and I did discuss the use of custom made functional orthotic devices to control their biomechanical abnormalities and reduce stress and strain to the sinus tarsi. The conservative treatment options were discussed with the patient which include: custom functional foot orthotics, cortisone injections, ankle joint strengthening and range of motion exercises, physical therapy, RICE, immobilization, anti-inflammatories (NSAIDs), and shoe modification.

Insert Skin Substitute Exam

Vascular exam (including ABI and toe pressures): [ ] Location of ulcer: [ ] Ulcer length: [ ] Ulcer width: [ ] Ulcer depth: [ ] Ulcer stage: [ ] This ulcer does not involve tendon, muscle, or joint capsule. There is no bone exposed and there are no sinus tracts or undermining. The base of this ulcer is mostly clean and granular and ready to receive a graft. After preparation, the ulcer bed is free of any necrotic tissue, debris, or exudate. There is no redness, heat, odor, fluctuance, purulence, or any sign of infection. There is no bone exposure and no concern for osteomyelitis. Deepest depth of tissue exposed: [dermis, subcutaneous, muscle/fascia, bone] Ulcer color: [red, pink, red/pink mix] Drainage type : [None, Mild, Serous, Sanguinous, Serosanguinous, Purulent] There is no undermining or tunneling.

Insert Skin Substitute Plan

This is not an acute wound. This is a chronic wound, an ulcer that has failed to progress as it should after four weeks of treatment. This ulcer is not demonstrating signs that lead one to believe it will heal if current treatment continues and advanced healing options are not instituted. There is not enough healing by contraction or advancement of epithelial margins over the last 4 weeks of treatment to suggest that eventual healing will occur if current treatment continues. Ulcers of this nature of a high rate of failure to heal, and high rates of infection, amputation, other morbidity, and even mortality associated with them. Therefore, advanced treatment in the form of a skin substitute product is indicated in an effort to heal this chronic ulcer and prevent amputation, use of [ ] (product). The reason this was selected is [ ] No local anesthesia was used given the neuropathy present that impacts the area treated. Attention was directed to the ulcer on the [ ] . A sterile prep of the area was performed. A scalpel was utilized for sharp debridement to remove the hyperkeratotic rim and small amount of nonviable tissue from the wound bed. After this light debridement, the ulcer bed was free of any necrotic tissue, debris, or exudate and ready to receive the graft. Hemostasis was obtained with pressure. The graft was prepared as directed by package insert. The graft was applied to the wound bed. There was [ ]sq cm of excess graft that was trimmed away and discarded. A total of [ ] sq cm of graft was used and a total of[ ] sq cm of graft was discarded. The graft was covered with adaptic and fixed in place with steri-strips. It was then covered with absorbent foam and covered with a dry sterile dressing. Coban was applied to achieve a degree of compression to address edema. We discussed the importance of offloading and the role it plays in healing and protecting this graft. Patient will use [ ] for offloading and was asked to wear this during [ ]. Patient instructions given include:[ ] Patient was asked to follow up next week. Patient was told to keep this bandage clean, dry, and intact and to watch for any redness, heat, or swelling around the bandage. Asked patient to contact us right away if any of these are seen. Also asked the patient to let us know right away if they experience any nausea, vomiting, fever, or chills. We reviewed the importance of glycemic control and nutrition and the role they play in protecting this graft and optimizing chances of success.

Insert Soft Tissue Mass Exam

Examination of the [RIGHT, LEFT, BILATERAL] extremity reveals a soft tissue mass. Location: [Location Mass Size: [ ] cm x [ ] cm Shape: [Round, Oval, Irregular] Consistency: [Soft, Firm] Mass Mobility: [No, Yes] Transillumination: [No, Yes] Percussion Pain: [No, Yes] Bruits/Thrills: [No, Yes] Regional Lymph Node Enlargement: [No, Yes] Subjective Pain Level (NRS) Scale: [1-10] Additional Findings: [N/A]

