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MICHAEL I. VENDER, M.D.
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PRASANTA TALURI, M.D.
SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

DONNA J. KERSTING, MBA
EXECUTIVE DIRECTOR

ARLINGTON HEIGHTS
515 W. ALGONQUIN RD.
ARLINGTON HEIGHTS, IL 60005
TEL: 847-956-0099
FAX: 847-956-0433

ALSIP
4600 W. 123TH STREET
ALSIP, IL 60803

BOLINGBROOK
301 S. BOLINGBROOK DR.
BOLINGBROOK, IL 60440

CHICAGO
600 W. ADAMS ST.
CHICAGO, IL 60661

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360 W. BUTTERFIELD RD., STE. 150
ELMHURST, IL 60123

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2150 PFINGSTEN RD., STE. 2200
GLENVIEW, IL 60026

OAK LAWN
9311 W. 95TH STREET
OAK LAWN, IL 60453

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VERNON HILLS, IL 60061

www.hssc.com

February 29, 2012

FRANK SEK, M.D.
4606 W. ELM STREET
MC HENRY, IL 60050

RE: PAUL DULBERG
OV: 02/27/2012

Dear Dr. Sek:

On February 27, 2012, I evaluated your patient, Mr. Paul Dulberg, concerning his right arm. He sustained a laceration of his forearm from a chainsaw accident on June 28, 2011. He developed symptoms of numbness in the small finger with weakness. He was treated with therapy. He had an EMG test and MRI scan.

PAST MEDICAL HISTORY: Remarkable for arthritis and cervical disc disease

MEDICATIONS: Naproxen, Tramadol, Cyclobenzoprine, Flexetine.

PHYSICAL EXAMINATION: The right forearm shows a 7 cm. transverse scar at the ulnar aspect of the mid forearm. There is local tenderness and sensitivity to percussion with a positive Tinel sign and paresthesias radiating into the small finger. There is also sensitivity at the cubital tunnel region. Wrist and elbow motion are unrestricted. There is no visible atrophy. He is unable to adduct the small finger. Flexion strength is grossly normal. Sensation is decreased to light touch in the small finger only with inconsistent two point discrimination.

X-RAY EXAMINATION: Outside films of the right forearm from June 20, 2011 were reviewed. There is no fracture or foreign body.

MRI films of the right forearm from February 3, 2012 were reviewed. No abnormality is seen.

A nerve conduction study by Dr. Levin from August 10, 2011 shows no evidence of diffuse neuropathy.

Sharply Nerve damage.

IMPRESSION: Right forearm laceration with probable partial ulnar nerve injury.

TREATMENT PLAN: I explained the diagnosis. For further evaluation, the patient was referred for additional electrodiagnostic testing including an EMG.

Occupational therapy reports were reviewed.

I explained the potential indication for surgery for nerve exploration, pending review of the electrical study.

He will follow-up after the EMG. Work status is no restriction.

If you have any further questions regarding Mr. Paul Dulberg, please feel free to contact me.

Sincerely,

Scott D. Sagerman, M.D.

SDS/sld
Cc: Karen Levin, MD

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MICHAEL I. VENDER, MD. PRASANT ATLURI, M.D.
SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 04/02/2012

CHART NOTE:
The patient was in the office today for evaluation of the right hand. He reports no change in his symptoms.

He had an EMG test by Dr. Levin, and the report from March 13, 2012 shows no evidence for neuropathy. The EMG portion showed no denervation, and ulnar nerve conduction was within normal limits.

PHYSICAL EXAMINATION: The right forearm scar is stable and nontender. There is sensitivity to percussion with a positive Tinel sign at the ulnar aspect of the scar. Adduction of the small finger remains limited consistent with a positive Wartenberg's sign.

TREATMENT PLAN: I explained the findings of the EMG test. Treatment options were given. He does not wish to pursue any surgery at this time.

A therapy referral was given for strengthening exercises and scar management.

NEXT VISIT: Six weeks or PRN.

ACTIVITY/WORK STATUS: Unrestricted.
Scott D. Sagerman, MD./all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
ELMHURST GLENVIEW OAKLAWN VERNON HILLS

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MICHAEL I. VENDER, MD. PRASANT ATLURI, M.D.
SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 05/14/2012

CHART NOTE:
The patient was in the office today for evaluation of the right arm. He reports persistent pain with use of his arm, especially gripping activities. He has had additional therapy which has been beneficial. He reports no change in his symptoms of numbness which is not bothersome. However, his function is limited due to his pain symptoms.

PHYSICAL EXAMINATION: The right forearm scar is tender at the ulnar aspect with a positive Tinel sign and local sensitivity. Composite finger flexion is full. There is no triggering or locking, there is no clawing. Wartenberg sign is positive. Intrinsic strength is slightly weak.

TREATMENT PLAN: I reviewed the diagnosis and treatment options. The possible surgical indication for ulnar nerve neurolysis was discussed. Before deciding on surgery, the patient will contact Dr. Levin for discussion of medication to address his nerve-related pain symptoms.

He will also see Dr. Biafora for a second opinion regarding possible surgical intervention.

NEXT VISIT: 5/17/2012 with Dr. Biafora.

ACTIVITY/WORK STATUS: Unrestricted.
Scott D. Sagerman, MD./all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
EMHURST GLENVIEW OAKLAWN VERNON HILLS

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MICHAEL I. VENDER, MD. PRASANT ATLURI, M.D.
SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Dr. Birman

Patient ID:	80330
Patient Name:	PAUL DULBERG
Date of Birth:	03/19/1970
Date of Service:	05/17/2012

CHART NOTE:
The patient was seen in the office today for evaluation of the right upper extremity. Mr. Dulberg is a patient of Dr. Sagerman's who presents today for a second opinion, referred by Dr. Sagerman. Briefly, Mr. Dulberg is a 41 year old, right hand dominant male who on June 28, 2011 sustained a chain saw injury to the right forearm. The patient states that he was told he had a partial nerve injury in the emergency room. Today, he reports some weakness in his right hand. He reports numbness in his right small and ring fingers at rest with occasional tingling. He also reports occasional shooting, burning type pain which radiates both proximally and distally from the area of the injury in the proximal forearm. This occurs several times a day at rest and more predictably with use. He denies ny previous injuries. He has undergone electrodiagnostic tests in the recent past. He was recently seen by Dr. Levin a few days ago and has been taking Neurontin over the past couple of days. The patient is currently applying for disability, secondary to his injury as he states that he is unable to perform his previous work activities.

PAST MEDICAL HISTORY: Arthritis, migraine headaches.

PAST SURGICAL HISTORY: Ulnar nerve decompression at the elbow with anterior transposition.

MEDICATIONS: Neurontin, Naproxen, Flexitine, Tramadol, Cyclobenzoprine.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: He smokes one pack of cigarettes per day.

PHYSICAL EXAM: Examination of the right upper extremity – elbow motion is from 0 to 140 degrees with full forearm rotation which is painless. There is a positive Tinel at the cubital tunnel through to approximately several centimeters distal to this. There is a transverse swelling and a healed scar, several millimeters in length in the proximal third of the forearm on the ulnar side. There is a positive Tinel over the scar at the most volar radial aspect of the scar. There is also significant tenderness at the scar to deep palpation on its most ulnar and distal border near the ulna. The Tinel over the most volar and radial aspect of the scar radiates into the ulnar digits. Moving two point discrimination in the small finger is 6-7 mm. There appears to be good strength to first dorsal

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
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Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 05/17/2012

Interosseous testing. Negative Froment's sign. Positive Wartenberg's. Full digital motion. He has good strength to DIP flexion of the small and ring fingers. There is pain at the scar on its most dorsal and ulnar border with resisted DIP flexion of the small finger. FCU function also appears to be intact, also eliciting pain at the scar. Electrodiagnostic studies dated March 13, 2012 has been reviewed.

