OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name Christine Townsend	Date of Birth 5-15-73	Social Security Number 073-60-0318
Patient Address 59 Briggs Ave, Buffalo, N.Y. 14207		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. **Name and address of health provider or entity to release this information:**
Dr. Joseph Donald Gentile, 4239 Maple Rd 14226

8. **Name and address of person(s) or category of person to whom this information will be sent:**
The Law Offices of Matthew Albert Esq. 254 Richmond Avenue, Buffalo, NY 14222

9 (a). **Specific information to be released:**

☐ Medical Record from (insert date) 12-10-10 to (insert date) Present

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐Other: ____________

Include: (*Indicate by Initialing*)

MA __ **Alcohol/Drug Treatment**

MA __ **Mental Health Information**

____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☒ By initialing here CT (Initials) I authorize Joseph Gentile (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

The Laws Offices of Matthew Albert Esq.

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☒At request of individual ☐ Other:	11. Date or event on which this authorization will expire: **At the conclusion of the trial**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

[signature] Date: 12/21/15

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts**

Case No. ______ Patient's Name Christine Townsend Sheet ______ of ______

Mo.	Day	Yr.	Subsequent Visits And Findings
9	20	13	FS only [signature]
1	13	14	[illegible handwriting] Imp [illegible] [signature]
5	16	14	Imm. Care 5/9/14 — (L) ankle sprain [illegible handwriting] Imp [illegible] (L) ankle [illegible] [signature]

Case No. ____________

Patient's Name Christine Townsend

Sheet ______ of ______

Insurance Co. ____________

☐HMO Copay $ ______

Mail Claim To ____________

☐PPO Copay $ ______

Policy No. ____________

Date Mo.	Day	Yr.	Subsequent Visits And Findings
4	23	15	283#
			① [illegible]
			② [illegible]
			[illegible] — [illegible] MRI [illegible]
			③ [illegible] — [illegible] NSAID — [illegible]
			[illegible] BP 130/80
			[illegible]
			[illegible]

Case No. ______

Patient's Name ______

Sheet ______ of ______

Case No.

Patient's Name Christine Townsend Sheet ____ of ____

Date			Subsequent Visits And Findings
Mo.	Day	Yr.	
1	14	13	[illegible signatures]

Case No.

Patient's Name

Sheet ____ of ____

Case No. ____________

Patient's Name ____________ Sheet ____ of ____

Insurance Co. ____________ ☐HMO Copay $____

Mail Claim To ____________ ☐PPO Copay $____

Policy No. ____________

Date			Subsequent Visits And Findings
Mo.	Day	Yr.	
9	4	12	259# [illegible]
			[illegible]
			[illegible]
			[illegible]
			[illegible] 12/22/84
			[illegible]
			[illegible] BPV
			[illegible]
			[illegible] 25 [illegible]
			[illegible] 10 [illegible]
1	7	14	OOW since 12/31/12
			[illegible]
			[illegible] 12 [illegible]
			[illegible]
			[illegible] 12/4/82
			[illegible]
			RTW 1/10/13 [illegible]

Case No. ____ Patient's Name ____ Sheet ____ of ____

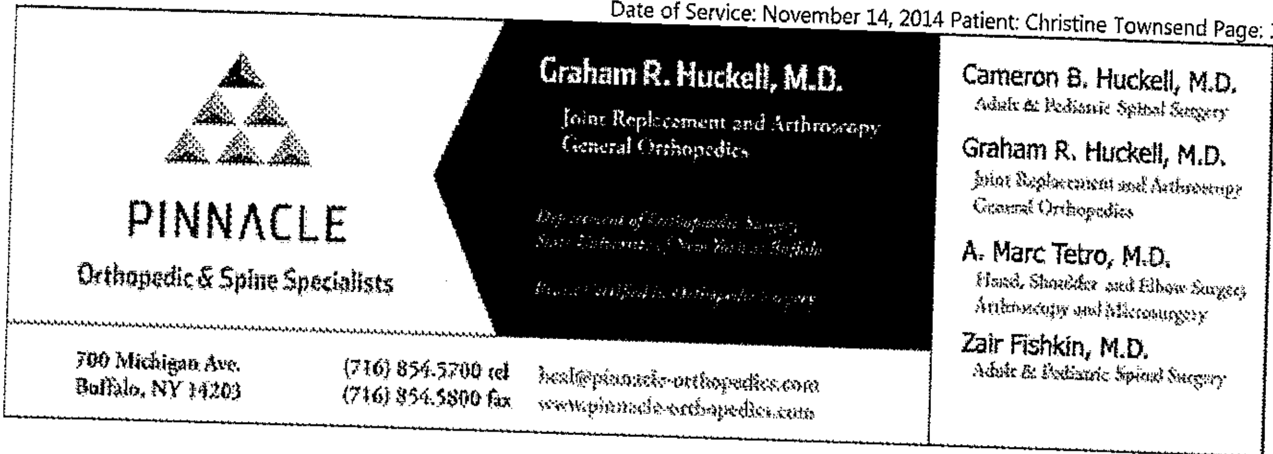
Case No. ______ Patient's Name Christine Townsend Sheet ______ of ______

Mo.	Day	Yr.	Subsequent Visits And Findings
2	16	10	[illegible]
8	3	11	[illegible]
9	27	12	[illegible]

Case No. ______

Patient's Name ______

Sheet ______ of ______



CORRECTED COPY

11/14/2014

William Owens DC
191 North Street Suite 104
Buffalo, NY 14201

RE: Christine Townsend
59 Briggs Ave
Buffalo NY 14207
SS#: 073-60-0318
DOB: 5/15/1973
MR#: 86775

Dear Dr. William Owens

I enjoyed seeing Christine Townsend in consultation today.

Chief Complaint:
Left ankle and foot pain since May 9, 2014

History:
Christine Townsend, a 41 year(s) female, presents to the office today with complaints of pain in the left ankle and foot following the injury on May 9, 2014.

Christine presents for reevaluation of the left ankle for a MRI review. She continues to experience anterior and lateral left ankle pain. She denies any new injury or trauma to the left ankle.

The focus of today's consultation was limited to the left ankle. The quality of the pain is described as dull and aching and sharp in character. On a scale of 10, with 10 being the worst pain, Christine rates it to be a 7. The pain has been present since 5/9/14. The pain is made worse with increased activities, and better with rest. Associated signs and symptoms include: Lateral and anterior left ankle pain.

Occupation:	RN
Work Status:	Full Time
Recreational activities:	Travel

Medical History and Review of Systems:

Past Medical History: No Medical Problems Reported

Past Surgical History: Tonsillectomy

Medication: Protonix (pantoprazole) (Dosage: 40 mg|granules DR for susp in packet)

Allergies:
Cephalosporins Group: urticaria (hives): unspecified
ibuprofen: swelling: unspecified
naproxen: swelling: unspecified
Sulfa (Sulfonamide Antibiotics) Group: urticaria (hives): unspecified

Social History:
Alcohol: Denies
Drug Use: Denies
Education: Some College
Employment: Full-Time
Marital Status: Separated
Tobacco: Denies

Family History:
Diabetes
Heart disease

Review of Systems:

YES	NO	
( )	(X)	Constitutional -- weight-loss, weight gain, fatigue, night sweats, fever
( )	(X)	Eyes
( )	(X)	Ears, nose, throat -- balance, nosebleeds
( )	(X)	Cardiovascular, heart, circulation
( )	(X)	Respiratory -- breathing, shortness of breath
( )	(X)	Gastrointestinal -- stomach ulcers, stomach upset, constipation, diarrhea
( )	(X)	GU -- burning on urination, frequency, nocturia
( )	(X)	Musculoskeletal -- bone or joint problems
( )	(X)	Integumentary -- skin problems
( )	(X)	Neurologic -- stroke, TIA, numbness, tingling
( )	(X)	Psychiatric -- depression, anxiety
( )	(X)	Endocrine -- blood sugar, thyroid problems
( )	(X)	Hem/ Lymph -- anemia, bleeding
( )	(X)	Allergic/immunologic -- seasonal allergies, frequent infections

Physical Examination:

Constitutional: Well nourished, good color on room air.
HEIGHT / LENGTH: 5' 6"
TEMPERATURE: 99.3
PULSE: 93
PULSE OX: 99

Cardiovascular: Peripheral pulses are palpable, dorsalis pedis, posterior tibial. Capillary fill less than 2 seconds.

Lymphatic: No jugular venous distension.

Musculoskeletal: Gait: Normal
Inspection: Left ankle: no deformity, skin is intact, no ecchymosis, tenderness to palpation over the medial talus, tenderness to palpation over the anterior talofibular ligament, tenderness to palpation of the lateral malleolus, mild tenderness to palpation of the medial malleolus, no tenderness over the posterior talofibular ligament or calcaneofibular ligament, no tenderness over the deltoid ligament. No tenderness on the Achilles tendon, no palpable defects; negative thompson test; no calf tenderness

	ROM: Left ankle: Dorsiflexion 30°, plantar flexion 60°, inversion 25°, eversion 30°; functional range of motion left knee
	Stability: Negative drawer sign left ankle
	Strength: 5/5 left lower extremity
Skin:	Normal left foot and ankle
Neurologic:	Sensation: Normal
	Coordination: Normal
Psychiatric:	Alert and oriented x 3. Has normal mood and affect.

INVESTIGATIONS:

X-RAY: November 4, 2014, AP, lateral, and mortise view of the right ankle reveals preservation of the joint space. There is a defect noted of the medial talar dome without evidence of significant displacement. Lucency is present in the medial talus. No dislocation is evident. No degenerative changes are present.

X-RAY INTERPRETATION: Lucency medial talus right ankle, possible osteochondral fracture.

XRAY: November 4, 2014 AP, lateral, and oblique of the left foot reveals mild degenerative changes in the tarsal area of the left foot was slight dorsal spurring evident. A small calcaneal spur is evident. No dislocation or fracture is evident.

XRAY INTERPRETATION: Mild osteoarthritis left foot.

MRIS:

Accession No. : 01315188
Patient Name / ID : TOWNSEND, CHRISTINE / 204520
Exam Date : 11/05/2014 18:33:28 (Approved)
Study Comment : TEACHANKLEOCDPB SPLIT
Sex / Age : F / 041Y

torreMRI LEFT ANKLE

CLINICAL INDICATIONS: Injury 05/2014 with persistent ankle pain.

IMAGING SEQUENCES:Both spin echo and inversion recovery sequences were utilized to evaluate the ankle in the sagittal, axial, and coronal planes.

FINDINGS:There is a large (10 mm) osteochondral defect in the medial talar dome. This osteochondral fragment is undercut by fluid indicating a free fragment. This is best seen on the T2 coronal image #14. The remainder of the talus is intact. The distal tibia, distal fibula, and calcaneus are intact.

The medial and lateral ligaments are intact. The medial tendons are intact.

There is fluid in the peroneal tendon sheath. There is a longitudinal split-thickness tear of the peroneus brevis tendon at its crosses the lateral malleolus. The peroneus longus is intact. The Achilles tendon is intact.

There are small dorsal intertarsal marginal osteophytes. There are small tarsal metatarsal marginal osteophytes and subchondral cysts.

IMPRESSION:
1.LARGE OSTEOCHONDRAL DEFECT AT THE MEDIAL ASPECT OF THE TALAR DOME UNDERCUT BY FLUID INDICATING A FREE FRAGMENT.
2.PERONEAL TENOSYNOVITIS WITH A LONGITUDINAL SPLIT TEAR OF THE PERONEUS BREVISTENDON.
3.TARSAL METATARSAL AND INTERTARSAL OSTEOARTHRITIS.

ASSESSMENT:
Left ankle sprain
Mild osteoarthritis left foot
Osteochondral defect medial talus
Left peroneus brevis tendon split tear

PLAN:

Christine Townsend has been primarily over the lateral aspect of the ankle following a twisting injury on May 9, 2014.

Christine continues to experience anterior and lateral left ankle pain. I reviewed the MRI results, which demonstrate an osteochondral defect at the medial talar dome with a peroneal tenosynovitis with a split tear. We discussed the possibility of developmental deformity due to the location of the osteochondral defect. Due to her symptoms, she will be immobilized in the in-line walker partial weightbearing as tolerated; however, the in-line walker did not fit properly and the patient was then immobilized in a short leg cast with the postoperative shoe. Cast precautions were discussed. She will continue to rest, ice, and elevate the left ankle as needed. She will continue to modify her activities avoiding any physical activities. She will return for reevaluation of the left ankle in 6 weeks. At that time, we may further discuss further treatment options including surgical intervention if she continues to experience symptoms despite conservative treatment. All of her questions were answered.

I discussed the anatomy and function of the ankle in regards to her condition. We discussed treatment options.

Christine has a history that requires the use of a foot/ankle splint in order to treat this condition. Therefore, **the foot/ ankle *splint is a DME medical necessity* and was provided to the patient in the office today.**

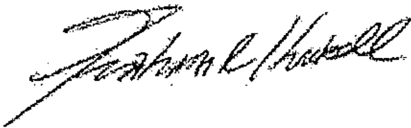
Disability:	Christine is working as such I need not see her level of disability..
Prescriptions:	No data for Prescription
Tests Ordered:	None
F/U Visit:	6 weeks
X-rays Next Visit:	Left ankle

I appreciate the opportunity to meet Christine in consultation today. I will continue to keep you updated regarding progress, investigations and treatment.

Yours respectfully,

Cassie Allen, RPA-C

Dictating with



Graham R. Huckell M.D.

Copy to: Christine Townsend
Joseph Gentile, MD

ICD-9: 845.00–Ankle-Spr/Str
715.17–Osteoarthritis Foot/Ankle
718.87–Internal Derangement Ankle/foot
CPT: 99214–Estab. – IV - Extended (25)

.Synthet–Casting Material
29425–Leg Cast – Short Leg Walk
Q4038–Leg Cast – Short Leg Cast Adult [+11yrs]
L3260–Foot – Surgical boot/shoe, each

Note: The patient`s office visit was somewhat prolonged in nature with greater than 25 to 30 minutes spent with the patient discussing the above condition. With time as a consideration, greater than 50% of the time was spent counseling or in the coordination of care.

Fax Created - Name: Owens, William Number: 716-939-3867 Dated 11/17/2014 1:05:19 PM

Triage Note

Age: 41 yrs **Sex:** Female **DOB:** 05/15/1973
Arrival Date: 03/07/2015 **Time:** 15:18

Western NY Immediate Care

Private MD: Gentile, Joseph, D

Presentation:

03/07 15:40 Presenting complaint: Patient states: pt states right side sinus pain for 3 weeks. pt states facial pressure, tenderness, and right ear is affected as well. pt states unproductive cough began within the last week. pt states history of sinus infections and symptoms seem similar. Transition of care: patient was not received from another setting of care. jlg

15:40 Method Of Arrival: Walk in. jlg

15:40 Acuity: Non-Urgent. jlg

15:46 Method of Arrival: Walk in. jlg

15:46 Acuity: Non-Urgent. jlg

Triage Assessment:

15:46 **General:** Appears in no apparent distress, comfortable, Behavior is appropriate for age, cooperative. **Pain:** Complains of pain in right ear, right temple, right zygomatic area, right cheek and right mandible Pain currently is 8 out of 10 on a pain scale. Quality of pain is described as pressure, tender, Is continuous. jlg

Historical:

- **Allergies:** SULFA (SULFONAMIDES); CEPHALOSPORINS; Macrobid; Zithromax Z-Pak;
- **Home Meds:**
  1. Motrin Oral
  2. Advair Diskus Inhl
  3. Synthroid Oral
  4. Protonix Oral
- **PMHx:** GERD (GASTRO ESOPHAGEAL REFLUX DISEASE); ASTHMA; HYPOTHYRIODISM; Viral Illness (January 10, 2013)
- **PSHx:** TONSILLECTOMY
- **Immunization history:** Up to Date.
- **Social history:** Smoking status: Patient/guardian denies using tobacco, Patient/guardian denies using alcohol,.
- **Family history::** Reviewed and not pertinent. .