Insert Strapping Plan BILATERAL

BILATERAL Ankle/Foot Strapping was applied to the lower extremity during today´s office visit (29540). The purpose of the strapping is to rapidly decrease the pain and inflammation present. Tape adhesive was first used on the affected limb(s). A series of 3-inch nylon tape was then applied around the posterior aspect of the calcaneus ensuring to plantarflex the first ray to recreate the medial longitudinal arch. A series of 3-inch strips were placed just distal to the calcaneal tubercles in the standard Campbell fashion to suspend the plantar fascia. The placement of the strapping was to provide restriction of movement of the feet, the longitudinal arch of the feet, and hold bilateral arches in their position of optimal function. The patient was sitting up with their legs hanging down and knees bent at a 90-degree angle. The subtalar joints were held in the neutral position. Upon completion, the neurovascular status of the distal feet and toes was checked and found to be normal. Instruction regarding how to care for these bilateral strappings were provided to the patient.

Insert Strapping Plan LEFT

LEFT Ankle/Foot Strapping was applied to the lower extremity during today´s office visit (29540). The purpose of the strapping is to rapidly decrease the pain and inflammation present. Tape adhesive was first used on the affected limb(s). A series of 3-inch nylon tape was then applied around the posterior aspect of the calcaneus ensuring to plantarflex the first ray to recreate the medial longitudinal arch. A series of 3-inch strips were placed just distal to the calcaneal tubercles in the standard Campbell fashion to suspend the plantar fascia. The placement of the strapping was to provide restriction of movement of the feet, the longitudinal arch of the feet, and hold bilateral arches in their position of optimal function. The patient was sitting up with their legs hanging down and knees bent at a 90-degree angle. The subtalar joints were held in the neutral position. Upon completion, the neurovascular status of the distal feet and toes was checked and found to be normal. Instruction regarding how to care for these bilateral strappings were provided to the patient.

Insert Strapping Plan RIGHT

RIGHT Ankle/Foot Strapping was applied to the lower extremity during today´s office visit (29540). The purpose of the strapping is to rapidly decrease the pain and inflammation present. Tape adhesive was first used on the affected limb(s). A series of 3-inch nylon tape was then applied around the posterior aspect of the calcaneus ensuring to plantarflex the first ray to recreate the medial longitudinal arch. A series of 3-inch strips were placed just distal to the calcaneal tubercles in the standard Campbell fashion to suspend the plantar fascia. The placement of the strapping was to provide restriction of movement of the feet, the longitudinal arch of the feet, and hold bilateral arches in their position of optimal function. The patient was sitting up with their legs hanging down and knees bent at a 90-degree angle. The subtalar joints were held in the neutral position. Upon completion, the neurovascular status of the distal feet and toes was checked and found to be normal. Instruction regarding how to care for these bilateral strappings were provided to the patient.

Insert Surgical Shoe Plan

Due to the patient´s condition, signs, and symptoms I am recommending the patient ambulate only in a stiff-soled surgical style shoe. The surgical shoe is designed to: (1) prevent digital extension during the push-off phase of gait, (2) alleviate the flexor apparatus from pulling the digits downward, (3) provide an open environment for the digits that would otherwise be compromised in closed shoe gear, (4) prevent worsening of their condition, and (5) hasten overall healing time.

Insert Tailor Bunion Exam

Examination reveals a tailor bunion deformity with the fifth metatarsal deviated laterally and the 5th toe deviated medially on the [RIGHT, LEFT, BILATERAL] foot/feet. A bony prominence at the lateral aspect of the 5th MPJ observed. Pain of the Lateral Eminence: [No, Yes] Erythema Over Lateral Eminence: [No, Yes] Ulceration Over Lateral Eminence: [No, Yes] ROM 5th MPJ Pain Level (NRS Scale) RIGHT: [0-10] ROM 5th MPJ Pain Level (NRS Scale) LEFT: [0-10]

Insert Tailor Bunion Plan

The abnormal biomechanics of their feet and lower extremity were reviewed as it relates to their conditions and symptoms with discussion of the use of custom made functional orthotic devices to control their biomechanical abnormalities, reduce stress and strain throughout the 5th MPJ, slow the progression of the deformity, and help prevent surgical intervention. The surgical options were briefly discussed with the patient. Explanation that the orthotic devices will help to rebalance the abnormal forces across all planes of the foot causing the progressive misalignment as well as help to rebalance intrinsic and extrinsic musculature throughout the lower extremity. Proper shoe gear was reviewed with the patient.