ASSESSMENT: Approximately one year status post right forearm laceration with likely partial ulnar nerve injury, with ulnar nerve neuritis.

PLAN: The nature of the patient's condition has been explained in detail. All of his questions were answered. The patient may benefit from an ulnar nerve exploration with neurolysis. I would recommend this also include a cubital tunnel decompression with possible anterior transposition. He understands that this will not likely improve the motor deficits in his hand, however, it may improve he pain to his forearm. An ulnar nerve repair of a partial laceration is unlikely at this point. He also has a separate and distinct tenderness in the most dorsal ulnar aspect of the wound. He may require exploration of this portion of the scar as well. The patient would like some time to think about this. He will continue to be treated with the Neurotin under the neurologist. He will follow-up with Dr. Sagerman in four weeks.

NEXT VISIT: Four weeks.

ACTIVITY/WORK STATUS: Unrestricted.
Sam J. Biafora, MD/sld

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 06/06/2012

CHART NOTE:
The patient was in the office today for evaluation of the right elbow. He reports no change in his symptoms despite medication. He has side effects from the medication which interfere with functioning. He would like to proceed with surgery which was discussed with Dr. Biafora previously. He had additional therapy, but this was discontinued due to lack of progress.

PHYSICAL EXAMINATION: Examination of the right elbow and forearm is unchanged. A positive Tinel sign is present at the cubital tunnel without ulnar nerve subluxation. The forearm scar is stable with tenderness and sensitivity to percussion. He indicates pain with gripping activities localized to the forearm region and resulting in increased numbness in his ring and small fingers with weakness of his grip.

TREATMENT PLAN: I reviewed the diagnosis and treatment options. The surgical indication was discussed. Informed consent was obtained for the procedure. He understands the risks, benefits and possible complications of surgery as well as the expected outcome. The prognosis is guarded in terms of symptom improvement. However, he feels that any improvement in symptoms would be beneficial in terms of his arm functioning.

He was advised to contact the neurologist to report his symptoms associated with the use of Neurontin medication. Medical clearance will be obtained from his primary care physician before surgery is scheduled.

NEXT VISIT: After surgery.

ACTIVITY/WORK STATUS: Unrestricted.
Scott D. Sagerman, MD./all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

MLS: 55223
DD: Mon Jul 09 17:36:30 2012 EST
DT: Tue Jul 10 02:03:22 2012 EST
JN: 51418590

DSC OPERATIVE REPORT

DATE OF OPERATION: 07/09/2012

PREOPERATIVE DIAGNOSES:
1. Right cubital tunnel syndrome.
2. Right ulnar nerve injury at the forearm.

POSTOPERATIVE DIAGNOSES:
1. Right cubital tunnel syndrome.
2. Right ulnar nerve injury at the forearm.

PROCEDURES:
1. Right cubital tunnel release.
2. Right ulnar neurolysis at the forearm.

SURGEON: Scott Sagerman, MD.

ASSISTANT: Sam Biafora, MD.

ANESTHESIA: Regional block.

COMPLICATIONS: None.

TOURNIQUET TIME: 1 hour.

FINDINGS: The right cubital tunnel showed thickening of the cubital tunnel ligament with scarring of the ulnar nerve to the floor of the cubital tunnel and local constriction. The nerve also appeared constricted at the flexor pronator aponeurosis at the distal aspect of the cubital tunnel. Also, a thick arcade of Struthers was present proximal to the cubital tunnel, though the ulnar nerve was not visibly constricted at this level.

The right forearm, the site of the previous chainsaw laceration revealed extension to the subcutaneous tissue and fascia overlying the flexor carpi ulnaris muscle. A piece of retained absorbable suture material was present. The muscle fibers were intact. The ulnar nerve was intact beneath the muscle belly. There was no visible scarring around the ulnar nerve at this level.

DESCRIPTION OF PROCEDURE: Informed consent was obtained from the patient. Prophylactic IV antibiotic was given. He received medical clearance from his primary care physician. Regional block anesthetic was administered by the

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DSC OPERATIVE REPORT Page 1 of 2
cc: Sam Biafora, MD

DSC OPERATIVE REPORT, continued

NORTHWEST COMMUNITY HOSPITAL
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anesthesiologist in the right upper extremity. The right arm was prepped and draped sterilely. A sterile tourniquet was applied to the right upper arm, and it was elevated following exsanguination of the limb.

A longitudinal incision was made over the posteromedial aspect of the right elbow centered at the cubital tunnel. Under loupe magnification, the subcutaneous tissue was dissected. Superficial veins were ligated with bipolar cautery. A branch of the medial antebrachial cutaneous nerve was identified. This was gently retracted safely and protected. The fascia was incised proximal to the cubital tunnel, and the ulnar nerve was visualized. The cubital tunnel ligament was divided and completely released. The flexor pronator aponeurosis was also incised and released, and the nerve was dissected distally into the musculature where motor branches were identified. The release was then carried proximally, and the arcade of Struthers was divided and completely released. The ulnar nerve was inspected. The nerve was mobilized from adhesions with gentle blunt dissection. Nerve gliding was checked and found to be satisfactory. The ulnar nerve was stable at the cubital tunnel. The field was irrigated with antibiotic solution. The subcutaneous tissue was reapproximated with buried Vicryl sutures, and the skin edges were reapproximated with nylon sutures.

Attention was then directed to the forearm scar. A longitudinal incision was made over the ulnar aspect of the mid forearm centered at the site of the scar. Under loupe magnification, the subcutaneous tissue was dissected. The fascia was visualized. Superficial vein was ligated with bipolar cautery. The dermis was elevated off of the scarred fascia with blunt dissection. The retained suture material was removed. The muscle fibers were visualized and found to be in continuity. The ulnar nerve was exposed in the interval between the flexor digitorum and flexor carpi ulnaris muscle bellies. The nerve was dissected proximal and distal from the region of the laceration. The nerve was completely intact at this level with no visible scarring or adhesions. The field was irrigated with antibiotic solution. The subcutaneous tissue was reapproximated with buried Vicryl sutures, and the skin edges were reapproximated with nylon sutures.

A sterile bulky gauze dressing was applied. The tourniquet was deflated. Circulation returned to the right arm
with normal capillary refill distally. The patient was transported to recovery in stable condition. He tolerated the procedure well. There were no complications. An arm sling was applied for protection.

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DSC OPERATIVE REPORT Page 2 of 2
cc: Sam Biafora, MD

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cc: Sam Biafora, MD

Authenticated and Edited by Scott Sagerman MD On 7/10/12 11:58:39 AM

HAND SURGERY ASSOCIATES, S.C.

SPECIALISTS IN THE SHOULDER, ELBOW WRIST AND HAND

MICHAEL I. VENDER, MD. PRASANT ATLURI, M.D.
SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 07/11/2012

CHART NOTE:
The patient was in the office today for evaluation of the right arm. He is doing Ok. No problems after surgery. His pain is controlled.