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
15:47	118 / 80 RA⇍ (auto/reg)	85	15 S	98.8(T)	100% on R/A	99.79 kg / 220 lbs (R)	5 ft. 6 in. (167.64 cm) (R)	8/10	jlg

15:47 Body Mass Index 35.51 (99.79 kg, 167.64 cm) jlg

OB/GYN:

15:47 LMP 2/27/2015 jlg

Signatures:

Downey, Jodi, Reg	Reg	jd	Muff, Andrew, PA	PA	am5
Greene, Jared, MA	MA	jlg			

Physician Documentation

Western NY Immediate Care

Name: Christine Townsend
Age: 41 yrs **Sex:** Female **DOB:** 05/15/1973
Arrival Date: 03/07/2015 **Time:** 15:18
Bed B6
ED Physician Azadfard,

Patient ID: 255180
Account#: 7011950
Private MD: Gentile, Joseph, D

HPI:

03/07 16:07 The patient presents with nasal drainage, that is purulent. Onset: The symptoms/episode began/occurred acutely. am5

16:07 The patient presents with sinus pressure/pain. Onset: The symptoms/episode began/occurred 3 week(s) ago. Modifying factors: The symptoms are alleviated by nothing. the symptoms are aggravated by nothing. Associated signs and symptoms: Pertinent positives: cough, rhinorrhea, sore throat, Pertinent negatives: blurred vision, chest pain. Severity of symptoms: At their worst the symptoms were moderate today, in the emergency department the symptoms are unchanged. am5

OB/GYN:

15:47 LMP 2/27/2015 jlg

Historical:

- **Allergies:** SULFA (SULFONAMIDES); CEPHALOSPORINS; Macrobid; Zithromax Z-Pak;
- **Home Meds:**
  1. Motrin Oral
  2. Advair Diskus Inhl
  3. Synthroid Oral
  4. Protonix Oral
- **PMHx:** GERD (GASTRO ESOPHAGEAL REFLUX DISEASE); ASTHMA; HYPOTHYRIODISM; Viral Illness (January 10, 2013)
- **PSHx:** TONSILLECTOMY
- **Immunization history:** Up to Date.
- **Social history:** Smoking status: Patient/guardian denies using tobacco, Patient/guardian denies using alcohol,.
- **Family history::** Reviewed and not pertinent. .

ROS:

16:07 am5

Constitutional: Negative for fever, chills, and weight loss,
Neck: Negative for injury, pain, and swelling,
Cardiovascular: Negative for palpitations, and edema.
ENT: Positive for nasal discharge, rhinorrhea, sinus congestion, sinus pain, sore throat, Negative for ear pain.
Respiratory: Positive for cough, with no reported sputum, Negative for dyspnea on exertion, hemoptysis, orthopnea, pleuritic pain, shortness of breath, sputum production, wheezing.
Neuro: Negative for dizziness.

Exam:

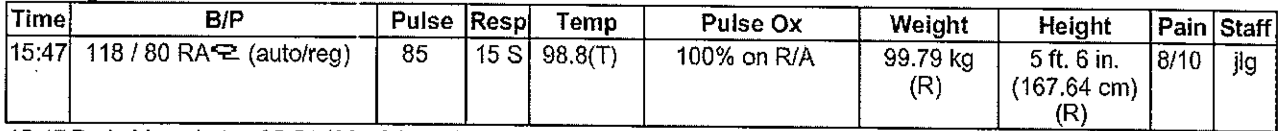
16:08 am5

Constitutional: This is a well developed, well nourished patient who is awake, alert, and in no acute distress.
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. No pulse deficits.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis.
Psych: Awake, alert, with orientation to person, place and time. Behavior, mood, and affect are within normal limits.
Head/face: Sinus tenderness, that is moderate, is located over the right maxillary sinus.
ENT: External ear(s): are unremarkable, Ear canal(s): are normal, TM's: are normal, Nose: is normal, Sinuses: Tender right maxillary Mouth: is normal, Posterior pharynx: is normal, airway is patent, no erythema, no exudate, no peritonsilar mass, no pooling of secretions, no swelling, normal tonsil apperance,

Physician Documentation Con't.

normal sized tonsils, normal uvula appearance, normal uvula size.

Vital Signs:



Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
15:47	118 / 80 RA (auto/reg)	85	15 S	98.8(T)	100% on R/A	99.79 kg (R)	5 ft. 6 in. (167.64 cm) (R)	8/10	jlg

15:47 Body Mass Index 35.51 (99.79 kg, 167.64 cm) jlg

MDM:

16:08 am5

Data reviewed: vital signs, nurses notes. Smoking Cessation Not Applicable.
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, the need for outpatient follow up, for definitive care, an ENT specialist, to return to the Urgent Care or emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

Dispensed Medications:
No medications were administered

Disposition:
16:15 Attestation: I am signing the PA chart. ma2

Disposition:
03/07/15 16:04 Discharged to Home. Impression: Acute Sinusitis.

- Condition is Stable.
- Discharge Instructions: Cough, Generic, Sinusitis.
- Prescriptions for
  Astepro 0.15 % (205.5 mcg) Nasal Spray, Non
  - Aerosol - spray 1 spray by INTRANASAL route 1-2 times daily; 1 bottle.
  Augmentin 875
  - 125 mg Oral Tablet - take 1 tablet by ORAL route every 12 hours for 10 days; 20 tablet.
- Concerns and Adv. Directives, Medication Reconciliation form.
- Follow up: Private Physician; When: 2 - 3 days; Reason: Recheck today's complaints.
- Symptoms have improved.
- Problem is new.

Signatures:

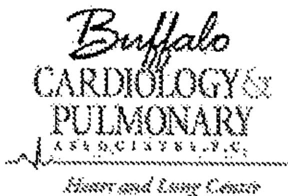
Muff, Andrew, PA	PA	am5	Azadfard, Mohammadreza, MD	MD	ma2
Greene, Jared, MA	MA	jlg			

Lab and Rad Results

Name: Christine Townsend
41 yrs / / Female
Chief Complaint: Sinus Congestion

MRN: 255180
Arrival: 03/07/2015 15:18
Departure Date 03/07/2015
Departure Time 16:11

There are currently no results for this order.



6460 Main Street, Williamsville NY 14221 716-634-5107

Date: 09/05/2014

Christine Townsend
DOB: 05/15/1973

Dear Dr. Joseph Gentile,

Your patient was seen in the office today for a cardiology visit. Below is a summary of the visit.

Reason for Visit

Cardiac Follow-Up

HPI

41-year-old Caucasian female, recently evaluated by Dr. Kozlowski with complaints of lower extremity edema and atypical chest pain. The patient underwent a 14 day event monitor and stress echocardiogram for complete evaluation. Since her last visit, the patient has discontinued the use of daily Motrin. She subsequently has noted that her lower extremity edema has completely resolved. She had chest pain on one occasion while grocery shopping. She did not have any chest pain during her stress echocardiogram.

Otherwise, the patient is without cardiovascular complaints. She denies any palpitations, lightheadedness or dizziness. She has had no syncope or near syncope. She continues to work as a VNA nurse carrying a heavy bag, climbing stairs, etc over the course of her work day.

Assessment/Plan

1. **Chest pain** - 41-year-old with risk factors that include obesity, and strong family history with recurrent chest discomfort. EKG is without acute change. Her stress echocardiogram is unremarkable with preserved EF, no significant valvular changes
   786.50: Chest pain, unspecified

2. **Obesity** - Dietary changes exercise regimen and weight reduction were strongly encouraged. ACC guidelines were reviewed with Ms. Townsend.
   278.00: Obesity, unspecified

3. **Hyperlipidemia** - Under your expertise.
   272.4: Other and unspecified hyperlipidemia

4. **Intermittent palpitations** - Resolved with unremarkable 14 day event monitor.
   785.1: Palpitations

5. **Edema** - Resolved with the eliminated of NSAIDs.
   782.3: Edema

Discussion

Discussion Notes

Ms. Townsend was counseled regarding current American Heart Association guidelines for cardiovascular health in women.. I have made recommendations including a heart healthy diet (Mediterranean type)., 30-45 min. of regular exercise 5-6 days a week and 2-3 days of weight training. The patient would benefit from weight reductionand regular exercise program.

Return to Office

- Lisa C. Kozlowski, MD for PA Follow-Up at BCPA on 09/05/2014 at 10:30 AM

Vitals

Ht:	5 ft 6 in	**Wt:**	268 lbs	**BMI:**	43.3
BP:	122/88 sitting R arm	**Pulse:**	68 bpm regular	**RR:**	16

Physical Exam

Patient is a 41-year-old female.

General: Alert, confortable. She is obese.
Skin warm and dry.

Procedure Documentation

None recorded.

Medications

Reviewed Medications

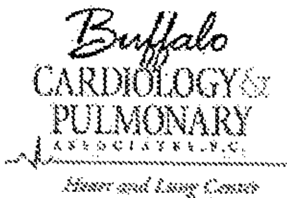
Name	Date	
Protonix 40 mg tablet,delayed release Take 1 tablet(s) every day by oral route.	07/29/14	entered

Thank you for allowing us to see your patient in consultation.

Sincerely,

Electronically Signed By: VIRGINIA M. HART, NP

Encounter signed-off by Lisa C. Kozlowski, MD, 09/05/2014.



6460 Main Street, Williamsville NY 14221 716-634-5151

Cardiac Rhythm Monitor

Date: 08/04/2014

Patient Name: Christine Townsend

DOB: 05/15/1973

Reason for Visit
Event Monitor, Palpitations

Procedure

EVENT MONITOR:

Ordering Physician: Dr.Kozlowski

Event Monitor

Indications: Palpitations

Findings: There were 1 reports transmitted

Conclusion:

A 14 day event monitor documented an underlying rhythm of normal sinus with sinus arrhytthmia.

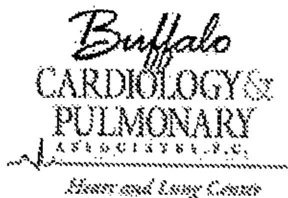
On 8/4/2014. Patient did experiennce chest pain. This correlated with sinus tachycardia at a rate of 122 beats per minute.

No further transmissions were submitted

The detailed information supporting this report is available through our office. If you wish a copy please don't hesitate to call.

Sincerely,

Electronically Signed by: LISA C. KOZLOWSKI, MD



6460 Main Street, Williamsville NY 14221 716-634-8100

Exercise Echocardiogram

Date: 08/04/2014

Patient Name: Christine Townsend

DOB: 05/15/1973

Procedure

Exercise Stress Echocardiogram:

Ordering Provider: Dr. Kozlowski

CLINICAL HISTORY:

Patient is a 41 year old female undergoing evaluation for chest pain.
Risk factors: dyslipidemia, family history of heart disease, obesity.
Cardiac history: denies.
Medications: no significant cardiac medications

Sonographer: S. Ciliberto, RDCS

BSA: 2.3 Height: 5 ft. 6 in. Weight: 268 lbs.
GENDER: Female BP: 130/80 Tape Number: 670#19

RESTING ECHOCARDIOGRAM

4.9 cm LV end-diastole (Normal Range Female 3.9 - 5.3 cm)(Normal Range Male 4.2 - 5.9 cm)
2.9 cm LV end-systole (Normal Range 2.3 - 3.9 cm)
.9 cm LV inferolateral wall thickness end-diastole (Normal Range Female 0.6 - 0.9 cm)(Normal Range Male 0.6 - 1.0 cm)
.9 cm LV septal wall thickness end-diastole (Normal Range Female 0.6 - 0.9 cm)(Normal Range Male 0.6 - 1.0 cm)
.8 E wave M/sec (Normal Range 0.7 - 1.00 M/sec)
.7 A wave M/sec (Normal Range 0.48 - 0.70 M/sec)
1.2 E/A Ratio
50 msec IV Relaxation Time (Normal Range 60 - 109 msec)
184 msec Deceleration Time (Normal Range 151 - 239 msec)
2.8 cm Right ventricle (Normal Range 2.6 - 4.3 cm)
3.4 cm Left atrium (Normal Range Female 2.7- 3.8 cm)(Normal Range Male 3.0- 4.0 cm)
2.8 cm Right atrium (Normal Range 3.0 - 4.6 cm)
2.8 cm Aorta (Normal Range 2.0 - 3.7 cm)
28 mmHg systolic Pulmonary artery (Normal Range 20 - 37 mmHg)

A two-dimensional, M-mode, and Color Doppler examination was performed. The technical quality of the study was satisfactory.

Left Ventricle:
Cavity size was normal.
The was no concentric left ventricular hypertrophy.
Global systolic function was normal.
Regional was motion was normal.
Left ventricular ejection fraction estimated at 60-65%.
Left ventricular diastolic function was normal.
Right Ventricle:
Cavity size was normal.

Global systolic function was normal.

Left Atrium: Cavity size was normal.
Right Atrium: Cavity size was normal.

Aortic Valve: Normal. No aortic stenosis. No aortic regurgitation.
Mitral Valve: Normal. Physiologic mitral regurgitation.
Pulmonic Valve: Normal. Physiologic pulmonic regurgitation.
Tricuspid Valve: Normal. Physiologic tricuspid regurgitation.

Aorta: The aortic root size at the sinuses of Valsalva is normal.
Pulmonary Artery: Estimated pulmonary artery/right ventricular systolic pressure is normal.
Pericardium: No pericardial effusion..
Atrial Septum: Normal..
IVC: Normal.

STRESS PROCEDURE:
Type of test: Bruce protocol
Duration of exercise: 4 minutes 00 seconds
Estimated work load: 5.5 METS.
Reason for termination: fatigue.
Stress symptoms: denied..
Heart rate at rest: 61 beats per minute.
Heart rate at peak exercise: 170 beats per minute, or 94% maximal predicted heart rate for age.
Heart rate response to exercise: accelerated.
Heart rate recovery: normal.
Blood pressure at rest: 130/80mmHg.
Blood pressure at peak stress: 170/90mmHg.
Blood pressure in recovery:140/80mmHg.
Blood pressure response to exercise: normal.
Resting electrocardiogram sinus rhythm with sinus arrhythmia and minor ST elevation most likely due to early repolarization
Stress arrhythmia: rare premature ventricular complexes occurring with exercise
Stress ST segment: no significant changes
Oxygen saturation: Resting SaO2 99%, Stress SaO2 99%
Duke treadmill score: 4 (moderate risk)
Stress completed by R. Traina, RN

POST STRESS IMAGES:
Left ventricular cavity size decreased with stress.
Global left ventricular function increased immediately after stress.
Immediate post-stress regional wall motion was normal.
Immediate post-stress left ventricular ejection fraction estimated at 70-75%.
Post-stress right ventricular systolic function increased.
Estimated post-stress right ventricular/pulmonary artery systolic pressure 36 mmHg.