Insert Tendon Ultrasound Exam

Ultrasound examination of [RIGHT, LEFT, BILATERAL] [tendon] tendon reveals: Thickening and/or Hypoechoic Changes: [NEGATIVE, POSITIVE] Disruption and/or Tear: [NEGATIVE, POSITIVE] Peri-Tendon Hypoechoic Changes and/or Tenosynovitis: [NEGATIVE, POSITIVE].

Insert Tinea Pedis Exam

Examination of the [RIGHT, LEFT, BILATERAL] foot demonstrates a pruritic area consistent with a tinea pedis infection. Location: [Interdigitally, Dorsally, Plantarly, Moccasin] Webspace Maceration: [No, Yes] Evidence of Fissuring: [No, Yes] Secondary Bacterial Infection: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Tinea Pedis Plan

The diagnosis, prognosis, treatment alternatives and challenges associated with treating tinea pedis were discussed with patient. I explained the realistic expectations of using topical medications and the need for at least 1 month of continuous treatment. We discussed preventative measures such as wearing cotton socks, changing socks at least once in the middle of the day, using absorbent powder, keeping between the toes dry, and treating the shoes with antifungal shoe spray. We also did review preventative measures for spread of tinea pedis.

Insert Total Contact Cast Plan

This is a limb-threatening ulcer and ulcers of this nature of a high rate of failure to heal and high complication rate, including infection and amputation. Peer-reviewed, evidence-based literature suggests that the best option for this ulcer is a total contact cast. Explained the potential risks and potential benefits of total contact cast to the patient. Explained the high rate of healing associated with total contact cast. Also explained the potential risks, including iatrogenic new ulcers and infection and even osteomyelitis and amputation. After discussing all this, we agreed the potential benefits outweighed the potential risks and the patient requested treatment with a total contact cast. The ulcer was covered with a bordered foam. A stockinette was applied to the [left, right] lower extremity. Adhesive felt padding was placed over the medial and lateral malleoli and along the tibial crest. Adhesive padding was placed over the toes for protection. Undercast padding was wrapped from the base of the toe padding up to the tibial tuberosity with care taken to avoid any bunching of the padding. Casting material was then utilized to apply the total contact cast, using multiple layers of different size casting tape and with care taken to not offend the peroneal nerve and to not place pressure on any boney prominences. There was no bunching or pinching of the cast material. While the cast tape was being applied, the knee was bent and care was taken to hold the foot at 90 degrees to the leg. The cast was allowed to dry and the patient stated it was comfortable and did not feel too tight. A cast shoe was applied. The patient walked out of the office comfortably and with stability. Instructed the patient to keep this cast on and keep it clean, dry, and intact. Patient was told to limit weight bearing as much as possible. Asked patient to call us right away if they notice any redness, heat, odor, or pain associated with the cast. Follow up one week.

Insert Two to Four Callus Plan

At risk foot care with trimming of skin lesion x2 to 4, utilization of a sharp instrumentation, the lesions were trimmed to level appropriate in conjunction with patient tolerance and medical standard of care. Each location of the lesions were referenced in the examination.

Insert Ulcer Debridement to Bone Plan

Attention was directed to the ulcer [plantar 1st metatarsal head, plantar 5th metatarsal head, plantar heel, plantar central midfoot] [right, left] foot. Anesthesia was not necessary given the patient´s peripheral neuropathy. A sterile prep of the area was performed. A [scalpel, scissors, curette] was utilized for sharp debridement to remove the [hyperkeratotic rim and] [necrotic tissue, devitalized tissue, fibrotic tissue] from the wound bed. There was non-viable bone and debridement was carried out to the depth of bone with nonviable bone removed. The deepest depth of tissue removed was bone. A total of [1,2,3,4,5,6,7,8,9,10] sq cm of bone was removed. Hemostasis was obtained with pressure. Upon completion, the wound was dressed with triple antibiotic ointment and a dry sterile dressing. This debridement was performed in an effort to decrease bioburden, decrease risk of infection, and promote healing. The patient was asked to clean this ulcer daily, [apply topical antibiotic,] cover with a dry sterile dressing and use their offloading device as instructed. The patient was asked to follow up here in one week. This ulcer is [unchanged, improved, worse] compared to last evaluation. My best estimation of how long this ulcer will require treatment is [1,2,3,4,5,6] more months. During that time, to optimize outcomes I expect the patient will need to be seen either once a week or every other week. We had a discussion today about nutrition as it relates to wound healing. [This patient has diabetes and we discussed the importance of excellent glycemic control and how that relates to healing potential and limb salvage.] The potential for this ulcer to heal is [excellent, good, fair, poor] The goal(s) of treating this chronic ulcer are: [healing, palliation, prevent or treat infection, prevent amputation].