PHYSICAL EXAMINATION: The right elbow and forearm incisions are clean. Sutures are in place. Minimal swelling. No drainage. No sign of infection. Circulation and sensation are intact distally.

TREATMENT PLAN: Operative findings were reviewed. Dressing was reapplied. Infection precautions were explained. Activity restrictions were given.

A therapy referral was provided for range-of-motion exercises and edema control measures. A padded elbow sleeve was applied for protection.

Follow up in two weeks for suture removal.

NEXT VISIT: Clinical 7/23/2012. Dr. Sagerman in Vernon Hills office 7/30/2012.

ACTIVITY/WORK STATUS: Off work.
Scott D. Sagerman, MD./all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 130 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 07/23/2012

CLINIC NOTE:
The patient was seen for a clinic visit today for evaluation of right forearm/elbow.

The patient states he is doing Ok.

All dressings are removed, and Steri-strips are applied.

NEXT VISIT: 7/30/2012 with Dr. Sagerman in the Vernon Hills office.

ACTIVITY/WORK STATUS: Off work.
Clinic Staff/all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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MICHAEL I. VENDER, MD. PRASANT ATLURI, M.D.
SCOTT D. SAGERMAN, M.D. SAM J. BIAFORA, M.D.
MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 07/30/2012

CHART NOTE:
The patient was in the office today for evaluation of the right forearm/elbow. He is doing well. His arm feels better. His hand function has increased, and he feels that his symptoms have improved since the surgery was performed.

PHYSICAL EXAMINATION: The right elbow and forearm incisions are healed. Scarring is stable. There is mild diffuse swelling adjacent to the forearm scar but no erythema, warmth or tenderness. Wrist, elbow and finger motion are satisfactory. Sensation is intact in all distributions. He indicates improved independent finger flexion in comparison to the preoperative function.

TREATMENT PLAN: I reviewed the operative findings. He will continue supervised therapy and home exercises, including light strengthening and scar management. A forearm sleeve will be prescribed for edema control.

Activity restrictions were reviewed. Follow up in one month.

NEXT VISIT: One month.

ACTIVITY/WORK STATUS: Restricted. Limited forceful gripping. No lifting/pushing/pulling.
Scott D. Sagerman, MD./all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 08/27/2012

CHART NOTE:
The patient was in the office today for evaluation of the right elbow. He is doing ok. His elbow is sore. He is participating in therapy. His progress is satisfactory. His grip strength has increased. His hand function has improved.

PHYSICAL EXAMINATION: The right elbow and forearm scars are stable. There is mild tenderness over the forearm scar at the ulnar aspect. There is no sign of infection. Elbow and wrist motion are unrestricted. There is no ulnar nerve subluxation. Intrinsic strength is increased. Sensation is intact in all distributions.

TREATMENT PLAN: The therapy progress report from August 21 2012 was reviewed. Additional therapy was prescribed, including scar management and strengthening. Continued improvement is expected over time.

He may advance activities as tolerated in conjunction with therapy. Follow-up six weeks. Work status is limited forceful gripping and no lifting/pushing/pulling.

NEXT VISIT: Six weeks.

ACTIVITY/WORK STATUS: Restricted. Limited forceful gripping and no lifting/pushing/pulling.
Scott D. Sagerman, MD./sld

PHONE: 847-956-0099 FAX: 847-956-0439
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 10/22/2012

CHART NOTE:
The patient was in the office today for evaluation of the right arm. He is feeling better. His function has improved. He had additional therapy with gains in his strength. The sensation in his fingers has improved. He is pleased that he can now grasp objects better than he did before surgery. He still has some difficulty with certain activities involving gripping and pinching small objects.

PHYSICAL EXAMINATION: The right elbow and forearm scars are stable and nontender. There is no sensitivity at the cubital tunnel. There is no ulnar nerve subluxation. He still has tenderness at the dorsal aspect of the forearm scar but less pain with gripping activities. His maximum grip strength was 112 pounds, according to the most recent therapy measurement.

TREATMENT PLAN: The patient will continue home exercises as previously directed by the therapist. He may advance activities with use of his right arm as tolerated. Continued improvement in strength is expected over time.

We discussed his work activities. He is currently unemployed and plans to pursue disability.

NEXT VISIT: Six weeks.

ACTIVITY/WORK STATUS: Restricted. Limited forceful gripping. Limited lifting/pushing/pulling.
Scott D. Sagerman, MD./all

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 12/03/2012

CHART NOTE:
The patient was in the office today for evaluation of his right hand. He still has some weakness in his pinch strength and difficulty grasping objects. He is performing home exercises.

He also reports a recent onset of left elbow symptoms with no preceding trauma.

PHYSICAL EXAMINATION: Examination of the right elbow and forearm scars are stable with no tenderness or sensitivity. Finger motion is normal. There is slight weakness in key pinch. Sensation is intact in all distributions.

The left elbow shows tenderness at the lateral epicondyle. Range of motion is guarded. There is pain at the end range of extension and pain is reproduced with resisted wrist extension. There is no effusion or bursitis. The posteromedial scar is stable. There is no joint crepitus.

X-RAY EXAMINATION: Multiple views of the left elbow today are negative.

IMPRESSION: Left lateral epicondylitis.

TREATMENT PLAN: I explained the diagnosis and treatment options. The etiology of the condition was discussed. A therapy referral is given for epicondylitis protocol. Activity modifications were explained. He will continue home exercises for the right hand for strengthening.

Follow-up 4-6 weeks. Work status is limited forceful gripping; limited lifting/pushing/pulling.

NEXT VISIT: 4-6 weeks.

ACTIVITY/WORK STATUS: Restricted. Limited forceful gripping; limited lifting/pushing/pulling.
Scott D. Sagerman, MD./sld

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
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MICHAEL V. BIRMAN, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 01/14/2013

CHART NOTE:
The patient was in the office today for evaluation of the left arm. He is doing ok. He is participating in therapy. His symptoms have improved.

PHYSICAL EXAMINATION: Examination of the left elbow shows tenderness at the lateral epicondyle which is improved. Range of motion is improved. There is slight pain with resisted wrist extension. There is no crepitus. The skin is intact.

TREATMENT PLAN: He will continue therapy and home exercises for epicondylitis protocol. Activity modifications reviewed. A counterforce forearm brace may also be tried in conjunction with the therapy program.

Follow-up one month. Work status is limited forceful gripping; limited lifting/pushing/pulling.

NEXT VISIT: One month.

ACTIVITY/WORK STATUS: Restricted. Limited forceful gripping; limited lifting/pushing/pulling.
Scott D. Sagerman, MD./sld

PHONE: 847-956-0099 FAX: 847-956-0433
515 W. ALGONQUIN ROAD, SUITE 120 ARLINGTON HEIGHTS, IL 60005
ALSIP BOLINGBROOK CHICAGO COUNTRYSIDE
EMHURST GLENVIEW OAKLAWN VERNON HILLS

WWW.HSASC.COM

HAND SURGERY ASSOCIATES, S.C.
SPECIALISTS IN THE SHOULDER, ELBOW WRIST AND HAND

MICHAEL I. VENDER, MD.
SCOTT D. SAGERMAN, M.D.
MICHAEL V. BIRMAN, M.D.
PRASANT ATLURI, M.D.
SAM J. BIAFORA, M.D.
AJAY K. BALARAM, M.D.