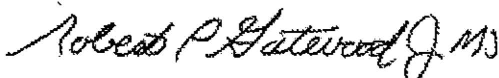
CONCLUSION:

No chest pain, diagnostic ST segment changes or stress echocardiographic evidence of ischemia was observed at a low moderate workload of 5.5 METS and 94% maximal predicted heart rate for age.

Global left and right ventricular systolic function was normal.

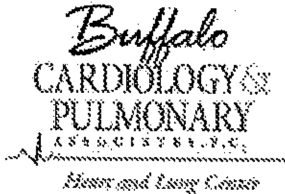
Resting left ventricular ejection fraction estimated at 60-65% and 70-75% immediately post-exercise.

Sincerely,



Electronically Signed by: ROBERT P. GATEWOOD JR., MD

TOWNSEND, CHRISTINE M (id #62142, dob: 05/15/1973)



6460 Main Street, Williamsville NY 14221 716-634-5100

Date: 07/29/2014

Christine Townsend
DOB: 05/15/1973

Dear Joseph Gentile MD,

Your patient was seen in the office today for a cardiology visit. Below is a summary of the visit.

Reason for Visit

Followup: Chest pain

HPI

I had the pleasure of seeing Christine Townsend today in cardiovascular initial evaluation. She is a 41-year-old female with cardiac risk factors that include strong family history, obesity, elevated LDL whom resents in further evaluation for chest discomfort. She states that she does have a history of ankle swelling after taking Motrin. In May 2014 she's did restart Motrin for headache and neck discomfort. She did note ankle swelling and chest discomfort. She stopped the Motrin approximately 2 weeks ago.Ankle swelling resolved. However, the chest discomfort has persisted. She noted chest discomfort under the left breast that radiates to the sternum and is a pressure-like sensation, it is random, associated both with rest and exertion. At times she does note nausea with these symptoms. She denies dyspnea PND, orthopnea. She also noted palpitations at times a fluttering sensation, which is fleeting and not associated with syncope near-syncope lightheadedness or dizziness. Last week she noted that her chest discomfort daily . It has been overall lessening but persistent.

Assessment/Plan

1. **Chest pain** - 41-year-old with risk factors that include obesity, and strong family history with recurrent chest discomfort. EKG is without acute change. At this time I am recommending a stress echocardiogram to assess LV systolic ffunction valvular function and exclude ischemia.
   786.50: Chest pain, unspecified
   - STRESS ECHOCARDIOGRAM

2. **Obesity** - Dietary changes exercise regimen and weight reduction were strongly encouraged. She'll wait completion of her stress echocardiogram prior to starting any routine exercise regimen. Pending results will always consider a sleep study as she does have a generalized fatigue.
   278.00: Obesity, unspecified
   - WEIGHT MANAGEMENT EDUCATION

3. **Hyperlipidemia** - Last LDL 137. We'll repeat Lipid profile and give recommendations pending profile.
   272.4: Other and unspecified hyperlipidemia
   - LIPID PANEL, SERUM
   - AST/SGOT (ASPARTATE AMINOTRANSFERASE), SERUM
   - ALT (ALANINE AMINOTRANSFERASE), SERUM

4. **Intermittent palpitations** - Patient does have a random and intermittent palpitations without significant associated symptomatology. They do not occur daily. At this time I am recommending a 14 day event monitor to quantitate further
   785.1: Palpitations
   - EVENT MONITOR

Return to Office

- STRESS ECHO for Echo_Stress Echo Add On at BCPA on 08/04/2014 at 11:00 AM
- HOLTER for Holter/Event at BCPA on 08/06/2014 at 09:30 AM
- Virginia M. Hart, NP for C_Follow Up 20 at BCPA on 09/05/2014 at 10:20 AM
- Lisa C. Kozlowski, MD for PA Follow-Up at BCPA on 09/05/2014 at 10:30 AM

Vitals

Ht:	5 ft 6 in	**Wt:**	268 lbs	**BMI:**	43.3
BP:	132/80 sitting R arm 124/84 sitting L arm	**Pulse:**	65 bpm regular	**RR:**	18

Physical Exam

Patient is a 41-year-old female.

Constitutional:
General Appearance: well-developed, appears stated age, and **obese**. Level of Distress: comfortable.

Psychiatric:
Mental Status: alert and oriented X3 and normal mood and affect.

Eyes:
Lids and Conjunctivae: non-injected, anicteric, and no xanthelasma.

Neck:
Jugular Veins: normal jugular venous pressure.

Lungs:
Respiratory Effort: unlabored. Auscultation: no wheezing, rales, or rhonchi and clear.

Cardiovascular:
Precordial Exam: **non palpable**. Rate And Rhythm: regular. Heart Sounds: no rub, gallop, or click and normal S1 (**S2**). Extremities: no cyanosis or edema.

Abdomen:
Inspection and Palpation: soft and non distended.

Musculoskeletal:
Inspection: no erythema.

Neurologic:
Gait: normal gait.

Skin:
Inspection and Palpation: warm and dry; **tattoo**.

Procedure Documentation

EKG:
NSR.

Medications

Reviewed Medications

Name	Date
Protonix 40 mg tablet,delayed release Take 1 tablet(s) every day by oral route.	07/29/14 entered

Thank you for allowing us to see your patient in consultation.

Sincerely,

Electronically Signed By: LISA C. KOZLOWSKI, MD

Encounter signed-off by Lisa C. Kozlowski, MD, 07/29/2014.

DENT
NEUROLOGIC INSTITUTE

Vernice Bates, MD
Bela Ajtai, MD
Horacio Capote, MD
Donna M. Czarnecki, PhD
Steve Dofitas, MD
J. Aubrey Duquin, PhD
Marc S. Frost, MD
Francis M. Gengo, PharmD
Sanjay Gupta, MD
Tomas Holmlund, MD
J. Maurice Hourihane, MD
Minsoo Kang, MD
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Laszlo Mechtler, MD
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Bennett Myers, MD
Malti Patel, MD
Mohammad M. Qasaymeh, MD
Michelle M. Rainka, PharmD
Luisa Rojas, MD
Nicolas Saikali, MD
Eugene Wang, MD
Lixin Zhang, MD, PhD
Joseph V. Fritz, PhD, CEO

Lixin Zhang, MD

Neurologic Consultation
Date: 03/13/2013

Patient Name: Townsend, Christine M
DOB: 05/15/1973 Age: 39 Y Sex: Female
PCP: Joseph Gentile, MD

Reason for Appointment

- Headache
- Neck pain

History of Present Illness

General:

I had the pleasure of seeing Christine Townsend today for the evaluation of headaches and neck pain due to your kind request to the DENT Neurologic Institute. Dr. Gentile, please refer to the consultation below for my evaluation and recommendations.

Christine is a 39-year-old female who has a history of a motor vehicle accident in 1999, but did not have any problem after that. Her problem, she feels this came after she took her current job, 19 years ago. After a few years of working on this job, she started to complain of some neck pain and headaches, mostly in the occipital region. She describes the best time is in the morning, but around 5:00 p.m. or 6:00 p.m. she starts to have this pain. Sometimes it can be really bad. This pain can happen 5-7 times per week. It is getting more frequent and severe, worse when she is driving or worsened later in the day as mentioned. She also complains of some dizziness at times, maybe related to positional changes.

She is separated and lives with her year-old-daughter. She has difficulty sleeping at night. She is waking up frequently throughout the night. She is not sure if she is snoring, but she feels tired in the morning at times, but mostly in the evening.

She does have some symptoms suggestive for premenopausal related symptoms. Her OB/GYN just put her on Celexa March 11.

Current Medications

- Motrin 800mg 1 tab prn
- Vitamin D3 2000 intl units tablet 1 tab(s) once a day
- Synthroid 25 mcg (0.025 mg) tablet 1 tab(s) once a day
- Protonix 40 mg enteric coated tablet 1 tab(s) once a day
- Celexa 10 mg tablet 1 tab(s) once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Hypothyroidism
- Esophageal reflux

Surgical History

- T & A
- D&C

Family History

Father: alive diabetes insipidus, coronary artery disease, neuropathy, depression, emphysema
Mother: alive diabetes, coronary artery disease, Fibromyalgia, depression, glaucoma
1 brother(s) - healthy.

Social History

Tobacco Use:
Smoking Patient is a non smoker.
Alcohol use:
Drinks Alcohol: Patient does not drink alcohol.
Illicit Drugs:
Using illicit drugs: Denies.
Resides with:
Children: Yes, Daughter.
Working:
Employed: Yes.
Marital Status:
Separated: Yes.
Driving:
Does Patient Drive: Yes.

Allergies

- Macrobid
- Sulfa
- Cephalosporins

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

CONSTITUTIONAL:
Positive for Weight gain.
ENDOCRINOLOGY:
Positive for Thyroid problems.
GASTROENTEROLOGY:
Positive for Heartburn.
NEUROLOGY:
Positive for Headache, Sleep problem.
RESPIRATORY:
Positive for Asthma.
No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 00, HR 00, RR 16, Ht 66, Wt 260, BMI 41.96, BP standing 128/90, BP supine 99/61, Pulse standing 90, Pulse supine 75, BSA 2.34.

Examination

GENERAL EXAMINATION:

(716) 250-2000
www.dentinstitute.com

Amherst Offices | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14127 | Fax: (716) 250-0315
Derby Office | 7060 Erie Road • Suite 500 • Derby, NY 14047 | Fax: (716) 819-3827
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES
MRI/CT, Arthrograms, Botox, Doppler/TCD, EEG, EMG, ImPACT, Infusion
Neuropsychology, Posturography, Sleep Studies, SPECT, Ultrasound, TMS, VNG

k

General Appearance: NAD, pleasant, well-developed and well-nourished. Eyes: Funduscopic exam: Discs sharp. Vessels normal. Oral Cavity: Normal posterior airway. Neck No bruits on either side. Heart: No murmurs, regular rate and rhythm. Extremities: No clubbing, no edema.

NEUROLOGICAL:

Mental Status: Oriented to time, place, and person with good attention and concentration. Short and long-term memory within normal limits. Language is intact with spontaneous speech naming, repeating and comprehension. Patient has a good fund of knowledge. Cranial Nerves: CRANIAL NERVE II: Visual acuity is intact. Visual fields are full to confrontation. Fundi examination is the same as above. CRANIAL NERVE III, IV, VI: Pupils are equal, round and reactive to light. EOM are full range with normal pursuit and saccade. CRANIAL NERVE V: Facial sensation is symmetrical to light touch and temperature; cornea is intact. CRANIAL NERVE VII: Facial movement are symmetrical and within normal limits. CRANIAL NERVE VIII: Acuity intact to finger rub bilaterally. CRANIAL NERVE IX, X: Palate rose in midline. CRANIAL NERVE XI: Sternocleidomastoid intact. Trapezius strength intact. CRANIAL NERVE XII: Tongue protruded midline without atrophy or fasciculation. Reflexes: Symmetrical in the upper and lower extremities including both ankles. Coordination: Finger to nose and rapid alternating movements were intact. No ataxia. Gait and Station: Within normal limits. Romberg was negative. Sensory: Normal to light touch, vibration, and pinprick sensation. Motor: Normal tone and bulk upper and lower extremities. No tremor or abnormal movements. No pronator drift. Full strength of upper and lower extremities.

ENT/Respiratory:

Ears: Otologic examination with a binocular microscopy showed normal canal and tympanic membranes. Basic vestibular examination recorded in Micromedical RealEyestm xDVR Monocular System was normal. Dix-HallPike maneuver was negative on either side and was recorded in the Micromedical System as well.

Assessments

1. Occipital neuralgia - 723.8 (Primary)
2. NECK DISORDER/SYMPT NOS - 723.9
3. Insomnia - 780.52
4. Fatigue/malaise - 780.79

This is a 39-year-old female who complains of occipital headache and dizziness as well as neck pain. I believe most of the symptoms are related to excessive stress in the neck area. The underlying reason may be related to the poor sleep at night. She has insomnia and possible sleep apnea as well. I will recommend her sleep schedule adjusted, try to avoid night shift work. I will put her on the trazodone at 50 mg, to replace the Celexa and get a sleep study done. We will check her up in 4 to 6 weeks.

Treatment

1. Occipital neuralgia

Stop Celexa tablet, 10 mg, 1 tab(s), orally, once a day
Start trazodone tablet, 50 mg, 1/2 tab qhs for 1wk, then 1 tab, orally, qhs, 30 day(s), 30, Refills 2
Diagnostic Imaging:SLEEP STUDY POLYSOMNOGRAM

2. Insomnia

Diagnostic Imaging:SLEEP STUDY POLYSOMNOGRAM

3. Fatigue/malaise

Diagnostic Imaging:SLEEP STUDY POLYSOMNOGRAM

Follow Up

4 Weeks

h

Electronically signed by Lixin Zhang , MD on 03/20/2013 at 12:08 PM EDT

Sign off status: Completed

Quest Diagnostics

CLINICAL LABORATORY REPORT

ONE SYLVAN PKWY
WEST AMHERST NY 14228

Quest Diagnostics Incorporated - Medical Directors:
Enrique Cotes, M.D. Twinsburg, OH
Kathleen A. Allen, M.D. Pittsburgh, PA
Rafiqa Fazili, M.D. Buffalo, NY
Quest Diagnostics Venture LLC
Kathleen A. Allen, M.D. Medical Director
Trevor Macpherson, M.D. Chief Medical Officer

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
TOWNSEND,CHRISTINE M	(800) 295-6598	(800) 837-3177	03/09/2013	9:13

03/09/2013

Patient Phone Number: 716 876-1569
Patient I.D.: 073600318
Referring Physician: JOSEPH GENTILE, M.

766015 22-99-099
JOSEPH GENTILE, M.D.
4239 MAPLE ROAD
AMHERST,NY 14226

Date Received	Date of Report
03/09/2013	03/12/2013

Sex	Age	Date of Birth
F	39	05/15/1973

Specimen Number	Accession Number
7660150010571	HT243048D

Report Notes: FASTING

TEST PROCEDURE	TEST RESULT		UNITS	REFERENCE RANGE
COMPREHENSIVE METABOLIC PANEL W/EGFR				
SODIUM	140		MMOL/L	135-146 P
POTASSIUM	4.6		MMOL/L	3.5-5.3 P
CHLORIDE	105		MMOL/L	98-110 P
CARBON DIOXIDE	25		MMOL/L	19-30 P
CALCIUM	9.0		MG/DL	8.6-10.2 P
ALKALINE PHOSPHATASE	85		U/L	33-115 P
AST	18		U/L	10-30 P
ALT	14		U/L	6-40 P
BILIRUBIN,TOTAL	0.4		MG/DL	0.2-1.2 P
GLUCOSE =A=	82		MG/DL	65-99 P
UREA NITROGEN	12		MG/DL	7-25 P
CREATININE	0.75		MG/DL	0.50-1.10 P
BUN/CREATININE RATIO	15.6			6-22 P
PROTEIN,TOTAL	6.8		G/DL	6.1-8.1 P
ALBUMIN	4.0		G/DL	3.6-5.1 P
GLOBULIN,CALCULATED	2.8		G/DL	1.9-3.7 P
A/G RATIO	1.4			1.0-2.5 P
EGFR NON-AFR. AMERICAN	100		ML/MIN/1.73M2	> OR = 60 P
EGFR AFRICAN AMERICAN	116		ML/MIN/1.73M2	> OR = 60 P
URIC ACID =B=	5.2		MG/DL	2.5-7.0 P
LIPID PANEL				
CHOLESTEROL	196		MG/DL	125-200 P
HDL CHOLESTEROL	47		MG/DL	> OR = 46 P
CHOLESTEROL/HDL RATIO	4.2			< OR = 5.0 P
LDL CHOL,CALCULATED=C=	134	H	MG/DL	<130 P
TRIGLYCERIDES	77		MG/DL	<150 P
NON-HDL CHOLESTEROL=D=	149		MG/DL	P

= FOOTNOTES =

=A= GLUCOSE REFERENCE RANGE BASED ON FASTING SPECIMEN.