Insert Ulcer Debridement to Dermis Plan

Attention was directed to the ulcer [plantar 1st metatarsal head, plantar 5th metatarsal head, plantar heel, plantar central midfoot] [right, left] foot. Anesthesia was not necessary given the patient´s peripheral neuropathy. A sterile prep of the area was performed. A [scalpel, scissors, curette] was utilized for sharp debridement to remove the [hyperkeratotic rim and] [necrotic tissue, devitalized tissue, fibrotic tissue] from the wound bed. Debridement was carried out to the depth of dermis with dermis serving as the deepest depth of tissue removed. A total of [1,2,3,4,5,6,7,8,9,10] sq cm of dermis was removed. Hemostasis was obtained with pressure. Upon completion, the wound was dressed with triple antibiotic ointment and a dry sterile dressing. This debridement was performed in an effort to decrease bioburden, decrease risk of infection, and promote healing. The patient was asked to clean this ulcer daily, [apply topical antibiotic,] cover with a dry sterile dressing and use their offloading device as instructed. The patient was asked to follow up here in one week. This ulcer is [unchanged, improved, worse] compared to last evaluation. My best estimation of how long this ulcer will require treatment is [1,2,3,4,5,6] more months. During that time, to optimize outcomes I expect the patient will need to be seen either once a week or every other week. We had a discussion today about nutrition as it relates to wound healing. [This patient has diabetes and we discussed the importance of excellent glycemic control and how that relates to healing potential and limb salvage.] The potential for this ulcer to heal is [excellent, good, fair, poor] The goal(s) of treating this chronic ulcer are: [healing, palliation, prevent or treat infection, prevent amputation].

Insert Ulcer Debridement to Muscle Plan

Attention was directed to the ulcer [plantar 1st metatarsal head, plantar 5th metatarsal head, plantar heel, plantar central midfoot] [right, left] foot. Anesthesia was not necessary given the patient´s peripheral neuropathy. A sterile prep of the area was performed. A [scalpel, scissors, curette] was utilized for sharp debridement to remove the [hyperkeratotic rim and] [necrotic tissue, devitalized tissue, fibrotic tissue] from the wound bed. Debridement was carried out to the depth of muscle with muscle serving as the deepest depth of tissue removed. A total of [1,2,3,4,5,6,7,8,9,10] sq cm of muscle was removed. Hemostasis was obtained with pressure. Upon completion, the wound was dressed with triple antibiotic ointment and a dry sterile dressing. This debridement was performed in an effort to decrease bioburden, decrease risk of infection, and promote healing. The patient was asked to clean this ulcer daily, [apply topical antibiotic,] cover with a dry sterile dressing and use their offloading device as instructed. The patient was asked to follow up here in one week. This ulcer is [unchanged, improved, worse] compared to last evaluation. My best estimation of how long this ulcer will require treatment is [1,2,3,4,5,6] more months. During that time, to optimize outcomes I expect the patient will need to be seen either once a week or every other week. We had a discussion today about nutrition as it relates to wound healing. [This patient has diabetes and we discussed the importance of excellent glycemic control and how that relates to healing potential and limb salvage.] The potential for this ulcer to heal is [excellent, good, fair, poor] The goal(s) of treating this chronic ulcer are: [healing, palliation, prevent or treat infection, prevent amputation].