Patient ID: 80330
Patient Name: PAUL DULBERG
Date of Birth: 03/19/1970
Date of Service: 03/25/2013

CHART NOTE:
The patient was in the office today for evaluation of left elbow. He is doing well. His elbow feels better following therapy.

He has intermittent soreness in his right forearm area.

PHYSICAL EXAMINATION: The left elbow shows minimal tenderness at the lateral epicondyle. The skin is intact. Range of motion is full. There is slight pain with resisted wrist extension. There is no weakness.

The right forearm scar is stable. There is mild sensitivity at the most ulnar aspect.

TREATMENT PLAN: He will continue therapy and home exercises for the left elbow epicondylitis protocol. Continued improvement is expected over time. It does not appear that any invasive treatment is needed.

For the right forearm scar, a padded elbow sleeve was provided for protection.

He may return for follow up on an as-needed basis if symptoms worsen.

NEXT VISIT: PRN.

ACTIVITY/WORK STATUS: Restricted. Limited forceful gripping. Limited lifting/pushing/pulling.
Scott D. Sagerman, MD./all

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History & Physical Report #1

Paul Dulberg
7/8/2013 10:39 AM
Location: VH Office
Patient #: 80330
DOB: 3/19/1970
Undefined / Language: English / Race: Undefined
Male

History of Present Illness (Kim E Brandon, RT; 7/8/2013 10:44 AM)

The patient is a 43 year old male who presents for an evaluation of elbow pain. The pain is located in the left elbow. The onset of the elbow pain has been gradual and has been occurring for months. The course has been worsening. There are no relieving factors. Previous evaluations / treatments include : occupational therapy.

Allergies (Kim E Brandon, RT; 7/8/2013 10:40 AM)
No Known Drug Allergies. 07/08/2013

Family History (Kim E Brandon, RT; 7/8/2013 3:34 PM)
Cancer
Diabetes Mellitus

Social History (Kim E Brandon, RT; 7/8/2013 3:34 PM)
Hand Dominance. Right Handed.
Current Occupation. not working
Alcohol use. 07/08/2013: does not drink alcoholic beverages
Diabetic Diet. 07/08/2013: no
Illicit drug use. 07/08/2013: no
Tobacco use. 07/08/2013: Current every day smoker: 0.5 pack per day; Smoker for 20 years

Medication History (Kim E Brandon, RT; 7/8/2013 10:40 AM)
Naproxen DR (Oral) Specific dose unknown - Active.

Other Problems (Kim E Brandon, RT; 7/8/2013 3:34 PM)
Chronic or past head / neck disorders
Depression
Head Injury
Neurological disorder
Pneumonia

Review of Systems (Kim E Brandon, RT; 7/8/2013 3:34 PM)
General: Present- Chronic pain. Not Present- Fatigue, Fever, Night Sweats, Rapid weight loss or gain and Varicose veins / leg swelling.
HEENT: Not Present- Headache, Blindness / vision problems, Wears glasses/contact lenses, Hearing Loss, Ringing in the Ears and Dentures.
Respiratory: Not Present- Chronic Cough, Home oxygen use, Shortness of breath while resting, Shortness of breath from exertion and Wheezing.
Breast: Not Present- Breast Mass.
Cardiovascular: Not Present- Difficulty Breathing Lying Down, Leg cramps from exertion, Palpitations and Swollen ankles.
Gastrointestinal: Not Present- Abdominal Pain, Constipation, Diarrhea, Frequent nausea / vomiting, Heartburn and Stomach ulcers.
Male Genitourinary: Not Present- Blood in Urine, Bladder control problems, Chronic or past urinary disorders, Painful Urination and Recurrent bladder / kidney infections.
Musculoskeletal: Not Present- Back Pain, Fractures, Joint Pain, Joint Swelling and Muscle Cramps.
Neurological: Present- Numbness or tingling and Weakness In Extremities. Not Present- Blackout spells, Dizziness and Memory lapses.
Hematology: Not Present- Abnormal Bleeding, Easy Bruising and Excessive bleeding.

Vitals (Kim E Brandon, RT; 7/8/2013 10:42 AM)
7/8/2013 10:42 AM
Weight: 165 lb **Height:** 69 in
Body Surface Area: 1.91 m² **Body Mass Index:** 24.37 kg/m²

Physical Exam (Scott D Sagerman, MD; 7/8/2013 10:52 AM)
The physical exam findings are as follows:
Note: Left elbow slight tenderness over the lateral epicondyle. Skin intact. Range of motion full. Slight pain with resisted wrist extension.

Assessment & Plan (Kim E Brandon, RT; 7/8/2013 3:35 PM)

Lateral Epicondylitis (Tennis Elbow) (726.32)
Current Plans
| Treatment options explained
| Patient provided with referral for Occupational Therapy
| Intermediate Joint (Wrist / Elbow) Injection / Aspiration (20605)
| PROCEDURE / INJECTION

PROCEDURE: STEROID INJECTION

SITE: left elbow

Treatment options were reviewed. Explained risks, benefits, expectations, and possible side effects of steroid injection. The patient elected to proceed.

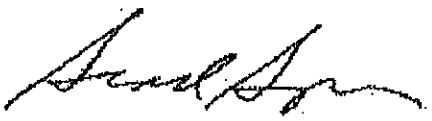
A Betadine and/or alcohol prep was performed. Precautions following the injection were explained. The patient tolerated the procedure well. Following the procedure there were no complaints. The patient was instructed to contact the office if any adverse reactions were noted.
| 1% Lidocaine HCl Injection, USP (J3490) (3 Units)
| Dexamethasone Sodium Phosphate Injection, USP (4mg/mL) (J1100)
| Follow up in 6 weeks
| Return to Work Date: _7-8-13_____

Work status discussed with patient and written statement was provided.

[x] Unrestricted [ ] Restricted Therapy: [ ] Yes [ ] No

[ ] Keep wound clean & dry [ ] No overhead use [ ] No lifting / pushing / pulling
[ ] No use of affected hand / arm [ ] Limited overhead use
[ ] Limited lifting / pushing / pulling _____#
[ ] Wear Splint / Sling / Cast [ ] No forceful gripping [ ] No gym / sports
[ ] Sedentary [ ] Limited forceful gripping

[ ] Other:



Signed electronically by Scott D Sagerman, MD (7/12/2013 10:59 AM)

Procedures

Intermediate Joint (Wrist / Elbow) Injection / Aspiration (20605) Performed: 07/08/2013 (Ordered)
1% Lidocaine HCl Injection, USP (J3490) (3 Units) Performed: 07/08/2013 (Ordered)
Dexamethasone Sodium Phosphate Injection, USP (4mg/mL) (J1100) Performed: 07/08/2013 (Ordered)

History & Physical Report #2

Paul Dulberg
8/26/2013 10:57 AM
Location: VH Office
Patient #: 80330
DOB: 3/19/1970
Undefined / Language: English / Race: Undefined
Male

History of Present Illness (Scott D Sagerman, MD; 8/29/2013 5:01 PM)
The patient is a 43 year old male presenting for a follow up visit. The patient is improving (Still complains of intermittent right forearm muscle cramping).

Physical Exam (Scott D Sagerman, MD; 8/26/2013 11:15 AM)
The physical exam findings are as follows:
Note: left elbow shows the tenderness in the lateral condyle region. Skin is intact. Range of motion full. No pain with resisted wrist extension. No joint crepitus.
right forearm scar is stable with no focal tenderness or sensitivity. He describes intermittent muscle spasms with the discomfort despite medication.