=B=
Therapeutic target for gout patients: <6.0 mg/dL

PAGE 1: CONTINUED ON PAGE: 2

add vit D 2000 units daily

3/19/13

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Quest Diagnostics

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ONE SYLVAN PKWY
WEST AMHERST NY 14228

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Sex	Age	Date of Birth
F	39	05/15/1973

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7660150010571	HT243048D

Report Notes: FASTING

TEST PROCEDURE		TEST RESULT	UNITS	REFERENCE RANGE

=C=

RISK CATEGORY*	LDL-CHOLESTEROL GOAL
VERY HIGH (E.G. DIABETES + CVD)	<70 MG/DL
HIGH (DIABETICS; CHD RISK EQUIVALENTS)	<100 MG/DL
MODERATELY HIGH (MULTIPLE(2+) RISK FACTORS)	<130 MG/DL
0 TO 1 RISK FACTORS	<160 MG/DL

* NCEP REPORT. CIRCULATION 2004; 110: 227-239

=D=

Target for non-HDL cholesterol is 30 mg/dL higher than LDL cholesterol target.

CBC W/ DIFF and PLT

TEST PROCEDURE	OUT OF RANGE		TEST RESULT	UNITS	REFERENCE RANGE	
WBC			5.9	THOUS/MCL	3.8-10.8	P
RBC			4.85	MILL/MCL	3.80-5.10	P
HEMOGLOBIN			12.6	G/DL	11.7-15.5	P
HEMATOCRIT			38.2	%	35.0-45.0	P
MCV	78.9	L		FL	80.0-100.0	P
MCH	25.9	L		PG	27.0-33.0	P
MCHC			32.8	G/DL	32.0-36.0	P
RDW			14.6	%	11.0-15.0	P
PLATELET COUNT			317	THOUS/MCL	140-400	P
NEUTROPHILS,ABSOLUTE			3580	CELLS/MCL	1500-7800	P
LYMPHOCYTES,ABSOLUTE			1670	CELLS/MCL	850-3900	P
MONOCYTES,ABSOLUTE			490	CELLS/MCL	200-950	P
EOSINOPHILS,ABSOLUTE			80	CELLS/MCL	15-500	P
BASOPHILS,ABSOLUTE			50	CELLS/MCL	0-200	P
TOTAL NEUTROPHILS,%			61	%	38-80	P
TOTAL LYMPHOCYTES,%			28	%	15-49	P

PAGE 2: CONTINUED ON PAGE: 3

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Quest Diagnostics

CLINICAL LABORATORY REPORT

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Sex	Age	Date of Birth
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7660150010571	HT243048D

Report Notes: FASTING

TEST PROCEDURE		TEST RESULT	UNITS	REFERENCE RANGE
MONOCYTES,%		8	%	0-13 P
EOSINOPHILS,%		1	%	0-8 P
BASOPHILS,%		1	%	0-2 P
T4,TOTAL		6.5	MCG/DL	4.5-12.0 P
HEMOGLOBIN A1C	5.7	H	%	0.0-5.6 P

A1C VALUE(% OF TOTAL HEMOGLOBIN)	INTERPRETATION
< 5.7	DECREASED RISK OF DIABETES
5.7 - 6.0	INCREASED RISK OF DIABETES
6.1 - 6.4	HIGHER RISK OF DIABETES
> OR = 6.5	CONSISTENT WITH DIABETES

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE
TSH	2.74	mIU/L	0.40-4.50 P

REFERENCE RANGES BELOW ARE APPLICABLE TO PREGNANT FEMALES

FIRST TRIMESTER - 0.26 - 2.66 mIU/L
SECOND TRIMESTER - 0.55 - 2.73 mIU/L
THIRD TRIMESTER - 0.43 - 2.91 mIU/L

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE
VITAMIN B12,SERUM	416	PG/ML	200-1100 P
URINALYSIS,COMPLETE			
BILIRUBIN	NEGATIVE		NEGATIVE P
KETONES	NEGATIVE		NEGATIVE P
GLUCOSE,QUAL	NEGATIVE		NEGATIVE P
PROTEIN,TOTAL,QUAL	NEGATIVE		NEGATIVE P
HEMOGLOBIN,QUAL	NEGATIVE		NEGATIVE P
PH	6.0		5.0-8.0 P
NITRITE	NEGATIVE		NEGATIVE P
LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE P
COLOR	YELLOW		YELLOW P
APPEARANCE	CLEAR		CLEAR P
SPECIFIC GRAVITY	1.020		1.001-1.035 P
HYALINE CASTS	NONE SEEN	LPF	NONE SEEN P
RBC/HPF CELLS	NONE SEEN		0-3 P
WBC/HPF CELLS	NONE SEEN		0-5 P

PAGE 3: CONTINUED ON PAGE: 4

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CLINICAL LABORATORY REPORT

ONE SYLVAN PKWY
WEST AMHERST NY 14228

Quest Diagnostics Incorporated - Medical Directors:
Enrique Cotes, M.D.
Twinsburg, OH
Kathleen A. Allen, M.D.
Pittsburgh, PA
Rafiqa Fazili, M.D.
Buffalo, NY
Quest Diagnostics Venture LLC
Kathleen A. Allen, M.D.
Medical Director
Trevor Macpherson, M.D.
Chief Medical Officer

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
TOWNSEND,CHRISTINE M	(800) 295-6598	(800) 837-3177	03/09/2013	9:13

03/09/2013

Patient Phone Number: 716 876-1569
Patient I.D.: 073600318
Referring Physician: JOSEPH GENTILE, M.

766015 22-99-099
JOSEPH GENTILE, M.D.
4239 MAPLE ROAD
AMHERST,NY 14226

Date Received	Date of Report
03/09/2013	03/12/2013

Sex	Age	Date of Birth
F	39	05/15/1973

Specimen Number	Accession Number
7660150010571	HT243048D

Report Notes: FASTING

TEST PROCEDURE		TEST RESULT	UNITS	REFERENCE RANGE	
BACTERIA		NONE SEEN		NONE SEEN	P
SQUAMOUS EPI CELLS		NONE SEEN	HPF	0-5	P
VITAMIN D,25-OH,LCMSMS					
VITAMIN D,25-OH,TOTAL	12	L	ng/mL	30-100	G
VITAMIN D,25-OH,D3		12	ng/mL		G
VITAMIN D,25-OH,D2		<4	ng/mL		G

25-OHD3 indicates both endogenous production and supplementation. 25-OHD2 is an indicator of exogenous sources such as diet or supplementation. Therapy is based on measurement of Total 25-OHD, with levels <20 ng/mL indicative of Vitamin D deficiency while levels between 20 ng/mL and 30 ng/mL suggest insufficiency. Optimal levels are > or = 30ng/mL.

For more information on this test, go to
http://education.questdiagnostics.com/faq/25-OHVitaminD

CODE	PERFORMING SITE	ADDRESS
G	QUEST DIAGNOSTICS NICHOLS INSTITUTE	14225 NEWBROOK DRIVE CHANTILLY, VA 20151
P	QUEST DIAGNOSTICS	875 GREENTREE ROAD 4 PARKWAY CENTER PITTSBURGH, PA 15220

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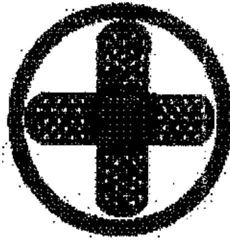
RX-FAX
03/12/13 15:51 #8249245 4/5



MASH Urgent Care

1751 Sheridan Dr.
Tonawanda NY 14223
716-844-7100
Dept Fax: 716-873-0230

May 9, 2014
Time of Visit : 11:45 AM

JOSEPH GENTILE, M.D.
4239 Maple Road
Amherst, NY 14226

RE: Christine Townsend
5/15/1973

Dear Dr. Gentile:

We recently treated your patient, Christine Townsend at MASH Urgent Care. Below is a summary of services provided.

The patient's vitals today are as follows BP 137/81 | Pulse 108 | Temp 99.5 °F (37.5 °C) (Oral) | Resp 16 | Ht 5' 6" (1.676 m) | Wt 250 lb (113.399 kg) | BMI 40.37 kg/m2 | SpO2 96% | LMP 04/20/2014.

Patient is a 40 year old female presenting with extremity pain.

Arm Pain

This is a new problem. The current episode started yesterday. The pain is present in the left wrist and right wrist. The quality of the pain is described as aching. The pain is at a severity of 3/10. The pain is mild. Pertinent negatives include no numbness, full range of motion, no stiffness, no tingling and no itching. The symptoms are aggravated by activity. She has tried nothing for the symptoms. There has been a history of trauma. Family history is significant for no rheumatoid arthritis and no gout.

Review of Systems
Musculoskeletal: Negative for stiffness.
Skin: Negative for itching.
Neurological: Negative for tingling and numbness.
All other systems reviewed and are negative.

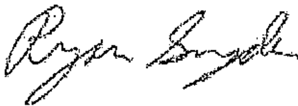
Physical Exam

Nursing note and vitals reviewed.
Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae normal and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate and regular rhythm.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: Normal range of motion.
Neurological: She is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: Mood and affect normal.

ASSESSMENT AND PLAN
Bilateral wrist contusion with left ankle sprain. No indication for xrays. Pt able to bear weight. No anatomical snuff box tenderness. neurvascular intact. Will discharge with ace wrap.

We thank you and your patient for the opportunity to serve you. Please think of us if a future need arises.

Sincerely,



RYAN SNYDER, MD

Letters

Letter Information

	Status
Ryan E. Snyder on 5/9/2014	Sent

Letter Information

	Status
Ryan E. Snyder on 5/9/2014	Sent

Routing History

Recipient	Method	User	Date
JOSEPH GENTILE, M.D. Fax: 716-835-1470 Phone: 716-832-9747	Fax	Ryan E. Snyder Letter: created on 5/9/2014 by Ryan E. Snyder	5/9/2014

Nurse's Notes

Western NY Immediate Care

Name: Christine Townsend
Age: 39 years **Sex:** Female **DOB:** 05/15/1973
Arrival Date: 01/10/2013 **Time:** 09:18
Bed B5
Diagnosis: Viral illness

Patient ID: 255180
Account#: 4184860
Private MD: Gentile, Joseph, D

Presentation:

01/10 09:29 Presenting complaint: Patient states: Pt states she has had asthma exacerbation and URI for six weeks. Pt states as of last night she had a fever, body aches, and ear pain. Transition of care: patient was not received from another setting of care. kd2

09:29 Method Of Arrival: Walk in. kd2

09:29 Acuity: Non-Urgent. kd2

09:30 Method of Arrival: Walk in. kd2

09:30 Acuity: Non-Urgent. kd2

Triage Assessment:

09:32 **Headache History:** Denies past history of headaches. **General:** Appears in no apparent distress, comfortable, Behavior is appropriate for age, cooperative. **Pain:** Pain currently is 8 out of 10 on a pain scale. kd2

OB/GYN:

09:32 LMP 12/31/2012 kd2

Historical:

- **Allergies:** SULFA (SULFONAMIDES); CEPHALOSPORINS; Macrobid;
- **Home Meds:**
  1. Tessalon Perles Oral
  2. Motrin Oral
  3. Advair Diskus Inhl
  4. Synthroid Oral
  5. Protonix Oral
- **PMHx:** GERD (Gastro Esophageal Reflux Disease); Asthma; Hypothyriodism
- **PSHx:** Tonsillectomy
- **Immunization history:** Up to Date.
- **Social history:** Smoking status: Patient/guardian denies using tobacco, Patient/guardian denies using alcohol,.
- **Family history::** Not pertinent for current visit..

Screening:

09:33 **Abuse screen:**
Denies threats or abuse. kd2

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
09:32	129 / 87 LA (auto/lg)	94	20	98.5(O)	99% on R/A	113.4 kg	5 ft. 6 in. (168 cm)	8/10	kd2

09:32 Body Mass Index 40.4 (113.40 kg, 168 cm) kd2

ED Course:

09:18 Patient arrived in Immediate Care. cc2

09:18 Patient visited by Coplin, Christy. cc2

09:19 Gentile, Joseph is Private Physician. cc2

09:22 Pease, Christopher, PA is PHCP. cp1

09:22 Patient visited by Pease, Christopher, PA. cp1

09:22 Turco, Katherine, DO is Attending Physician. cp1

09:29 Etheridge, Darlene, RN is Primary Nurse. kd2

09:33 Influenza Screen Sent. kd2

09:51 Gentile, Joseph is Referral Physician. cp1

Nurse's Notes Con't

Administered Medications:
No medications were administered

Outcome:

09:51	Discharge ordered by MD.	cp1
09:55	Discharged to home ambulatory. Discharge instructions given to patient, Instructed on discharge instructions, follow up and referral plans. medication usage, Demonstrated understanding of instructions, medications, Prescriptions given X 1. **Condition:** stable	de1
09:55	Patient left the Immediate Care.	de1

Signatures:

Pease, Christopher, PA	PA	cp1	Etheridge, Darlene, RN	RN	de1
Dole, Katherine		kd2	Coplin, Christy		cc2

A

Physician Documentation

Western NY Immediate Care

Name: Christine Townsend

Age: 39 years **Sex:** Female **DOB:** 05/15/1973
Arrival Date: 01/10/2013 **Time:** 09:18
Bed B5
ED Physician Turco, Katherine

Patient ID: 255180
Account#: 4184860
Private MD: Gentile, Joseph, D

HPI:

01/10 09:35 The patient or guardian reports cough, that is intermittent, described as moderate, with no sputum. Onset: The symptoms/episode began/occurred yesterday. Severity of symptoms: At their worst the symptoms were moderate, in the emergency department the symptoms are unchanged. Modifying factors: The symptoms are alleviated by nothing, despite nebulizer and MDI and sudafed the symptoms are aggravated by nothing. Associated signs and symptoms: Pertinent positives: earache, fever, rhinorrhea, sore throat, Pertinent negatives: chest pain, nausea, vomiting. The patient has not experienced similar symptoms in the past. The patient has been recently seen by a physician: the patient's primary care provider, 4 day(s) ago, with different complaint(s), for resolving URI for 6 weeks. No treatment. Felt good Tuesday and Wed and last night developed new flu like symptoms. cp1

OB/GYN:

09:32 LMP 12/31/2012 kd2

Historical:

- **Allergies:** SULFA (SULFONAMIDES); CEPHALOSPORINS; Macrobid;
- **Home Meds:**
  1. Tessalon Perles Oral
  2. Motrin Oral
  3. Advair Diskus Inhl
  4. Synthroid Oral
  5. Protonix Oral
- **PMHx:** GERD (Gastro Esophageal Reflux Disease); Asthma; Hypothyriodism
- **PSHx:** Tonsillectomy
- **Immunization history:** Up to Date.
- **Social history:** Smoking status: Patient/guardian denies using tobacco, Patient/guardian denies using alcohol,.
- **Family history::** Not pertinent for current visit..