Insert Ulcer Debridement to Subcutaneous Plan

Attention was directed to the ulcer: [metatarsal head, plantar heel, plantar central midfoot] [right, left] foot. Anesthesia was not necessary given the patient´s peripheral neuropathy. A sterile prep of the area was performed. A [scalpel, scissors, curette] was utilized for sharp debridement to remove the [hyperkeratotic rim and] [necrotic tissue, devitalized tissue, fibrotic tissue] from the wound bed. Debridement was carried out to the depth of subcutaneous tissue with subcutaneous tissue serving as the deepest depth of tissue removed. A total of [1,2,3,4,5,6,7,8,9,10] sq cm of subcutaneous tissue was removed. Hemostasis was obtained with pressure. Upon completion, the wound was dressed with triple antibiotic ointment and a dry sterile dressing. This debridement was performed in an effort to decrease bioburden, decrease risk of infection, and promote healing. The patient was asked to clean this ulcer daily, [apply topical antibiotic,] cover with a dry sterile dressing and use their offloading device as instructed. The patient was asked to follow up here in one week. This ulcer is [unchanged, improved, worse] compared to last evaluation. My best estimation of how long this ulcer will require treatment is [1,2,3,4,5,6] more months. During that time, to optimize outcomes I expect the patient will need to be seen either once a week or every other week. We had a discussion today about nutrition as it relates to wound healing. [This patient has diabetes and we discussed the importance of excellent glycemic control and how that relates to healing potential and limb salvage.] The potential for this ulcer to heal is [excellent, good, fair, poor] The goal(s) of treating this chronic ulcer are: [healing, palliation, prevent or treat infection, prevent amputation].

Insert Ulcer Exam

Location of Ulcer: [LOCATION] PRE-Debridement Measurements: Ulcer Length: [ ] cm Ulcer Width: [ ] cm Ulcer Depth: [ ] cm POST-Debridement Measurements: Ulcer Length: [ ] cm Ulcer Width: [ ] cm Ulcer Depth: [ ] cm Ulcer Stage: Wagner [1,2,3,4] Deepest Layer of Tissue Exposed: [Dermis, Subcutaneous, Muscle/Fascia, Bone] Ulcer Color: [Red, Yellow, Red/Yellow Mix, Gray, Black] Drainage Type : [Serous, Sanguinous, Serosanguinous, Purulent, None] Malodor: [NEGATIVE, POSITIVE] Undermining / Tunneling: [NEGATIVE, POSITIVE] Epibole Formation: [NEGATIVE, POSITIVE] Wound Bed: [describe, granular, fibrotic, necrotic] Probe to Bone: [NEGATIVE, POSITIVE] Exposed Bone: [NEGATIVE, POSITIVE] Peri-Wound: [Hyperkeratotic, Macerated, Erythematous] Necrosis Prior to Debridement? [Yes, No]

Insert Unna Boot Plan

An Unna Boot Compression Wrap was applied to the [RIGHT, LEFT, BILATERAL] lower extremity (29580) todays visit. Adequate soft roll was utilized prior to Coban exterior to prevent skin irritation. The purpose of the Unna boot is to rapidly decrease the edema, pain, and inflammation present. Detailed instructions were given to the patient to watch for redness, irritation, blistering, and pain. The patient was instructed to call the office immediately if any of the aforementioned complications were to occur. The patient was made a follow up appointment and was told to call the office with any questions.

Insert Wart Exam

Examination reveals a verrucous type lesion noted at [LOCATION] with punctate capillaries throughout, interrupted skin lines, overlying hyperkeratotic tissue, and pinpoint bleeding upon sharp debridement consistent with a plantar verruca. Status: [New, Improved, Worsened] Lesion Size: [ ] cm x [ ] cm Satellite Lesions: [No, Yes] Subjective Pain Level (NRS Scale): [0-10] Additional Findings: [N/A]