Assessment & Plan (Scott D Sagerman, MD; 8/29/2013 5:00 PM)
Lateral Epicondylitis (Tennis Elbow) (726.32)
Story: Left
Current Plans
Treatment options explained
Therapy notes reviewed / discussed with patient
Patient instructed to continue home exercise program. When morning stiffness has resolved, then home exercises may be discontinued.
Activity restrictions discussed
Follow up as needed
Return to Work Date: _08/26/13_____

Work status discussed with patient and written statement was provided.

[xx] Unrestricted [ ] Restricted Therapy: [ ] Yes [ ] No

[ ] Keep wound clean & dry [ ] No overhead use [ ] No lifting / pushing / pulling
[ ] No use of affected hand / arm [ ] Limited overhead use
[ ] Limited lifting / pushing / pulling _____#
[ ] Wear Splint / Sling / Cast [ ] No forceful gripping [ ] No gym / sports
[ ] Sedentary [ ] Limited forceful gripping

[ ] Other:

PAIN IN JOINT, FOREARM / ELBOW (719.43)
Story: right
Current Plans
Referral to Neurology, Dr Kathleen Kujawa

Note: the patient's neurologist suspects possible dystonia. Referral suggested for evaluation and medical treatment. Discussed with Dr. Levin.

Signed electronically by Scott D Sagerman, MD (8/29/2013 5:01 PM)

Open Advanced MRI

PATIENT: DULBERG, PAUL
MRN: 1585839
DOB: 03/19/1970

PHYSICIAN: LEVIN, MD, KAREN
EXAM: MR FOREARM W/ AND W/O 73220
DOS: 02/03/2012

EXAMINATION: MRI examination of the right forearm without and with intravenous contrast infusion..

CLINICAL HISTORY: History of right forearm trauma with a chainsaw. Possible neuroma, nerve impingement or injury in the forearm. Possible tendon disruption. It appears that the patient had some difficulty holding still during image acquisition. There is motion artifact on this examination. Weakness in the fourth and fifth fingers. Pain in the forearm and hand.

TECHNIQUE: Multiplanar T1 and T2-weighted spin-echo pulse sequences and STIR sequence. Post-infusion multiplanar T1-weighted sequences were performed. A skin marker was taped to the point of maximal symptoms.

Contrast: 15 cc of gadolinium was infused.

FINDINGS: There is no bone abnormality seen. The bone marrow signal characteristics are normal.

There is no cystic or solid mass appreciated. The visualized muscles have normal signal characteristics.

There is no abnormal soft tissue infiltration or induration. Specifically, in the area of the skin marker which is marking the point of maximal symptoms, there is no soft tissue abnormality appreciated.

There is no abnormality identified along the course of the ulnar nerve in the forearm.

IMPRESSION: There is no forearm abnormality appreciated. This does not exclude the possibility of an ulnar nerve impingement or injury but there is no gross mass or abnormal infiltration along the expected course of the ulnar nerve. No obvious tendon or muscle abnormality appreciated at this time.

Thank you for referring your patient to Open Advanced MRI. If you have any questions, Dr. Levin, please feel free to contact me at my direct line which is: 630.885.2100.

720 Rollins Road Round Lake Beach, IL 60073 Phone: 847-546-3600 Fax: 847-546-3633
www.openadvancedmri.com

Open Advanced MRI

DULBERG, PAUL
MR FOREARM W/ AND W/O 73220
02/03/2012

Thank you for referring your patient to Open Advanced MRI of Round Lake.

Electronically Signed By: THOMAS A. PREDEY MD

To the referring or consulting physician: If you would like to discuss this case in more detail or have any questions, please feel free to contact the author of this report: Dr. Ian Fisher (847) 414-5055, Dr. Jay Korach (847) 691-7673

720 Rollins Road Round Lake Beach, IL 60073 Phone: 847 546-3600 Fax: 847-546-3633
www.openadvancedmri.com

ASSOCIATED NEUROLOGY, S.C.

MITCHELL S. GROBMAN, M.D.
KAREN F. LEVIN, M.D.

July 28, 2011

Mr. Hans Mast
3416 W. Elm Street
McHenry, IL 60050

RE: Paul Dulberg

Dear Mr. Mast,

Mr. Dulberg was previously seen by my associate, Dr. Mitchell Grobman, in 2002 for left ulnar neuropathy, and had surgery and essentially became asymptomatic by 2007 and who had never had difficulty in his right arm. Approximately a month prior to the evaluation, he had been holding a branch for a neighbor when the chainsaw came up and cut his right forearm. He was taken to Northern Illinois Medical Center where they put in inner stitches in the muscle and outer stitches. He originally had very significant pain, but as the pain was getting better, he started noticing that he had numbness in his fifth digit in the inner aspect of his forearm. He had not been dropping things. It was mostly just a tingling and a numb feeling. He denies ever having any right-sided symptoms or right-sided injuries. His examination was significant for a healing scar in the right forearm and for decreased light touch, pinprick, and temperature sensation in the ulnar distribution of the right arm. His strength was normal. Given the distribution, it was felt that this was a branch neuropathy to the sensory nerves. I did have him undergo nerve conductions to make sure that the median and ulnar nerves were all without involvement and they were. I recommended that he see a hand surgeon as well just to be certain that there were no other treatment options for him; however, most likely this was just a sensory branch neuropathy that may improve or may result in permanent numbness in the distribution that he was showing numbness. Mr. Dulberg should followup if any additional symptoms develop or if he wished to try any neuropathic pain treatment if it became painful and not just numb.

Sincerely,

Karen Levin, MD (endm)

Karen F. Levin, M.D.

KFL/klm

1900 HOLLISTER DRIVE, SUITE 250, LIBERTYVILLE, IL 60048
PHONE (847) 549-0055 • FAX (847) 549-0404

FAXED 8/29/13 ct

DYNAMIC HAND THERAPY
Re-Evaluation of Progress, Goals and Plan of Care

Patient: Paul Dulberg Physician: Dr. Sagerman Date: 8/20/13
Diagnosis: (L) Lateral Epicondylitis Date of Injury: 11/12
Surgical Hx: Date 7/8/13 Procedure Cortisone Injection (L) elbow Start of Care: 7/23/13
~~Number of visits to date:~~

SUBJECTIVE:
(L) Pain: ø /10 at rest / best 2-3 /10 with activity / ~~[illegible]~~ 5-6/10 c heavy grasp.
Details: Pain improved from 3-4/10 c activity ; 5-6/10 worst unchanged
Function/ADL's:
~~Improvements: Bringing hand to mouth (i.e. [illegible] [illegible])~~
Continued difficulties: Strength and lifting of objects

OBJECTIVE:
Wound/Scar: ø
See flow sheet for:
☐ Edema: No sig edema noted
☐ Sensation:
☑ ROM: Slight impairments noted in ✓/ /, sup in LUE
☑ Strength: (L) 3pt c 2pt pinch impaired ; (B) grasp decreased (R > L)
Treatment summary to date: Focus of Rx has been stga, stretching, Deep tissue massage, and modalities (MHP c US)

Goals: STG's met: ☐ yes ☑ no LTG's met: ☐ yes ☑ no

Revised functional goals:

1. TBA y pt RTOT
2.
3.

08/26/2013 MON 8:54 AM [TX/RX NO 6851] 0003

08/26/2013 08:51 FAX 18479560433 Hand Surgery Associates 0004/0007
AUG-26-2013 MON 09:26 AM P. 003

Patient: Paul Dulberg Date: 8/22/13

Assessment/therapist impression: Pt has made some improvements, but has also regressed in grip bilaterally — he reports "having a weak day today" — will continue to perform OT per MD order.