ROS:

09:37 cp1

Constitutional: Positive for body aches, chills, fatigue, fever, malaise.
Eyes: Negative for itching, pain, photophobia, redness.
ENT: Positive for ear pain, rhinorrhea, sinus congestion, sore throat.
Neck: Positive for swollen nodes, Negative for stiffness.
Respiratory: Positive for cough, with no reported sputum, Negative for dyspnea on exertion, shortness of breath, wheezing.
Abdomen/GI: Negative for nausea, vomiting, diarrhea.
Skin: Negative for lesions, rash.
Neuro: Positive for headache, Negative for altered mental status, dizziness, gait disturbance. All other systems are negative,

Exam:

09:37 cp1

Constitutional: The patient appears alert, awake.
Head/face: Sinus tenderness, is not appreciated.
Eyes: Exam is negative for drainage, edema, erythema, exudate.
ENT: TM's: dullness, bilaterally, Nose: Nasal mucosa: edematous, erythematous, Turbinates: are swollen bilaterally, Sinuses: Non-Tender Posterior pharynx: erythema, that is mild, exudate, is not appreciated, Voice: is normal.
Neck: ROM/movement: is normal, Lymph nodes: lymphadenopathy is appreciated, anterior cervical nodes.
Cardiovascular: Rate: actual rate is 94 bpm, Rhythm: regular.
Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, Breath sounds: are normal.
Neuro: Orientation: is normal, Mentation: is normal, Gait: is steady, at a normal pace, without difficulty.

k

Physician Documentation Con't.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
09:32	129 / 87 LA (auto/lg)	94	20	98.5(O)	99% on R/A	113.4 kg	5 ft. 6 in. (168 cm)	8/10	kd2

09:32 Body Mass Index 40.4 (113.40 kg, 168 cm) kd2

MDM:

09:39 cp1

Data reviewed: vital signs, nurses notes, lab test result(s), Rapid Flu. Smoking Cessation Not Applicable.
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, the need for outpatient follow up with a primary care physician. to return to the Urgent Care or emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home.

Time	Order name	Complete Time	Staff
09:25	Influenza Screen	09:51	cp1
09:25	Interpretation: Normal.		cp1

Dispensed Medications:
No medications were administered

Disposition:

09:51 Disposition. cp1
12:46 Attestation: I am signing the PA chart. kt1

Disposition:
01/10/13 09:51 Discharged to Home. Impression: Viral Illness.

- Condition is Stable.
- Discharge Instructions: Antibiotic Non-Use, Salt Water Gargle, Viral Illness.
- Prescriptions for
  Tamiflu 75 mg Oral Capsule
  - take 1 capsule by ORAL route 2 times per day for 5 days; 10 capsule.
- Medication Reconciliation, Work release form form.
- Follow up: Joseph Gentile; When: 2 - 3 days; Reason: Recheck today's complaints.
- Symptoms are unchanged.
- Problem is new.

Signatures:

Dispatcher MedHost		EDMS	Pease, Christopher, PA	PA	cp1
Etheridge, Darlene, RN	RN	de1	Turco, Katherine, DO	DO	kt1
Dole, Katherine		kd2			

Name: Christine Townsend

MRN: 255180
Account#: 4184860

GASTROENTEROLOGY ASSOCIATES, LLP
60 Maple RD
Williamsville, NY 14221-2917

716-626-5250

01/10/12

Joseph Gentile M.D.
4239 Maple Road
Amherst, NY 14226

RE: Christine Townsend
DOB: 05/15/1973

Dear Dr. Gentile,

We had the pleasure of evaluating Christine Townsend at your kind request.

CC: Patient presents for evaluation of heartburn and sore throat.

HPI: Christine Townsend was seen in the office on 1/10/12. As you know, she is a 38-year-old female who presents today for evaluation of longstanding heartburn symptoms. This is dated back at least seven years. She would have frequent heartburn and has been on omeprazole as well as Dexilant in the past without good results. She also has known asthma. She was getting frequent respiratory infections and sore throats. She was evaluated by Dr. Gass from ear, nose and throat in April. Office laryngoscopy had revealed irritation in the back of her throat felt consistent with reflux. She has been maintained on Protonix which she takes in the morning which has been somewhat helpful. She continues to have heartburn sensation on a daily basis. Sore throats are somewhat improved. She denies dysphagia, regurgitation, nausea, vomiting, decreased appetite or weight loss. She has decreased her caffeine from 12 cups down to 2. She does not regularly drink citrus drinks, carbonated beverages or alcohol. She does have a history of heavy nonsteroidal anti-inflammatory use but has limited this in the last several months. She does have regular bowel movements. On a rare occasion, she sees a scant amount of blood on the toilet tissue which she attributes to hemorrhoids. There is a family history of colon polyps in her mother. Christine does occasionally have nighttime symptoms. She is unable to sleep with the head of the bed flat secondary to neck discomfort. She has attempted weight loss efforts in the past but she has been unsuccessful.

Allergies: Macrobid, Sulfa, Cephalosporins

Medication List:
Protonix
Synthroid

PMH:
Problem List: 784.1 - Throat Pain, 787.1 - Heartburn
Health Maintenance:
Negative For EGD, Colonoscopy
Medical Problems:
Gastroesophageal Reflux Disease (GERD), Asthma, Thyroid Disease, Hypothyroidism
Surgical Hx:

Tonsillectomy
Reviewed and updated.
SH:
Marital: Married.**Lives With**: Spouse.**Occupation**: RN - Kaleida Health.
Personal Habits: Cigarette Use: Never Smoked Cigarettes.**Alcohol**: Denies alcohol use.
Reviewed and updated.
FH:
Prostate Cancer - father
Lung Cancer - grandmother
Ovarian Cancer - cousin
Colorectal Polyps - mother-in her 40's.
Reviewed and updated.
ROS:
Const: Reports fatigue, but denies chills, fever, night sweats and weight change.
Eyes: Denies dryness, infection, blurred vision and vision loss.
ENMT: Does not need to wear a hearing aid. Denies bloody nose. Denies bleeding gums, cold sores, dry mouth, hoarseness/voice change and sore throat.
CV: Denies chest pain, irregular heartbeat, lightheadedness, palpitations and swelling of ankles.
Resp: Denies cough, hemoptysis, sleep apnea, SOB and wheezing.
GU: Denies frequency, hematuria, pain on urination and frequent UTI's.
Musculo: Denies fibromyalgia, joint pain, joint stiffness, trouble walking and weakness.
Skin: Reports tattoo, but denies flushing, itchy skin and rashes.
Neuro: Reports vertigo but denies headache, incoordination, involuntary movement, loss of consciousness, numbness/tingling and weakness.
Psych: Denies anxiety, difficulty concentrating, depression and sleep pattern disturbance.
Hema/Lymph: Denies excessive bleeding, excessive bruising and enlarged lymph nodes.
Reviewed and updated.

Vitals: **BP:** 118/82 **Ht:** 66" 5'6" **Wt:** 278lb 2oz **BMI:** 44.9
Exam:
Const: Appears healthy and well developed.
Eyes: Conjunctivae shows no icterus or pallor in the eyes. Pupils equal, round and reactive to light.
ENMT: External ears WNL. External nose WNL. Oropharynx: Appears normal. Oral mucosa: moist with no thrush or ulcers.
Neck: Symmetric. Palpation reveals no adenopathy. No masses appreciated. Thyroid is normal in size and texture.
Resp: Respiration rate is normal. No wheezing. Lungs are clear bilaterally.
CV: Regular rate and rhythm for S1. Regular rate and rhythm for S2. No heart murmur appreciated.
Extremities: No clubbing, cyanosis or edema.
Abdomen: The abdomen is obese. No visible herniations. No abdominal scars. Positive bowel sounds in all quadrants. No bruits. Normal to percussion. Palpation reveals no distension, muscle guarding, rebound tenderness or rigidity. No abdominal masses palpable. No palpable hepatosplenomegaly.
Lymph: No palpable or visible regional lymphadenopathy.
Musculo: Walks with a normal gait and station. **Lower Extremities:** Strength: Motor strength is intact. Normal muscle tone bilaterally.
Skin: No lesions or rash. Skin normal to inspection and palpation overall.
Neuro: Alert and oriented x3. No involuntary movement.
Cranial Nerves: Cranial nerves grossly intact.
Psych: Mood/Affect: Mood is normal. Affect is normal.

9.

IMPRESSION/PLAN: Christine has chronic heartburn. I do suspect underlying gastroesophageal reflux disease. I did review antireflux measures with her today including the necessity for weight loss measures as well. We will plan for an upper endoscopy to rule out chronic inflammatory changes. Risks were reviewed and she is agreeable to proceed. I have asked her to continue her Protonix in the morning and consider utilizing ranitidine 150 mg at h.s. Any change in pharmacologic therapy will be made pending endoscopy results.

In regards to her family history of colon polyps, I have also recommended that she consider colonoscopy evaluation at the age of 40 given her mother's history.

Assessment:
1. 784.1 Throat Pain
2. 787.1 Heartburn

Plan:
Order : EGD

The principal risks and complications of EGD Procedure including but not limited to perforation, bleeding, medication phlebitis, and other risks were discussed and the patient verbalized understanding and was agreeable to proceed with the procedure.

Thank you for allowing us to see Christine Townsend. If you have any further questions, please do not hesitate to contact our office.

Sincerely,

Ann Lillis ANP-C

01/11/2012

Ann F. Lillis, A.N.P.C.

AFL/amr

4

PROGRESS NOTE

Christine Townsend
DOB: 05/15/1973

DATE: 08/23/11

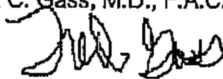
HISTORY: Christine returns feeling 80% improved. She changed from Prilosec to Dexilant. She has minimal throat symptoms at the current time. She has also modified her diet.

EXAM TODAY: The ear canals are clear. The TMs are translucent. The nasal cavity did not show any polyps or unusual drainage. The oral cavity and oropharynx are clear with no evidence of erythema, lesions or exudate. Mirrored exam of the larynx and hypopharynx is unremarkable. There is no cervical lymphadenopathy.

IMPRESSION: Christine has a normal exam today. She gets an occasional sensation of something moving in her right ear, but she's reassured I don't see any cerumen or foreign bodies in the ear canal. The TMs are translucent.

PLAN: I'll see her back should she develop any further reflux. At some point, she could go off the reflux medication to see how she does with just conservative measures.

Frederick C. Gass, M.D., F.A.C.S.



08/24/2011

cc: Joseph Gentile MD

WNYIC NFB

2099 Niagara Falls BLVD
Amherst , NY 14228
Phone: 716-564-2273
Fax: 716-564-2272

Christine M Townsend **ID:** 255180 **DOB:** 05/15/1973 (37 years)

Date of Encounter: 04/06/2011 06:31 PM

History of Present Illness

Patient Words:

Patient states has burning in chest, cough, and right ear pain. Onset was 3 weeks ago.

 # Upper Respiratory Infection (Reason for Visit)

The patient is a 37 year old female who presents with a complaint of # upper respiratory infection. The onset of the # upper respiratory infection has been acute and has been occurring in a persistent pattern for 3 weeks. The course has been constant. Associated features include chills, cough, ear pain and sinus congestion. There has been no use of medications. The # upper respiratory infection is described as moderate. # Upper Respiratory Infection notes: Pt is asthmatic. Occasionally feels SOB. Continues to take PO well. Patient states she is starting to ache from coughing so much. Has nebulizer at home for asthma but is currently out of albuterol ampules.

History

Allergy
- Sulfa Drugs
- macrobid
- cephlasporens

Past Medical
- Asthma
- Hypothyroidism
- chronic sinus infection
- Tonsillectomy

Social
- Non Drinker/No Alcohol Use
- Non Smoker/No Tobacco Use

Medications
- albuterol Active - Hx Entry.
- Synthroid (200MCG For Solution Injection) Active - Hx Entry.

Family
- Parents had cancer

Immunization
- up to date

Review of Systems

General: Not Present- Feeling well, Appetite Loss, Chills, Fatigue and Fever.
Skin: Not Present- Rash.
HEENT: Present- Ear Pain and Nasal Congestion. Not Present- Headache, Eye Redness, Ear Discharge, Rhinitis, Sinus Pain, Hoarseness, Sore Throat and Trismus.
Neck: Not Present- Neck Stiffness and Swollen Glands.
Respiratory: Present- Cough and Shortness of Breath. Not Present- Difficulty Breathing, Sputum Production and Wheezing.
Cardiovascular: Not Present- Chest Pain.
Gastrointestinal: Not Present- Abdominal Pain, Diarrhea, Nausea and Vomiting.
Musculoskeletal: Not Present- Muscle Pain.

Vitals

04/06/2011 06:33 PM
Weight: 215 lb **Height:** 66 in (Patient reported)
Body Surface Area: 2.06 m² **Body Mass Index:** 34.74 kg/m²
Pain level: 6/10 **LMP:** 03/11/2011
Temp.: 98.3 °F (Tympanic) **Pulse:** 91 (Regular) **Resp.:** 16 (Unlabored) **P. OX:** 99% (Room air)
BP: 127/83 Electronic (Sitting, Left Arm, Standard)

Physical Exam

General
Mental Status - Alert (in no acute distress). **General Appearance** - Well groomed. Not Lethargic / Slow. **Orientation** - Oriented X3. **Build & Nutrition** - Well nourished and Well developed. **Hydration** - Well hydrated.

Integumentary
General Characteristics: Overall examination of the patient's skin reveals - no rashes. **Color** - normal coloration of skin. **Skin Moisture** - normal skin moisture. **Temperature** - normal warmth is noted. **Mobility & Turgor** - normal mobility and turgor.

HEENT
Head
Head Shape - Normocephalic. **Face** - Atraumatic.
Ear
Auditory Canal - **Bilateral** - No Localized tenderness, Discharge or Cerumen. Not Obstructed. **External Auditory Meatus** - **Bilateral** - No Discharge. Not Obstructed. **Tympanic Membrane** - **Bilateral** - Bulging. No Inflammation or Purulent effusion.
Eye
Cornea - **Bilateral** - Normal. **Sclera/Conjunctiva** - **Bilateral** - No Discharge, Congestion or Subconjunctival hemorrhage. **Pupil** - **Bilateral** - Normal.
Nose & Sinuses
Nostrils - **Bilateral** - Patent. No Discharge. **Nasal Mucosa** - **Bilateral** - Not Congested. **Nasal Septum** - Normal and Midline. **Maxillary Sinuses** - **Bilateral** - Normal.
Mouth & Throat
Teeth and Gums - Normal dentition with no evidence of discoloration, inflammation, or infection. **Pharynx** - No Erythema, Exudate or Thrush.

Chest and Lung Exam
Inspection:
Chest Wall: - Normal. **Movements** - Normal and Symmetrical. **Accessory muscles** - No use of accessory muscles in breathing.
Auscultation:
Breath sounds: - Normal.
Breath sounds: no wheezes, rales, rhonchi or stridor. Good aeration bilaterally.

Cardiovascular
Auscultation: Rhythm - Regular. **Heart Sounds** - S1 WNL and S2 WNL. No S3 or S4.
Murmurs & Other Heart Sounds: Auscultation of the heart reveals - No Murmurs and No Pericardial Friction Rubs.

Abdomen
Inspection: Inspection of the abdomen reveals - No Hernias.
Palpation/Percussion: Palpation and Percussion of the abdomen reveal - Non Tender, No Rebound tenderness, No Rigidity (guarding) and No hepatosplenomegaly.
Auscultation: Auscultation of the abdomen reveals - Bowel sounds normal.

Lymphatic
General Lymphatics
Description - Localized lymphadenopathy (anterior cervical).

Assessments & Plans

BRONCHITIS (490.)