Insert Wart Plan

The suspected etiology of the verruca was discussed with the patient. Discussed different treatment options, including the potential risks and benefits of these different options and the potential advantages and disadvantages of these treatment options. Among the potential disadvantages of chemical destruction that were discussed included the possibility of scarring, pain, and verruca recurrence. After reviewing these options, I explained my recommendation to attempt chemical destruction of the verruca {CPT 17110}. The potential risks, potential benefits, and possible complications of the proposed procedure were explained. The verruca site was marked, and an informed consent was signed by the patient. Alcohol was used to prep the site. The area of hyperkeratotic tissue surrounding and overlying the verruca-type lesion was debrided down to pinpoint capillary bleeding. Hemostasis was achieved with pressure. Chemical destruction of the verruca was performed today utilizing 80% trichloroacetic acid (CPT 17110) and an occlusive dressing. The patient was advised to remove the occlusive dressing in 2-3 hours. It was explained that possible redness, warmth, pain and swelling may be expected. We discussed that multiple treatments may be required for full eradication. All questions were answered, and patient was told to contact the office right away with any other questions. The patient was advised if they experience nausea, vomiting, fever, or chills to contact us right away. The patient was given a follow up appointment.

Insert Wart Surgery Plan

Operative Report: Surgeon: [Provider], DPM Preoperative Diagnosis: Plantar Verruca [RIGHT, LEFT] Foot Postoperative Diagnosis: Plantar Verruca [RIGHT, LEFT] Foot Estimated Blood Loss: [ ]cc Anesthesia: 6cc of 1% Lidocaine (With Epinephrine) Hemostasis: Local Anesthetic With Epinephrine Pathology: None Complications: None After a very lengthy discussion with the patient apprising them of the risks, benefits, alternative treatment options, and possible complications of the proposed procedure an appropriate informed consent was signed. The patient demonstrated full understanding of the procedure and the possible complications that could result. These complications were explained to the patient at length. All questions were answered to the patient´s full satisfaction prior to starting the procedure. Informed consent was obtained. This patient was brought into the procedure room and placed on the treatment chair in the supine position. Local anesthesia was obtained utilizing a total of 6cc of 1% lidocaine with epinephrine in a local infiltration block fashion. The surgical site was then prepped, scrubbed, and draped in the usual sterile fashion. Attention was then directed to the aforementioned soft tissue lesion. Utilizing a #15 blade scalpel, the keratotic covering was sharply debrided from the area overlying the lesion. A hyfrecator was then utilized to ablate the lesion. The #15 blade scalpel and a sterile curette was then utilized to clear the base. The hyfrecator was used once again to cauterize the base. Close inspection of the wound area shows no further abnormal tissue. Antibiotic ointment was placed over the operative site followed by a multilayer bandage. Excellent capillary refill time and palpable pedal pulses were noted upon completion. Condition: The patient tolerated the procedure well without any complications. The patient was instructed to keep the dressing clean, dry, and intact. I explained the importance of not getting the dressing wet. Sponge bathing was recommended. The patient was scheduled a follow up appointment but was instructed to call the office with any questions or concerns they have.

Insert Xerosis Plan

I had a lengthy discussion with the patient about xerosis and the vast underlying etiologies that have been described. Causes include the following: very dry environments, lack of hydration, excessive chlorination, and family history. I explained that the treatment options for xerosis are aimed at rehydrating the stratum corneum. Emollients containing urea or alpha-hydroxy acids are particularly effective. I explained that excessive bathing or the use of alkaline soaps must be avoided during treatment. After evaluating the patient, I am recommending they start Kera-42.

Insert XRay Bunion

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT, BILATERAL] Foot Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Other Osseous Abnormalities: [No, Yes] Biomechanical Abnormalities: [Overpronation, Supination, None] Structural Abnormalities: HAV Deformity 1st Metatarsal Head Flattening / OA: [No, Yes] Evidence of Cystic Changes: [No, Yes] Intermetatarsal Angle (IMA): [Greater than 9, Less than 9] Hallux Abductus Angle (HAA): [Greater than 15, Less than15] Proximal Articular Set Angle (PASA): [Greater than 7.5, Less than 7.5] Distal Articular Set Ankle (DASA): [Greater than 7.5, Less then 7.5] Hallux Interphalangeal Angle (HIA): [Greater than 10, Less then 10] Tibial Sesamoid Position (TSP): Position [1-7] Metatarsus Adductus Angle (MAA): [Greater than 15, Less than 15]