Skilled therapy needed for: ☐ progression of exercise ☐ continued need for manual therapy

☐ other:

PLAN:

Modalities: Cont OT per MD order

Exercise:

Splinting:

Other:

Rehabilitation Potential: ☐ excellent ☐ good ☐ fair ☐ guarded ☐ other

Frequency/Duration: ____ times/week for ____ weeks or ____ additional visits

I have reviewed this plan of care and recertify a continuing need for services from the date of this updated plan of care; the above updated plan of care is herein established and will be reviewed every 30 days.

Additional requests/concerns: Add'l HEP

Therapist Signature

The above notes have been reviewed.
Physician's Signature (verbal RX. date
Written RX will be provided if appropriate

8/29/13

Fax this page back to 847-587-3346

08/26/2013 MON 8:54 AM [TX/RX NO 6851] 0004

Dynamic Hand Therapy Grip / Pinch Strength Flow Sheet

Patient Name: Paul Oelberg

Exam Date	8/2[illegible]/13							
Measurements: Kg / Lbs								
Grip Strength – Jamar 2nd Position	R	L	R	L	R	L	R	L
Trial 1	100	130						
Trial 2	100	126						
Trial 3	90	130						
Average	[illegible]	129						
[illegible]								
[illegible] Dynamometer								
Intrinsics: 1st Position								
2nd Position								
3rd Position								
4th Position								
Extrinsics: 5th Position								
[illegible]								
Rapid Alternating Test								
[illegible]								
Pinch Strengths								
3-Point (3-Jaw Chuck)	22	19 (14)						
2-Point (Pad)	17	16 (15)						
Lateral Key	26	20 (25)						
[illegible]								
Examiner's initials	MMB							

Patient: Paul Dulberg Date: 8/22/13

Assessment/therapist impression: Pt has made some improvements, but has also regressed in grip. Pt states "having a weak day today" but will continue to perform OT per MD order.

Skilled therapy needed for: ☐ progression of exercise ☐ continued need for manual therapy

☐ other: _____

PLAN:

Modalities: Cont OT per MD order

Exercise: _____

Splinting: _____

Other: _____

Rehabilitation Potential: ☐ excellent ☐ good ☑ fair ☐ guarded ☐ other _____

Frequency/Duration: _____ times/week for _____ weeks or _____ additional visits

I have reviewed this plan of care and recertify a continuing need for services from the date of this updated plan of care; the above updated plan of care is herein established and will be reviewed every 30 days.

Additional requests/concerns: Needs HEP

Date

Therapist Signature

The above notes have been reviewed.
*Physician's Signature previous RX. date
*New RX will be provided if appropriate

8/29/13

Fax this page back to 847-587-3346

Dynamic Hand Therapy Grip / Pinch Strength Flow Sheet

Patient Name: Paul Dulberg

Exam Date			8/26/13									
Measurements: Kg Lb			R									
Grip Strength – Jamar 2nd Position			L									
	Trial 1		150									
	Trial 2		150	130								
	Trial 3		96	124								
	Average		99	129								
Grip Curve – Jamar Dynamometer												
Jtrichs:	1st Position											
	2nd Position											
	3rd Position											
	4th Position											
Extrinsics:	5th Position											
Pinch Strengths												
3-Point (3-Jaw Chuck)			22	19 (14)								
2-Point (Pad)			17	16 (12)								
Lateral Key			26	24 (18)								
Examiner's Initials			JMS									

Dynamic Hand Therapy Grip / Pinch Strength Flow Sheet

Patient Name: Paul Dulberg

Exam Date	1/30/13		2-28-13		3/29/13		4/22/13		7/23/13	
Measurements: Kg Lb	R	L	R	L	R	L	R	L	R	L
Grip Strength – Jamar 2nd Position										
Trial 1	160	85	101	130	108	113	114	135	119	130
Trial 2	110	110	102	137	110	130	84	136	109	126
Trial 3	116	99	119	136	99	116	102	136	125	145
Average	109	98	107#	134#	105	120		136	118	134
Grip Curve – Jamar Dynamometer										
Intrinsics: 1st Position										
2nd Position										
3rd Position										
4th Position										
Extrinsics: 5th Position										
Alternating Test										
Pinch Strengths										
3-Point (3-Jaw Chuck)	16	12	15	23	11	22 (21#)	15	24 (22)	22	15
2-Point (Pad)	8	13	11	13	14	12 (16#)	13	15 (13)	15	15
Lateral Key	17	20	15	27	20	20 (17#)	20	28 (18)	25	26
Examiner's initials	MWS		NW		MWS		NW		MWS	

Dynamic Hand Therapy – Active Range of Motion Patient Name: Paul Dulberg

Exam Date	(L) 12/2/12	(L) 1/30/13	(L) 2/28/13	(L) 3/29/13	(L) 4/27/13	(L) 7/23/13	(L) 8/22/13
Shoulder							
Flexion							
Extension							
Abduction							
External Rotation							
Internal Rotation							
Elbow & Forearm							
Flexion	100	120-125	148	151	155	148	149
Extension	11	20-8	0	0	-8	-6	-4
Pronation	65	35	70	75	75+	75	75
Supination	70	75	75	75	80	75	75
Wrist							
Flexion	45	70+	75	75	75	75	
Extension	10	20+	70	75	70	70	
Radial Deviation	25	35	30	30	25	25	
Ulnar Deviation	25	35	30	35	30+	35	
Thumb							
MCP Extension/Flexion							
PIP Extension/Flexion							
Radial Abduction							
Palmar Abduction							
Opposition							
Index Finger							
MCP Extension/Flexion							
PIP Extension/Flexion							
DIP Extension/Flexion							
TAM							
Long Finger							
MCP Extension/Flexion							
PIP Extension/Flexion							
DIP Extension/Flexion							
TAM							
Ring Finger							
MCP Extension/Flexion							
PIP Extension/Flexion							
DIP Extension/Flexion							
TAM							
Small Finger							
MCP Extension/Flexion							
PIP Extension/Flexion							
DIP Extension/Flexion							
TAM							
Therapist Initials	LMS	LMS	NW	LMS	NW	LMS	LMS

Hand Surgery Associates, S.C.
Hand • Shoulder • Elbow • Wrist
TEL.: 847-956-0099 FAX: 847-956-0433
515 W. Algonquin Rd., Arlington Heights, IL 60005
ALSIP, BOLINGBROOK, CHICAGO, COUNTRYSIDE, ELMHURST, GLENVIEW, OAK LAWN, VERNON HILLS

PATIENT NAME: Dulberg, Paul

DOI: _____ DOS: _____ [ ] MUST BE SEEN TODAY [X] UPDATED ORDERS [ ] CAN BE RESCHEDULED

DIAGNOSIS: (L) fracture | Epicondylitis

THERAPY: ORDER/EOR _____ 1-2 VISITS 1-2 TIMES/WEEK 6 WEEKS FREQUENCY _____ CODE _____

SITE OF THERAPY ORDERED: SHOULDER ____ UPPER ARM ____ ELBOW ____ WRIST ____ HAND ____ PLEASE INDICATE R OR L

ACUTE HAND THERAPY
- ____ EVALUATE
- ✓ TREATMENT
- ✓ AROM
- ✓ PROM/STRETCHING
- ✓ STRENGTHENING
- ____ BTE
- ____ EDEMA CONTROL
- ____ SCAR MGMT/MOBILIZATION
- ____ DESENSITIZATION
- ✓ HOME PROGRAM
- PREVENTION