Medications
Biaxin XL Pac 500MG, 2 tablet(s) daily with food, 10 days starting 04/06/2011, No Refill. Ordered.
PredniSONE 20MG, 1 Tablet two times daily, #6, 3 days starting 04/06/2011, No Refill. Ordered.
Guaifenesin-Codeine 100-10MG/5ML, 10 milliliter(s) every 6 hours as needed, #6, 5 days starting 04/06/2011, No Refill. Ordered.
Albuterol Sulfate (2.5 MG/3ML)0.083%, 1 (one) Ampule(s) Q 4hr/PRN, #30, 04/06/2011, No Refill. Ordered.
Procedures
CHEST X-RAY, TWO VIEWS (71020) (1 Units)Joseph Gentile, MD NAD
IPRATROPIUM-ALBUTEROL, 0.5-2.5 (3)MG/3ML (Inhalation Solution) (J7620) (1 Units)breathing improved following treatment
Additional Instructions

YOU HAVE BEEN DIAGNOSED WITH: Bronchitis

FOLLOW UP WITH YOUR PRIMARY DOCTOR IN ONE WEEK

PLEASE REFER TO THE PATIENT EDUCATION SHEETS AND FILL ANY PRESCRIPTIONS AT YOUR LOCAL PHARMACY

PTS PMHX, MEDICATIONS, ALLERGIES, SOCIAL/FAMILY HISTORY, AND NURSING/MEDICAL ASSISTANT HX REVIEWED
Patient Education
Acute Bronchitis: acute bronchitis

History & Physical Note

Chart Review Note *(Eddy Capote; 4/6/2011 8:47:59 PM)*
I have reviewed the history and physical note and findings.

Susan M Eddy PA

Procedures

IPRATROPIUM-ALBUTEROL, 0.5-2.5 (3)MG/3ML (Inhalation Solution)
(J7620) *Performed: 04/06/2011 (Final, Reviewed)*
- *Comments: Duoneb administered with teaching. will monitor for effectiveness. ald.*

CHEST X-RAY, TWO VIEWS (71020) *Performed: 04/06/2011 (Ordered)*

CONSULTATION REPORT

Christine Townsend
DOB: 05/15/1973

DATE: 12/10/10

HISTORY: Christine presents with a history of a small lump on her anterior neck. She also gets recurrent sinus infections and has been told she needs sinus surgery and septoplasty. This surgery had been cancelled by another otolaryngologist due to the flu. I believe she is here for a second opinion. She does get intermittent infections. There's some drainage. She does not describe any significant restriction on one side of the nose or the other. Occasionally a tonsil remnant in the back of her throat will swell up when she gets cold symptoms or flu. She is not a tobacco user. She does not use alcohol products. The only previous ENT surgeries have included tonsillectomy and adenoidectomy. She has a history of asthma and some thyroid disease. Current meds include Synthroid and Advair Diskus. Christine is a patient of Dr Gentile.

EXAM TODAY: This is a well nourished, well developed individual, who is fully oriented to person, place, and time, with a normal ability to communicate with a strong voice.

Head and Face - there are no scars, lesions, or masses. There is no palpable sinus tenderness or facial nerve weakness. There is no major salivary gland tenderness or masses.

Eyes - Extraocular muscles are intact.

Neck - There is no tenderness to palpation, no palpable masses in Zones 1-5. There is good symmetry with midline trachea. Palpation of the neck does reveal a small dermal mobile cyst that's just 2-3mm in size. There are no other lumps or cysts noted in the neck. There is no cervical lymphadenopathy.

Thyroid - There is no palpable thyromegaly, no thyroid tenderness, and no nodules appreciated.

Ears - There are no visible lesions or inflammation of the pinna or external auditory canal. The tympanic membranes are translucent bilaterally without retraction, and mobile to insufflation. The patient responds well to whispered voice and tuning fork exam.

Nose - There are no lesions or inflammation of the external nose or nasal mucosa. There is no turbinate hypertrophy or inflammation. There is a deviation of the septum to the right. There are no nasal cavity polyps, or abnormal drainage of the osteomeatal complexes.

Lips, teeth, and gums - There are no lesions or inflammation.

Oral Cavity and Oropharynx - Buccal mucosa, upper and lower alveolar ridge, hard and soft palate, tongue, floor of mouth, retromolar trigone, and oropharynx show no asymmetry or lesions and appear normally hydrated.

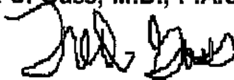
Hypopharynx and Larynx - The hypopharynx shows no pooling of saliva, asymmetry, or mucosal lesions. Mirror exam of the true vocal cords demonstrate bilateral mobility without lesions. Surrounding structures to include false vocal cords, epiglottis, arytenoids, pyriform sinuses, tongue base and vallecula, demonstrate no inflammation or mucosal lesions.

Nasopharynx - Mirror exam reveals no mucosal lesions of posterior nasopharyngeal wall, torus tubarius, or eustachian tube orifice. There is no abnomal drainage or asymmetry noted.

IMPRESSION/PLAN:
1) Recurrent sinusitis and deviated septum. The septum does have a mild deviation to the right anteriorly and there's a bone spur off to the left posteriorly. I don't think it's obstructing and I explained to her there might be slight improvement with septoplasty. I wouldn't anticipate a lot of improvement. I don't see any mucopurulent drainage from the sinuses today. I've recommended she come back should the sinuses become infected and we'll try to do a culture.

2) Small lump in her neck. We're going to follow this at the current time. It may represent a small lipoma or a small inclusion cyst, but it's just a few millimeters in size and she does not desire to have it removed at the current time.

Frederick C. Gass, M.D., F.A.C.S.



12/13/2010

cc: Joseph Gentile MD

WESTERN NEW YORK IMMEDIATE CARE NFB

2099 Niagara Falls Blvd., Amherst, NY 14228
Voice (716) 564-2273 Fax (716) 564-2272

Patient Name:	Account No:		MRN:
CHRISTINE M TOWNSEND	189267	123456	

AT THE REQUEST OF:	DOB:	SEX:	DOS:
EDDY CAPOTE, MD 2099 NIAGARA FALLS BLVD AMHERST, NY 14226-	05-15-73	F	04-06-11

XRAY CHEST 2 VIEWS

CLINICAL HISTORY:
Cough.

Frontal and lateral views of the chest reveal the cardiac silhouette, aorta and mediastinum to be unremarkable. No consolidation, pleural effusion or mass are seen.

IMPRESSION:
NO ACTIVE CARDIOPULMONARY PROCESS.

JAMES FITZGERALD, MD

JOSEPH GENTILE, MD

TRANSCRIBED: 04-07-2011 02:01:26 PM
RELEASED: JAMES FITZGERALD 04-07-2011 03:01:07 PM

JBF/DT

Review of Systems
Musculoskeletal: Negative for stiffness.
Skin: Negative for itching.
Neurological: Negative for tingling and numbness.
All other systems reviewed and are negative.

Physical Exam
Nursing note and vitals reviewed.
Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae normal and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate and regular rhythm.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: Normal range of motion.
Neurological: She is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: Mood and affect normal.

ASSESSMENT AND PLAN
Bilateral wrist contusion with left ankle sprain. No indication for xrays. Pt able to bear weight. No anatomical snuff box tenderness. neurvascular intact. Will discharge with ace wrap.

We thank you and your patient for the opportunity to serve you. Please think of us if a future need arises.

Sincerely,

RYAN SNYDER, MD

BUFFALO , NY 14203
CC3:

---------------- FINAL REPORT ----------------

torreMRI LEFT ANKLE

CLINICAL INDICATIONS: Injury 05/2014 with persistent ankle pain.

IMAGING SEQUENCES:Both spin echo and inversion recovery sequences were utilized to evaluate the ankle in the sagittal, axial, and coronal planes.

FINDINGS:There is a large (10 mm) osteochondral defect in the medial talar dome. This osteochondral fragment is undercut by fluid indicating a free fragment. This is best seen on the T2 coronal image #14. The remainder of the talus is intact. The distal tibia, distal fibula, and calcaneus are intact.

The medial and lateral ligaments are intact. The medial tendons are intact.

There is fluid in the peroneal tendon sheath. There is a longitudinal split-thickness tear of the peroneus brevis tendon at its crosses the lateral malleolus. The peroneus longus is intact. The Achilles tendon is intact.

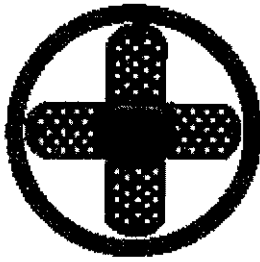
There are small dorsal intertarsal marginal osteophytes. There are small tarsal metatarsal marginal osteophytes and subchondral cysts.

IMPRESSION:
1.LARGE OSTEOCHONDRAL DEFECT AT THE MEDIAL ASPECT OF THE TALAR DOME UNDERCUT BY FLUID INDICATING A FREE FRAGMENT.
2.PERONEAL TENOSYNOVITIS WITH A LONGITUDINAL SPLIT TEAR OF THE PERONEUS BREVISTENDON.
3.TARSAL METATARSAL AND INTERTARSAL OSTEOARTHRITIS.

Thank you.

Krishnan Kartha, MD

Dictated: KARTHA, KRISH MD 11/06/2014
Transcribed: Radecki, Laurie 11/06/2014 09:31:51 AM
Electronically signed: KARTHA, KRISH MD 11/06/2014 12:17:45 PM



MASH Urgent Care

1751 Sheridan Dr.
Tonawanda NY 14223
716-844-7100
Dept Fax: 716-873-0230

May 9, 2014
Time of Visit : 11:45 AM

JOSEPH GENTILE, M.D.
4239 Maple Road
Amherst, NY 14226

RE: Christine Townsend
5/15/1973

Dear Dr. Gentile:

We recently treated your patient, Christine Townsend at MASH Urgent Care. Below is a summary of services provided.

The patient's vitals today are as follows BP 137/81 | Pulse 108 | Temp 99.5 °F (37.5 °C) (Oral) | Resp 16 | Ht 5' 6" (1.676 m) | Wt 250 lb (113.399 kg) | BMI 40.37 kg/m2 | SpO2 96% | LMP 04/20/2014.

Patient is a 40 year old female presenting with extremity pain.

Arm Pain

This is a new problem. The current episode started yesterday. The pain is present in the left wrist and right wrist. The quality of the pain is described as aching. The pain is at a severity of 3/10. The pain is mild. Pertinent negatives include no numbness, full range of motion, no stiffness, no tingling and no itching. The symptoms are aggravated by activity. She has tried nothing for the symptoms. There has been a history of trauma. Family history is significant for no rheumatoid arthritis and no gout.

Visit Information

	Provider	Clinic	Dept
5/9/2014 11:45 AM	RYAN SNYDER, MD	B.M.G	Mash KT

Patient Demographics

Patient Name	MRN	Sex	DOB	Address	Phone
Townsend, Christine	108966	Female	5/15/1973	59 BRIGGS AVE BUFFALO NY 14207	716-544-3585 (Home)

Reason for Visit

Generalized Body Aches

Referring Provider

Joseph Gentile

Nurse's Notes

CARRIE MICHELS, RN Fri May 9, 2014 12:00 PM

Patient presents with:
Generalized Body Aches
for 0 day(s)

C/O bilateral ankle, knee, shoulder, wrist, neck, upper back pain, nausea, dizziness, left ankle swelling, bruising to arms
Denies head injury
States last night she was placed in handcuffs by police and thrown to the ground face first

Questionnaire Answers

No questionnaire available.

Not recorded

Progress Notes

RYAN SNYDER, MD 5/9/2014 12:42 PM Signed

Patient is a 40 year old female presenting with extremity pain.

Arm Pain

This is a new problem. The current episode started yesterday. The pain is present in the left wrist and right wrist. The quality of the pain is described as aching. The pain is at a severity of 3/10. The pain is mild. Pertinent negatives include no numbness, full range of motion, no stiffness, no tingling and no itching. The symptoms are aggravated by activity. She has tried nothing for the symptoms. There has been a history of trauma. Family history is significant for no rheumatoid arthritis and no gout.

Review of Systems
Musculoskeletal: Negative for stiffness.
Skin: Negative for itching.
Neurological: Negative for tingling and numbness.
All other systems reviewed and are negative.

Physical Exam
Nursing note and vitals reviewed.
Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress.
HENT:
Head: Normocephalic and atraumatic.

Eyes: Conjunctivae normal and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate and regular rhythm.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: Normal range of motion.
Neurological: She is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: Mood and affect normal.

ASSESSMENT AND PLAN
Bilateral wrist contusion with left ankle sprain. No indication for xrays. Pt able to bear weight. No anatomical snuff box tenderness. neurvascular intact. Will discharge with ace wrap.

Electronic signature on 5/9/2014 11:46 AM
Electronic signature on 5/9/2014 11:46 AM

No results for this visit

Medications Last Reviewed During Encounter By

CARRIE MICHELS, RN on 5/9/2014 at 12:00 PM

Reviewed Medications

Outpatient Medications	Ordered On	Taking
CELEXA 10 MG PO TABS	2/21/2013	No
PROTONIX PO	2/21/2013	Yes
SYNTHROID PO	2/21/2013	Yes
VITAMIN D3 2000 UNITS PO TABS	2/21/2013	Yes

Allergies as of 5/9/2014 — **Reviewed** On: **5/9/2014** By: **Carrie Michels, RN**

	Noted	Type	Reactions
Cephalosporins	2/21/2013		
Macrobid (Nitrofurantoin Monohydrate Macrocrystals)	2/21/2013		
Motrin	5/9/2014		Swelling
Sulfa Antibiotics	2/21/2013		

Problem List as of 5/9/2014 — Date Reviewed: **2/21/2013**

None

Vitals - Last Recorded

BP	Pulse	Temp	Resp	Ht	Wt
137/81	108	99.5 °F (37.5 °C) (Oral)	16	5' 6" (1.676 m)	250 lb (113.399 kg)

BMI	SpO2	LMP
40.37 kg/m2	96%	04/20/2014

BMI Data

Body Mass Index　　Body Surface Area

4. Blue or cold foot or toes
5. Numbness or tingling of your toes
6. Weakness or inability to move your foot or toes

What To Expect

1. Even with proper treatment, pain and swelling may increase over the first 1-2 days, but should gradually decrease after that.
2. Sprains get better most quickly if you gradually put more weight on the injured ankle after 24-48 hours of ice, rest, and elevation.

What To Do

1. Apply ice (wrapped in a towel) for 20 minutes per hour, for the first day or two. Elevate the area on padding.
2. Use splint or Ace wrap until pain and swelling improve, use crutches, and don't bear weight until rechecked.
3. See your care provider or an orthopedic surgeon within 2-3 days to evaluate the degree of this injury.

What Not To Do

1. DO NOT walk on your ankle until you have been cleared to do so by your care provider.
2. DO NOT apply heat.
3. DO NOT allow the ankle to hang down below the waist for the first 2 days.
4. DO NOT attempt to remove your splint yourself.

For further in-depth information the following website can provide more. www.medlineplus.gov

SEE A FOLLOW-UP PHYSICIAN IF NECESSARY:

If you do not improve as expected, additional evaluation by another care provider will be necessary. Please arrange to be seen by JOSEPH GENTILE, M.D.. Call the doctor's office soon to make an appointment. IF YOU ARE WORSE AND IF, FOR ANY REASON, YOU CANNOT ARRANGE TO SEE THE CARE PROVIDER, YOU MUST CALL THERE AS SOON AS POSSIBLE.