Insert XRay Cavus Foot

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Other Osseous Abnormalities: [No, Yes] Biomechanical Abnormalities: [Overpronation, Supination, None] Structural Abnormalities: [HAV, Hammertoes, etc.] AP Talo-Calcaneal Angle [Greater than 21, Less than 21] Metatarsus Adductus Angle (MAA): [Greater than 15, Less than 15] Talar Head Uncovering: [Greater than 25%, Less than 25%] Calcaneal Inclination [Greater than 21, Less than 21] Talar Declination [Greater than 21, Less than 21], Meary's Angle: [Normal, Negative] Cyma Line: [Normal, Posterior Break] Additional Findings: [N/A]

Insert XRay Charcot

The views of the foot taken include [Anterior-Posterior, Lateral, Medial Oblique, Lateral Oblique, Harrison, Calcaneal Axial, Sesamoidal] [Right, Left]. [Review reveals normal soft tissue density and no signs of edema, Review reveals increase soft tissue density and edema surrounding the [\_\_\_\_\_\_\_\_\_\_ joint]. Bone density appears [normal, decrease] given the patient's age. Xray shows [Right, Left] [\_\_\_\_\_\_\_\_] joint with [positive, negative] joint dissension, [positive, negative] fracture(s) of the [\_\_\_\_\_\_\_\_\_\_\_], [fracture(s) appears to be intra-articular], [positive, negative] fragmentation and debris, [positive, negative] subluxation, [positive, negative] sclerosis with resorption of debris, [positive, negative] fusion, [positive, negative] rocker bottom foot deformity. [positive, negative] previous amputation [\_\_\_\_\_\_], [positive, negative] pencil & cup deformities/resorption of bone ends. The views of the ankle taken include [Anterior-Posterior, Lateral, Medial Oblique, Lateral Oblique, Mortise ] [Right, Left]. Ankle Joint alignment appears normal.

Insert XRay Exam

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Other Osseous Abnormalities: [No, Yes] Biomechanical Abnormalities: [Overpronation, Supination, None] Structural Abnormalities: [HAV, Hammertoes, etc.] Additional Findings: [N/A]

Insert XRay Flatfoot

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] AP Talo-calcaneal Angle [Greater than 21, Less than 21], Calcaneocuboid Angle [Greater than 5, Less than 5], Talar Head Uncovering [Greater than 25%, Less than 25%], Calcaneal Inclination [Greater than 21, Less than 21], Talar Declination [Greater than 21, Less than 21], Meary´s Angle: [Normal, Positive] Cyma Line: [Normal, Anterior Break]

Insert Xray Hammertoe

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Flexion at the PIPJ: [No, Yes] Flexion at the DIPJ: [No, Yes] Hyperextension at the MTPJ: [No, Yes] Transverse Plane Deformity: [No, Yes] Gun Barrel Sign: [No, Yes] Additional Findings: [N/A]

Insert XRay Lisfranc Injury

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Other Osseous Abnormalities: [No, Yes] Biomechanical Abnormalities: [Overpronation, Supination, None] Structural Abnormalities: [HAV, Hammertoes, etc.] Fleck Sign: [No, Yes] 1st-2nd Metatarsal Base Diastasis: [No, Yes] Additional Findings: [N/A]

Insert XRay Neuroma

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Other Osseous Abnormalities: [No, Yes] Biomechanical Abnormalities: [Overpronation, Supination, None] Structural Abnormalities: [HAV, Hammertoes, etc.] Sullivan Sign: [No, Yes] Intermetatarsal Gapping: [No, Yes] Additional Findings: [N/A]

Insert Xray OA

Xray shows [Right, Left, BILATERAL] \_\_\_\_\_\_\_\_\_\_\_ joint with [positive, negative] joint space narrowing, [positive, negative] subchondral sclerosis, [positive, negative] subchondral cyst, [positive, negative] peri-articular exostosis, [positive, negative] peri-articular erosions, [positive, negative] intra-articular loose body.

Insert XRay Sesamoid Fracture

Xray shows [Right, Left, BILATERAL] [tibial, fibular] sesamoid irregular radiolucent line suggestive of a fracture, [positive, negative] comminution, [positive, negative] sesamoid diastasis, [positive, negative] sclerotic margin suggestive of a subacute or chronic fracture.