WOUND CARE
- ____ WHIRLPOOL
- FREQUENCY ____
- ____ DRESSING CHANGES
- TYPE _____
- FREQ _____

MODALITIES
- ✓ ULTRASOUND/PHONOPHORESIS
- ____ ELECTRICAL STIM ____
- ____ FLUIDOTHERAPY
- ____ PARAFFIN
- ____ IONTOPHORESIS ____ DEXAMETHASONE
- ✓ COLD/HOT PACKS
- ____ BIOFEEDBACK

SPLINTING: _STATIC _DYNAMIC
_ SERIAL STATIC
_ HAND BASED THUMB CMC
SPLINTS ALTERNATIVES
TO: _____

SPLINTING INSTRUCTIONS

SPECIAL THERAPY INSTRUCTIONS
NIRSCHL
Protocol

WORK READINESS

SIGNATURE: _____ DATE: 2/8/13

MICHAEL I. VENDER, M.D. SCOTT D. SAGERMAN, M.D. PRASANT ATLURI, M.D. SAN J. BIAFORA, M.D. MICHAEL V. BIRMAN, M.D.
SIGNATURE OF M.D. CONSTITUTES MEDICAL NECESSITY

#80330

Associated Neurology, S.C.

MITCHELL S. GROBMAN, M.D.
KAREN F. LEVIN, M.D.

NEUROPHYSIOLOGY REPORT

Name: Dulberg, Paul. Test No.: 12-0305 Date of Exam: 13 Mar 12
Consulting Doctor: Scott Sagerman, M.D.

Motor Nerve Conduction:

Nerve and Site	Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Median.R						
Wrist	3.9 ms	5.4 mV				
Elbow	8.3 ms	3.1 mV	Wrist-Elbow	4.4 ms	240 mm	55 m/s
Ulnar.R						
Wrist	3.0 ms	12.2 mV				
Below elbow	6.7 ms	11.4 mV	Wrist-Below elbow	3.7 ms	220 mm	59 m/s
Above elbow	8.4 ms	11.3 mV	Below elbow-Above elbow	1.7 ms	100 mm	59 m/s

F-Wave Studies:

Nerve	M-Latency	F-Latency
Median.R	3.9 ms	29.6 ms
Ulnar.R	3.3 ms	28.7 ms

Sensory Nerve Conduction:

Nerve and Site	Onset Latency	Peak Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Median.R							
Digit II (index finger)	2.4 ms	3.2 ms	23 µV	Wrist-Digit II (index finger)	2.4 ms	130 mm	53 m/s
Ulnar.R							
Digit V (little finger)	2.0 ms	2.7 ms	28 µV	Wrist-Digit V (little finger)	2.0 ms	110 mm	55 m/s

Needle EMG Examination:

Muscle	Spontaneous and Volitional Activity					
	Fibs	+Waves	Fasc's	Poly	Amp	Dur
Flexor carpi radialis.R	None	None	None	None	Normal	Normal
Flexor carpi ulnaris.R	None	None	None	None	Normal	Normal
Extensor indicis proprius.R	None	None	None	None	Normal	Normal
1st dorsal interosseous.R	None	None	None	None	Normal	Normal
Abductor digiti minimi (manus).R	None	None	None	None	Normal	Normal
Abductor pollicis brevis.R	None	None	None	None	Normal	Normal

Interpretation: NCV: Motor: Right median and ulnar motor responses are within normal limits. F-wave: Right median and ulnar f-waves are within normal limits. Sensory: Right median and ulnar responses are within normal limits.

EMG: No denervation potentials are seen.

Conclusions: No electrophysiologic evidence of focal or diffuse peripheral neuropathy.

Karen F. Levin, M.D.

1900 HOLLISTER DRIVE, SUITE 250, LIBERTYVILLE, IL 60048
PHONE (847) 549-0055 • FAX (847) 549-0404

Associated Neurology, S.C.

MITCHELL S. GROBMAN, M.D.
KAREN F. LEVIN, M.D.

NEUROPHYSIOLOGY REPORT

Name: Dulberg, Paul Test No.: 11-0802 Date of Exam: 10 Aug 11

Motor Nerve Conduction:

Nerve and Site	Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Median.R						
Wrist	3.9 ms	9.1 mV				
Elbow	8.8 ms	6.1 mV	Wrist-Elbow	4.9 ms	255 mm	52 m/s
Ulnar.R						
Wrist	2.9 ms	10.7 mV				
Below elbow	6.2 ms	10.1 mV	Wrist-Below elbow	3.3 ms	180 mm	55 m/s
Above elbow	7.7 ms	9.5 mV	Below elbow-Above elbow	1.5 ms	100 mm	67 m/s

F-Wave Studies:

Nerve	M-Latency	F-Latency
Median.R	3.8 ms	30.9 ms
Ulnar.R	2.9 ms	27.3 ms

Sensory Nerve Conduction:

Nerve and Site	Onset Latency	Peak Latency	Amplitude	Segment	Latency Difference	Distance	Conduction Velocity
Median.R							
Digit II (index fing	2.3 ms	2.9 ms	22 µV	Wrist-Digit II (index finger)	2.3 ms	130 mm	57 m/s
Ulnar.R							
Digit V (little fing	2.0 ms	2.6 ms	28 µV	Wrist-Digit V (little finger)	2.0 ms	110 mm	55 m/s

Interpretation: NCV: Motor: Right median and ulnar motor responses are within normal limits. F-wave: Right median and ulnar f-waves are within normal limits. Sensory: Right median and ulnar responses are within normal limits.

Conclusions: No electrophysiologic evidence of diffuse neuropathy.

Karen F. Levin, M.D.

3900 HOLLISTER DRIVE, SUITE 250, LIBERTYVILLE, IL 60048
PHONE (847) 549-0055 • FAX (847) 549-0404

DYNAMIC HAND THERAPY 4-24-13
Re-Evaluation of Progress, Goals and Plan of Care

Patient: Paul Dulberg Physician: Dr. Sagerman Date: 4-22-13

Diagnosis: (L) Lateral Epicondylitis Date of Injury: 11/12

Surgical Hx: Date _____ Procedure _____ Start of Care: _____

Number of visits to date: _____

SUBJECTIVE:
Pain: 2 /10 at rest / best 3-4 /10 with activity / at worst "3 Spikes up to 6/10

Details: Only using splint now "after I hurt it", Pain spikes 2 quick supination movements

Function/ADL's:
Improvements: Opening potato chip bags, ↓ing pain 2 most activities, lifting ½ gallon

Continued difficulties: Opening a yogurt, opening tight containers, resealing bags making bread, lifting full pots & pans

OBJECTIVE:
Wound/Scar: N/A

See flow sheet for:

☐ Edema: NT

☐ Sensation: NT

☑ ROM: ↑'d elbow ✓ & supination

☑ Strength: (L) grip ↑'d 16#, (L) 3pt ↑'d 2#, (L) 2pt ↑'d 3#, (L) Lat pinch ↑'d 8#

Treatment summary to date: Pt has been performing home exercises & using splint as needed for pain for past 4 wks. Pt has shown continuing improvements in strength & functional activities.