YOU MUST MAKE ARRANGEMENTS FOR FOLLOW-UP OF ANKLE SPRAIN

REMEMBER YOUR CARE IS NOT YET COMPLETED

IT IS IMPORTANT THAT WE HAVE A CORRECT TELEPHONE NUMBER, IN CASE IT IS NECESSARY TO CONTACT YOU.

Routing History

Recipient	Method	User	Date
JOSEPH GENTILE, M.D. Fax: 716-835-1470 Phone: 716-832-9747	Fax	Ryan E. Snyder Letter: created on 5/9/2014 by Ryan E. Snyder	5/9/2014

Letters

Letter Information

	Status
Ryan E. Snyder on 5/9/2014	Sent

Letter Information

	Status
Ryan E. Snyder on 5/9/2014	Sent

Friday, November 7, 2014

I have reviewed the attached MRI study including all films and I agree with the reading radiologist report.

PATIENT NAME:
TOWNSEND , CHRISTINE

DOB:
05/15/1973 00:00:00
AGE/SEX:
041Y / F

MRN #:
204520
ACC # :
01315188

EXAMINATION:
MRI ANKLE LT
CPT: 73721

STUDY DATE :
11/05/2014 18:33:28

Physician:
HUCKELL, GRAHAM MD
CC1:

700 MICHIGAN AVENUE
CC2:

BUFFALO , NY 14203
CC3:

———— FINAL REPORT ————

torreMRI LEFT ANKLE

CLINICAL INDICATIONS: Injury 05/2014 with persistent ankle pain.

IMAGING SEQUENCES:Both spin echo and inversion recovery sequences were utilized to evaluate the ankle in the sagittal, axial, and coronal planes.

FINDINGS:There is a large (10 mm) osteochondral defect in the medial talar dome. This osteochondral

This document contains confidential health information that is legally privileged and highly confidential. This information is intended only for the use of the addressee only to aid in providing specific healthcare services to this patient and/or to effectuate payment by the responsible payor. The authorized recipient of this document is prohibited from disclosing this information to any other party for any other purpose unless required to do so by law or regulation and is required to delete or destroy the information after its stated purpose has been satisfied. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or any action regarding the contents of this document is strictly prohibited, and are directed to immediately notify the sender and destroy this information. Any other use is a violation of Federal HIPAA laws which render substantial penalties for violations.

fragment is undercut by fluid indicating a free fragment. This is best seen on the T2 coronal image #14. The remainder of the talus is intact. The distal tibia, distal fibula, and calcaneus are intact.

The medial and lateral ligaments are intact. The medial tendons are intact.

There is fluid in the peroneal tendon sheath. There is a longitudinal split-thickness tear of the peroneus brevis tendon at its crosses the lateral malleolus. The peroneus longus is intact. The Achilles tendon is intact.

There are small dorsal intertarsal marginal osteophytes. There are small tarsal metatarsal marginal osteophytes and subchondral cysts.

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2.PERONEAL TENOSYNOVITIS WITH A LONGITUDINAL SPLIT TEAR OF THE PERONEUS BREVISTENDON.
3.TARSAL METATARSAL AND INTERTARSAL OSTEOARTHRITIS.

Thank you.

Krishnan Kartha, MD

Dictated: KARTHA, KRISH MD 11/06/2014
Transcribed: Radecki, Laurie 11/06/2014 09:31:51 AM
Electronically signed: KARTHA, KRISH MD 11/06/2014 12:17:45 PM
2

Greater Buffalo Accident & Injury
191 North St Suite 205 Buffalo NY 14201
P - 716.200.0651 F - 716.939-3867

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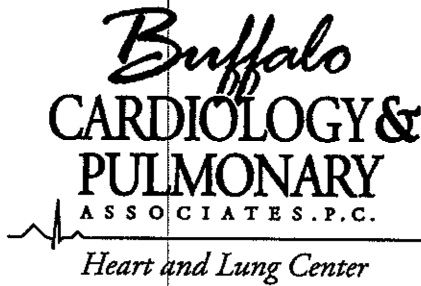
62142



FAX TRANSMITTAL FORM

Date:	1·12·16
To:	
Fax #:	608-1388
Company:	Law Offices of Matthew Albert
From:	Emily
Reply to Fax #:	
Comments:	Re: Christine Townsend
	* invoice enclosed

Total number of pages, including this one: ______

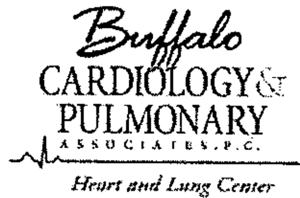
NOTICE TO RECIPIENT:

The information contained in this facsimile transmission is **privileged** and **confidential** information intended solely for the use of the addressee named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is **strictly prohibited**. If you have received this communication in error, please notify us immediately by telephone, and return the original facsimile transmission to me by mail.

PLEASE NOTIFY US IMMEDIATELY OF ANY PROBLEMS WITH TRANSMITTAL.

THANK YOU.

6460 Main Street
Williamsville, New York 14221-9060
(716) 634-5100
FAX: 634-5134



6460 Main Street, Williamsville NY 14221 716-634-5100

Date: 09/05/2014

Christine Townsend
DOB: 05/15/1973

Dear Dr. Joseph Gentile,

Your patient was seen in the office today for a cardiology visit. Below is a summary of the visit.

Reason for Visit

Cardiac Follow-Up

HPI

41-year-old Caucasian female, recently evaluated by Dr. Kozlowski with complaints of lower extremity edema and atypical chest pain. The patient underwent a 14 day event monitor and stress echocardiogram for complete evaluation. Since her last visit, the patient has discontinued the use of daily Motrin. She subsequently has noted that her lower extremity edema has completely resolved. She had chest pain on one occasion while grocery shopping. She did not have any chest pain during her stress echocardiogram.

Otherwise, the patient is without cardiovascular complaints. She denies any palpitations, lightheadedness or dizziness. She has had no syncope or near syncope. She continues to work as a VNA nurse carrying a heavy bag, climbing stairs, etc over the course of her work day.

Assessment/Plan

1. **Chest pain** - 41-year-old with risk factors that include obesity, and strong family history with recurrent chest discomfort. EKG is without acute change. Her stress echocardiogram is unremarkable with preserved EF, no significant valvular changes
   786.50: Chest pain, unspecified

2. **Obesity** - Dietary changes exercise regimen and weight reduction were strongly encouraged. ACC guidelines were reviewed with Ms. Townsend.
   278.00: Obesity, unspecified

3. **Hyperlipidemia** - Under your expertise.
   272.4: Other and unspecified hyperlipidemia

4. **Intermittent palpitations** - Resolved with unremarkable 14 day event monitor.
   785.1: Palpitations

5. **Edema** - Resolved with the eliminated of NSAIDs.
   782.3: Edema

Discussion

Discussion Notes

Ms. Townsend was counseled regarding current American Heart Association guidelines for cardiovascular health in women.. I have made recommendations including a heart healthy diet (Mediterranean type)., 30-45 min. of regular exercise 5-6 days a week and 2-3 days of weight training. The patient would benefit from weight reductionand regular exercise program.

Return to Office

TOWNSEND, CHRISTINE M (id #62142, dob: 05/15/1973)

- Lisa C. Kozlowski, MD for PA Follow-Up at BCPA on 09/05/2014 at 10:30 AM

Vitals

Ht:	5 ft 6 in	**Wt:**	268 lbs	**BMI:**	43.3
BP:	122/88 sitting R arm	**Pulse:**	68 bpm regular	**RR:**	16

Physical Exam

Patient is a 41-year-old female.

General: Alert, confortable. She is obese.
Skin warm and dry.

Procedure Documentation

None recorded.

Medications

Reviewed Medications

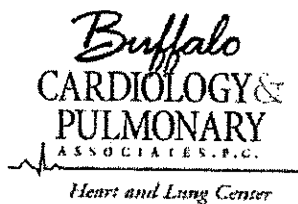
Name	Date
Protonix 40 mg tablet,delayed release Take 1 tablet(s) every day by oral route.	07/29/14 entered

Thank you for allowing us to see your patient in consultation.

Sincerely,

Electronically Signed By: VIRGINIA M. HART, NP

Encounter signed-off by Lisa C. Kozlowski, MD, 09/05/2014.



6460 Main Street, Williamsville NY 14221 716-634-5100

Cardiac Rhythm Monitor

Date: 08/04/2014

Patient Name: Christine Townsend

DOB: 05/15/1973

Reason for Visit
Event Monitor, Palpitations

Procedure

EVENT MONITOR:

Ordering Physician: Dr.Kozlowski

Event Monitor

Indications: Palpitations

Findings: There were 1 reports transmitted

Conclusion:

A 14 day event monitor documented an underlying rhythm of normal sinus with sinus arrhytthmia.

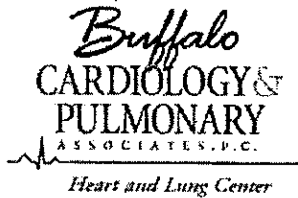
On 8/4/2014. Patient did experiennce chest pain. This correlated with sinus tachycardia at a rate of 122 beats per minute.

No further transmissions were submitted

The detailed information supporting this report is available through our office. If you wish a copy please don't hesitate to call.

Sincerely,

Electronically Signed by: LISA C. KOZLOWSKI, MD



6460 Main Street, Williamsville NY 14221 716-634-5100

Date: 07/29/2014

Christine Townsend
DOB: 05/15/1973

Dear Joseph Gentile MD,

Your patient was seen in the office today for a cardiology visit. Below is a summary of the visit.

Reason for Visit

Followup: Chest pain

HPI

I had the pleasure of seeing Christine Townsend today in cardiovascular initial evaluation. She is a 41-year-old female with cardiac risk factors that include strong family history, obesity, elevated LDL whom resents in further evaluation for chest discomfort. She states that she does have a history of ankle swelling after taking Motrin. In May 2014 she's did restart Motrin for headache and neck discomfort. She did note ankle swelling and chest discomfort. She stopped the Motrin approximately 2 weeks ago.Ankle swelling resolved. However, the chest discomfort has persisted. She noted chest discomfort under the left breast that radiates to the sternum and is a pressure-like sensation, it is random, associated both with rest and exertion. At times she does note nausea with these symptoms. She denies dyspnea PND, orthopnea. She also noted palpitations at times a fluttering sensation, which is fleeting and not associated with syncope near-syncope lightheadedness or dizziness. Last week she noted that her chest discomfort daily . It has been overall lessening but persistent.

Assessment/Plan

1. **Chest pain** - 41-year-old with risk factors that include obesity, and strong family history with recurrent chest discomfort. EKG is without acute change. At this time I am recommending a stress echocardiogram to assess LV systolic ffunction valvular function and exclude ischemia.
   786.50: Chest pain, unspecified
   - STRESS ECHOCARDIOGRAM

2. **Obesity** - Dietary changes exercise regimen and weight reduction were strongly encouraged. She'll wait completion of her stress echocardiogram prior to starting any routine exercise regimen. Pending results will always consider a sleep study as she does have a generalized fatigue.
   278.00: Obesity, unspecified
   - WEIGHT MANAGEMENT EDUCATION

3. **Hyperlipidemia** - Last LDL 137. We'll repeat Lipid profile and give recommendations pending profile.
   272.4: Other and unspecified hyperlipidemia
   - LIPID PANEL, SERUM
   - AST/SGOT (ASPARTATE AMINOTRANSFERASE), SERUM
   - ALT (ALANINE AMINOTRANSFERASE), SERUM

4. **Intermittent palpitations** - Patient does have a random and intermittent palpitations without significant associated symptomatology. They do not occur daily. At this time I am recommending a 14 day event monitor to quantitate further
   785.1: Palpitations
   - EVENT MONITOR

Return to Office

- STRESS ECHO for Echo_Stress Echo Add On at BCPA on 08/04/2014 at 11:00 AM
- HOLTER for Holter/Event at BCPA on 08/06/2014 at 09:30 AM
- Virginia M. Hart, NP for C Follow Up 20 at BCPA on 09/05/2014 at 10:20 AM

- Lisa C. Kozlowski, MD for PA Follow-Up at BCPA on 09/05/2014 at 10:30 AM

Vitals

Ht:	5 ft 6 in	**Wt:**	268 lbs	**BMI:**	43.3
BP:	132/80 sitting R arm 124/84 sitting L arm	**Pulse:**	65 bpm regular	**RR:**	18

Physical Exam

Patient is a 41-year-old female.

Constitutional:
General Appearance: well-developed, appears stated age, and **obese**. Level of Distress: comfortable.

Psychiatric:
Mental Status: alert and oriented X3 and normal mood and affect.

Eyes:
Lids and Conjunctivae: non-injected, anicteric, and no xanthelasma.

Neck:
Jugular Veins: normal jugular venous pressure.

Lungs:
Respiratory Effort: unlabored. Auscultation: no wheezing, rales, or rhonchi and clear.

Cardiovascular:
Precordial Exam: **non palpable.** Rate And Rhythm: regular. Heart Sounds: no rub, gallop, or click and normal S1 **S2).**
Extremities: no cyanosis or edema.

Abdomen:
Inspection and Palpation: soft and non distended.

Musculoskeletal:
Inspection: no erythema.

Neurologic:
Gait: normal gait.

Skin:
Inspection and Palpation: warm and dry;**tattoo.**

Procedure Documentation

EKG:
NSR.

Medications

Reviewed Medications

Name	Date
Protonix 40 mg tablet,delayed release Take 1 tablet(s) every day by oral route.	07/29/14 entered

Thank you for allowing us to see your patient in consultation.

Sincerely,

Electronically Signed By: LISA C. KOZLOWSKI, MD

TOWNSEND, CHRISTINE M (id #62142, dob: 05/15/1973)

Encounter signed-off by Lisa C. Kozlowski, MD, 07/29/2014.