Insert XRay Spur

Xray shows [Right, Left, BILATERAL] [positive, negative] infra-Infra-calcanea spur, [positive, negative] retro-calcaneal spur, [positive, negative] Haglud´s deformity of the calcaneus.

Insert Xray Tailor Bunion

The views of the foot taken include [Anterior-Posterior, Lateral, Medial Oblique, Lateral Oblique, Sesamoidal] [Right, Left, BILATERAL]. Review reveals normal soft tissue density and no signs of edema, Review reveals [Right, Left, BILATERAL] increase soft tissue density and edema surrounding the 5th metatarsal head]. Bone density appears normal and expected given the patient's age. X-ray shows lateral deviation of the 5th metatarsal with an increased 4th/5th intermetatarsal angle [with, without] hypertrophy of the 5th metatarsal head [Right, Left, BILATERAL].

Insert XRay Two Views

Radiographic 2 views of the foot were taken on todays visit.

Insert XRay Ulcer

Radiographic Examination: Views Obtained: [AP, Medial Oblique, Lateral] Laterality: [RIGHT, LEFT][Foot, Ankle] Soft Tissue Defect (Ulcer): Yes Normal Anatomic Alignment: [Yes, No] Degenerative Changes: [Yes, No] Soft Tissue Edema: [No, Yes] Fracture and/or Dislocation: [No, Yes] Cortical Erosion and/or Destruction: [No, Yes] Evidence of Osteomyelitis: [No, Yes] Age-Appropriate Bone Density: [Yes, No] Emphysema and/or Gas: [No, Yes] Periosteal Reaction: [No, Yes] Pathologic Fracture: [No, Yes] Additional Findings: [N/A]

lnsert Hinged Ankle Brace BILATERAL

BILATERAL prefabricated hinged AFO (Active Ankle Brace) (L1906) multiligamentous ankle support was dispensed and applied at this visit. Due to the patient's diagnosis and related symptoms this is medically necessary for treatment. These braces extend above the ankle and are fastened around the lower leg. The function of this device: (1) to restrict and limit motion, controlling the medial and lateral malleoli ankle joint (2) provide stabilization, (3) compression, and (4) decrease pain to the affected area. The goals and function of this device were explained to the patient at length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. The patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information were dispensed along with the Durable Medical Equipment standards. Patient signed written proof of delivery.

lnsert Hinged Ankle Brace LEFT

A LEFT prefabricated hinged AFO (Active Ankle Brace) (L1906) multiligamentous ankle support was dispensed and applied at this visit. Due to the patient's diagnosis and related symptoms this is medically necessary for treatment. These braces extend above the ankle and are fastened around the lower leg. The function of this device: (1) to restrict and limit motion, controlling the medial and lateral malleoli ankle joint (2) provide stabilization, (3) compression, and (4) decrease pain to the affected area. The goals and function of this device were explained to the patient at length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. The patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information were dispensed along with the Durable Medical Equipment standards. Patient signed written proof of delivery.

lnsert Hinged Ankle Brace RIGHT

A RIGHT prefabricated hinged AFO (Active Ankle Brace) (L1906) multiligamentous ankle support was dispensed and applied at this visit. Due to the patient's diagnosis and related symptoms this is medically necessary for treatment. These braces extend above the ankle and are fastened around the lower leg. The function of this device: (1) to restrict and limit motion, controlling the medial and lateral malleoli ankle joint (2) provide stabilization, (3) compression, and (4) decrease pain to the affected area. The goals and function of this device were explained to the patient at length. Upon examination, the device appeared to be fitting well and the patient states that the device is comfortable at this time. The patient was shown how to properly apply, wear, and care for the device. The patient demonstrated their ability to properly apply the device without difficulty. At the time the device was dispensed, it was in suitable condition and not substandard. No guarantees were given as to their effectiveness and all necessary precautions reviewed. An acknowledgment form was signed indicating that they received the product. Written instructions and warranty information were dispensed along with the Durable Medical Equipment standards. Patient signed written proof of delivery.

Any commands you would like us to enter?