~~**Goals:** STG's met: ☐ yes ☐ no LTG's met: ☐ yes ☐ no~~

Revised functional goals:

1. D/C OT. ☐ H.E.P.
2. _____
3. _____

Patient: Paul Dulberg Date: 4-22-13

Assessment/therapist impression: Pt has shown improvements in all areas while continuing w HEP & feels he is ready for discharge at this time

Skilled therapy needed for: ☐ progression of exercise ☐ continued need for manual therapy

☐ other: D/C O.T.

PLAN:

Modalities:

Exercise:

Splinting:

Other:

Rehabilitation Potential: ☐ excellent ☒ good ☐ fair ☐ guarded ☐ other

Frequency/Duration: 0 times/week for 0 weeks or 0 additional visits

I have reviewed this plan of care and recertify a continuing need for services from the date of this updated plan of care; the above updated plan of care is herein established and will be reviewed every 30 days.

Additional requests/concerns:

Therapist Signature

Physician's Signature 4/23/13 date

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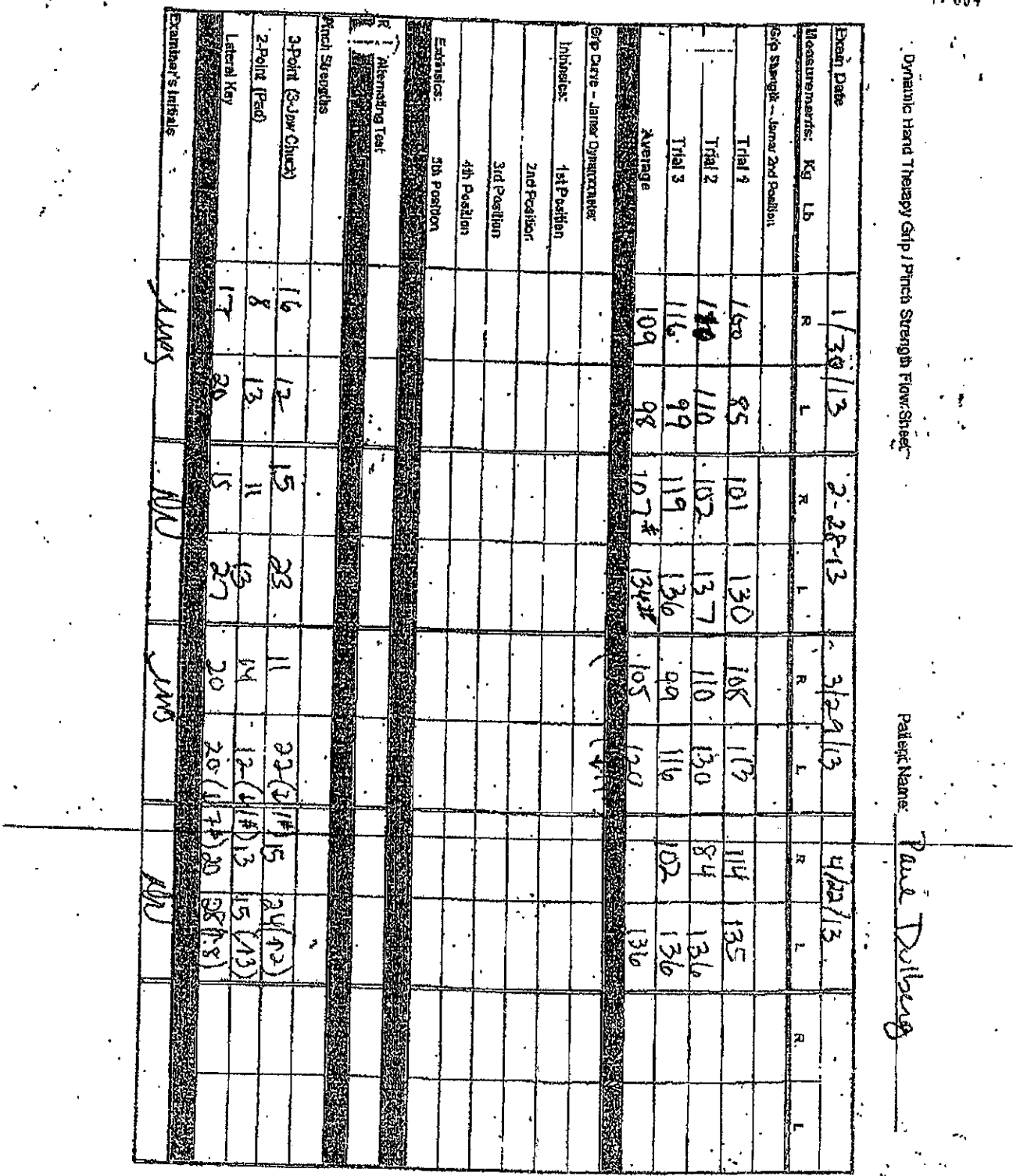

Dynamic Hand Therapy Grip / Pinch Strength Flowsheet

Patient Name: Paul Dulberg

Exam Date	1/30/13		2-28-13		3/29/13		4/22/13	
Measurements: Kg Lb	R	L	R	L	R	L	R	L
Grip Strength – Jamar 2nd Position								
Trial 1	130	85	101	130	108	113	114	135
Trial 2	110	110	102	137	110	130	84	136
Trial 3	116	99	119	136	99	116	102	136
Average	109	98	107#	134#	105	120		136
Grip Curve – Jamar Dynamometer								
Intrinsics: 1st Position								
2nd Position								
3rd Position								
4th Position								
Extrinsics: 5th Position								
R Alternating Test L								
Pinch Strengths								
3-Point (3-Jaw Chuck)	16	12	15	23	11	22(20#)	15	24(19)
2-Point (Pad)	8	13	11	13	14	12(11#)	13	15(13)
Lateral Key	17	20	15	27	20	20(17#)	20	28(18)
Examiner's Initials	JMS		ADU		JMS		ADU	

Dynamic Hand Therapy -- Active Range of Motion Patient Name: Paul Dulberg

	(L)	(L)	(L)	(L)	(L)
Exam Date	12/12/12	1/30/13	2/28/13	3/29/13	4/22/13
Shoulder					
Flexion					
Extension					
Abduction					
External Rotation					
Internal Rotation					
Elbow & Forearm					
Flexion	100	130	148	151	155
Extension	14	-8	0	0	-8
Pronation	65	75	70	75	75+
Supination	70	35	75	75	80
Wrist					
Flexion	45	70+	75	75	75
Extension	60	70+	70	75	70
Radial Deviation	25	25	30	30	25
Ulnar Deviation	25	35	30	35	30+
Thumb					
MCP Extension/Flexion					
PIP Extension/Flexion					
Radial Abduction					
Palmar Abduction					
Opposition					
Index Finger					
MCP Extension/Flexion					
PIP Extension/Flexion					
DIP Extension/Flexion					
TAM					
Long Finger					
MCP Extension/Flexion					
PIP Extension/Flexion					
DIP Extension/Flexion					
TAM					
Ring Finger					
MCP Extension/Flexion					
PIP Extension/Flexion					
DIP Extension/Flexion					
TAM					
Small Finger					
MCP Extension/Flexion					
PIP Extension/Flexion					
DIP Extension/Flexion					
TAM					
Therapist Initials	MMS	MMS	DD	MMS	DD