62142 29-Jul-2014 07:37:15 AM CHRISTINE TOWNSEND
Female

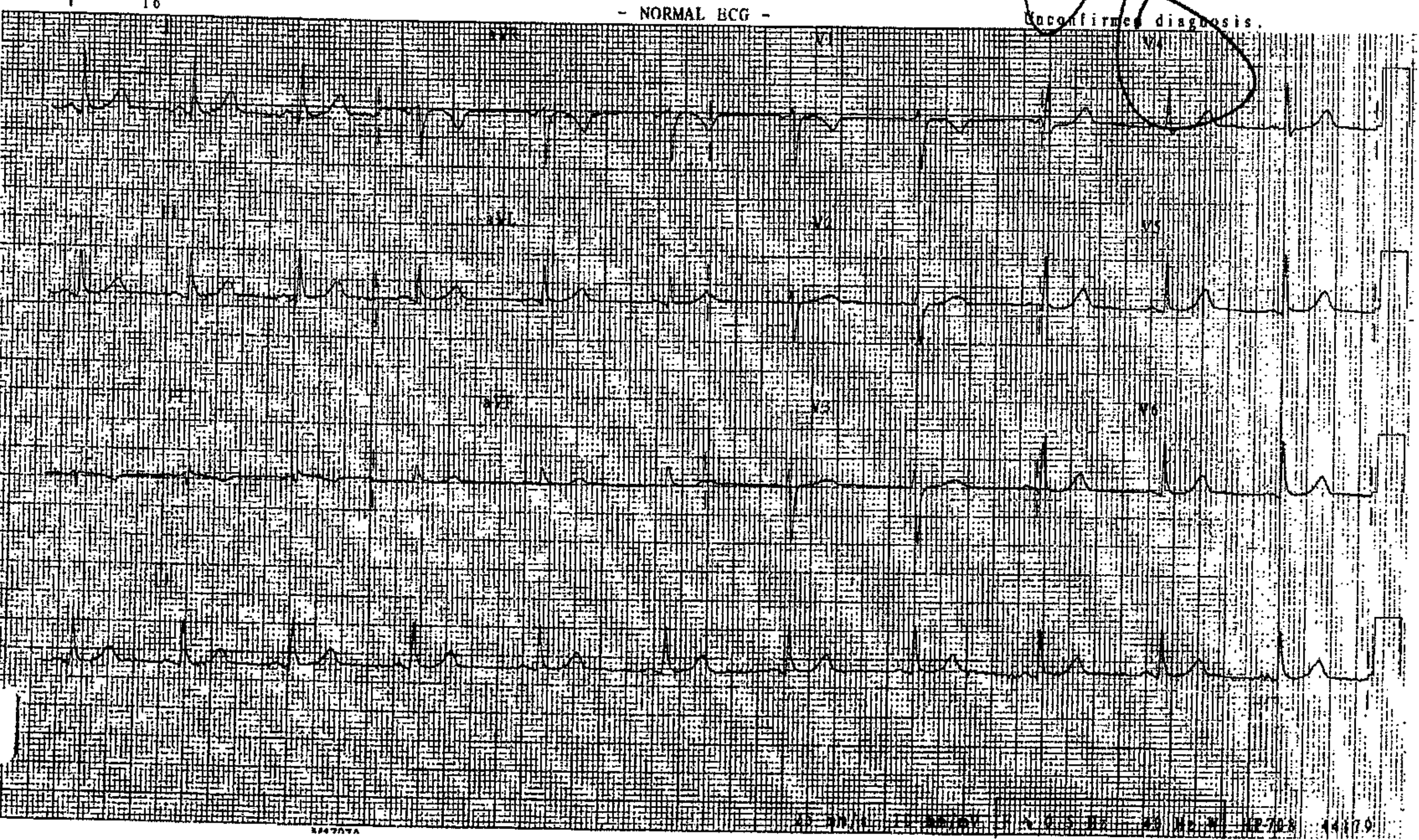
BUFFALO CARDIOLOGY AND PULMONARY ASSOC.

Rate 65 . Normal sinus rhythm, rate 65.....................Normal P axis, PR, rate & rhythm
PR 137
QRSD 88
QT 392
QTc 408

--Axis--
P 16
QRS 30
T 16

- NORMAL ECG -

Unconfirmed diagnosis.



Buffalo CARDIOLOGY & PULMONARY ASSOCIATES, P.C.

INVOICE

Date 1·12·16

Medical Record Invoice Acc# 62142

Company Requesting:

Law Offices of Matthew Albert
254 Richmond Ave.
Buffalo, NY 14222
ph: 445-4119
fax 608 1388

Regarding Patient Christine Townsend
Pages copied 7
$.75 per page Total $ 5.25

hyperlipidemia
LCK

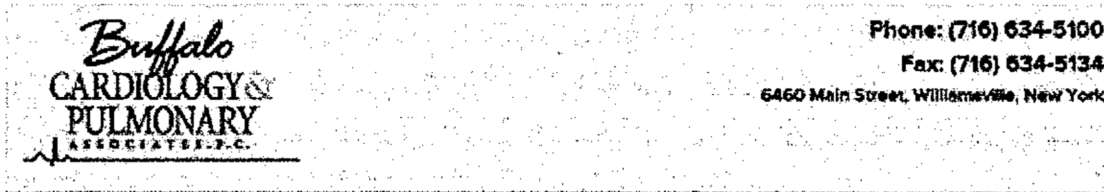
Remit payment to:

Buffalo Cardiology & Pulmonary
PO Box 13239
Belfast, ME 04915-4023

Faxed

Any questions regarding this invoice please call (716) 565-6632

From: **Billing** noreply@creditcard.athenahealth.com
Subject: Receipt from Buffalo Cardiology and Pulmonary Associates
Date: Today at 1:57 PM
To: rbaksa01@gmail.com



Payment Receipt

Thank you for your recent payment with Buffalo Cardiology and Pulmonary Associates on 02/22/2016, Buffalo Cardiology and Pulmonary Associates has charged your credit card (ending in 9170) in the amount of $5.25. A receipt for this payment is included below.

If you have any questions about this payment, please contact Buffalo Cardiology and Pulmonary Associates at (716) 634-5100.

Payment Information

Merchant ID:	8026805039
Approval code:	819023
Record number:	63878
Trace number:	502859
Transaction reference number:	222185706
Transaction identifier:	466053682275309
Transaction type:	PURCHASE
Date/time:	02/22/2016 01:57 PM EST
Type:	Visa
Card number ending in:	9170
Cardholder name:	Matthew Albert
Patient identifier:	62142
Subtotal:	5.25
Sales Tax:	0.00
Total:	5.25

LAW OFFCIES MATTHEW ALBERT
254 RICHMOND AVE

BUFFALO, NY 14222

PD PB 2/22/16

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

Field	Value
1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	05151973
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	TOWNSEND CHRISTINE M
3. PATIENT'S BIRTH DATE (MM DD YY) / SEX	05 15 1973 / F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	TOWNSEND CHRISTINE M
5. PATIENT'S ADDRESS (No., Street)	59 BRIGGS AVENUE
CITY / STATE	BUFFALO / NY
ZIP CODE / TELEPHONE (Include Area Code)	14207 / (716)8761569
6. PATIENT RELATIONSHIP TO INSURED	Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)	59 BRIGGS AVENUE
CITY / STATE	BUFFALO / NY
ZIP CODE / TELEPHONE (Include Area Code)	14207 / (716)8761569
8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
b. RESERVED FOR NUCC USE	
c. RESERVED FOR NUCC USE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	[ ] YES [X] NO
b. AUTO ACCIDENT? PLACE (State)	[ ] YES [X] NO
c. OTHER ACCIDENT?	[ ] YES [X] NO
10d. CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH / SEX	05 15 1973 / F [X]
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	LAW OFFCIES MATTHEW ALBERT
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	[ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 01 13 2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

Field	Value
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	01 12 2016 QUAL. 431
15. OTHER DATE	QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
20. OUTSIDE LAB? / $ CHARGES	[ ] YES [X] NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	0
A.	E785
B. C. D. E. F. G. H. I. J. K. L.	
22. RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24.	A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 12 16	01 12 16	11		99080		A	5 25	7		NPI	1548248834
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

Field	Value
25. FEDERAL TAX I.D. NUMBER (SSN EIN)	161054164 EIN [X]
26. PATIENT'S ACCOUNT NO.	196687V8292
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	[X] YES [ ] NO
28. TOTAL CHARGE	$ 5 25
29. AMOUNT PAID	$ 0 00
30. Rsvd for NUCC Use	5 25
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	LISA C. KOZLOWSKI, MD — SIGNED 01 13 2016 DATE
32. SERVICE FACILITY LOCATION INFORMATION	BUFFALO CARDIOLOGY ASSOCIA 6460 MAIN ST WILLIAMSVILLE NY 142215838 a. b.
33. BILLING PROVIDER INFO & PH # ( )	BUFFALO CARDIOLOGY AND PULMONA PO BOX 13239 BELFAST ME 049154023 a. 1407834872 b.

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — CR061653 — APPROVED OMB-0938-1197 FORM 1500 (02-12)

123493-7223

196687

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========== TRANSACTION RECORD ==========
WESTERN NEW YORK MRI LLP

AMHERST, NY
United States
WWW.MTB.COM

TYPE: Purchase

ACCT: Visa                    $ 3.48 USD

CARDHOLDER NAME : Matthew Albert, Esq.
CARD NUMBER     : ############9170
DATE/TIME       : 22 Feb 16 13:36:32
REFERENCE #     : 004 0376831 M
AUTHOR. #       : 734574
TRANS. REF.     :

    Approved - Thank You 100

SIGNATURE



----------------------------------------

Please retain this copy for your records.

Cardholder will pay above amount to
card issuer pursuant to cardholder
agreement.
========================================
```

222 Genesee Street, Buffalo, NY 14203
716-855-2866 Fax: 716-855-2860
www.wnymri.com

PATIENT NAME:	TOWNSEND , CHRISTINE		
DOB:	05/15/1973 00:00:00	AGE/SEX:	041Y/F
MRN #:	204520	ACC # :	01315188
EXAMINATION:	MRI ANKLE LT		CPT:73721
STUDY DATE :	11/05/2014 18:33:28		
Physician:	HUCKELL, GRAHAM MD	CC1:	
	700 MICHIGAN AVENUE	CC2:	
	BUFFALO, NY 14203	CC3:	

----------------- FINAL REPORT ----------------

torreMRI LEFT ANKLE

CLINICAL INDICATIONS: Injury 05/2014 with persistent ankle pain.

IMAGING SEQUENCES: Both spin echo and inversion recovery sequences were utilized to evaluate the ankle in the sagittal, axial, and coronal planes.

FINDINGS: There is a large (10 mm) osteochondral defect in the medial talar dome. This osteochondral fragment is undercut by fluid indicating a free fragment. This is best seen on the T2 coronal image #14. The remainder of the talus is intact. The distal tibia, distal fibula, and calcaneus are intact.

The medial and lateral ligaments are intact. The medial tendons are intact.

There is fluid in the peroneal tendon sheath. There is a longitudinal split-thickness tear of the peroneus brevis tendon at its crosses the lateral malleolus. The peroneus longus is intact. The Achilles tendon is intact.

There are small dorsal intertarsal marginal osteophytes. There are small tarsal metatarsal marginal osteophytes and subchondral cysts.

IMPRESSION:

1. LARGE OSTEOCHONDRAL DEFECT AT THE MEDIAL ASPECT OF THE TALAR DOME UNDERCUT BY FLUID INDICATING A FREE FRAGMENT.
2. PERONEAL TENOSYNOVITIS WITH A LONGITUDINAL SPLIT TEAR OF THE PERONEUS BREVIS

Dictated: KARTHA, KRISH MD 11/06/2014
Transcribed: LR 11/06/2014
Electronically signed: KARTHA, KRISH MD 11/06/2014

222 Genesee Street, Buffalo, NY 14203
716-855-2866 Fax: 716-855-2860
www.wnymri.com

PATIENT NAME:	**TOWNSEND , CHRISTINE**		
DOB:	**05/15/1973 00:00:00**	**AGE/SEX:**	**041Y/F**
MRN #:	**204520**	**ACC # :**	**01315188**
EXAMINATION:	**MRI ANKLE LT**		**CPT:73721**
STUDY DATE :	**11/05/2014 18:33:28**		
Physician:	**HUCKELL, GRAHAM MD**	**CC1:**	
	700 MICHIGAN AVENUE	**CC2:**	
	BUFFALO, NY 14203	**CC3:**	

TENDON.

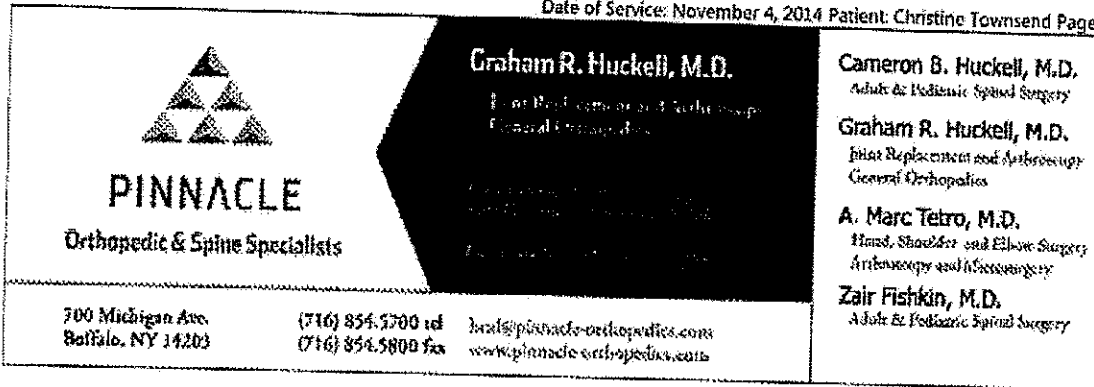
3. TARSAL METATARSAL AND INTERTARSAL OSTEOARTHRITIS.

Thank you.

Krishnan Kartha, MD

Dictated: KARTHA, KRISH MD 11/06/2014
Transcribed: LR 11/06/2014
Electronically signed: KARTHA, KRISH MD 11/06/2014

11/4/2014 12:33 PM FROM: Fax TO: 8562860 PAGE: 002 OF 003



Cameron B. Huckell, M.D.
Adult & Pediatric Spinal Surgery
Graham R. Huckell, M.D.
Joint Replacement and Arthroscopy
General Orthopedics
A. Marc Tetro, M.D.
Hand, Shoulder and Elbow Surgery
Arthroscopy and Microsurgery
Zair Fishkin, M.D.
Adult & Pediatric Spinal Surgery

700 Michigan Ave.
Buffalo, NY 14203
(716) 854.5700 tel
(716) 854.5800 fax
www.pinnacle-orthopedics.com

Investigation/Treatment Form

Date study ordered: 11/4/2014

Patient: Christine Townsend
59 Briggs Ave
Buffalo NY 14207
DOB: 5/15/1973
MR#: 86775
SS#: 073-60-0318

Home Phone#: (716) 544-3585

Insurance(s): Primary Insurance: Blue Cross - Blue Shield(Group #: 00414741, Policy #: WGT995042701)

HMO (X) / NF ( ) / WC ( ) / Other ( ) - **DOI must be included for WC/NF: N/A**

Operations: Tonsillectomy

Allergies: Cephalosporins Group: urticaria (hives): unspecified
ibuprofen: swelling: unspecified
naproxen: swelling: unspecified
Sulfa (Sulfonamide Antibiotics) Group: urticaria (hives): unspecified

Ordering Provider: Graham R Huckell

Diagnosis: Medial talus pain, lateral ankle pain

R/O: Osteochondral fracture, bone contusion

Procedure Requested:	Location:
( ) MRI with contrast:	( ) BGMC
(X) MRI without contrast: Left ankle without contrast	( ) Buffalo MRI: ( ) Closed / ( ) Open
( ) Venous Doppler:	( ) Buffalo Medical Group
( ) EMG/NCS:	( ) Buffalo Spine & Sport
( ) CT scan (with 3D Reconstruction):	( ) Dent
( ) CT Discogram:	( ) DIA
( ) Bone scan:	( ) Jamestown
( ) Hyalgan Injection X 5	( ) KEN-TON MRI: ( ) Open
( ) Synvisc injections X 3	( ) Lockport MRI
( ) Euflexxa injections X 3	( ) Olean
( ) FCE	( ) Great Lakes Medical Imaging:
( ) Other:	( ) Williamsville (open 1.2/closed unit)
( ) With Dr. for	( ) PIC
	( ) Pinnacle
	( ) Proscan
Current Status: Approved	( ) Seton MRI
	( ) Sister's Hospital
	(X) WNY MRI

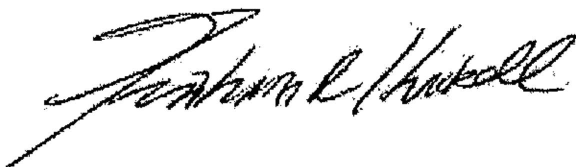
Validity Period: 11/4/2014-3/4/2015 Authorization: 14308H232 (Ankle MRI (left))	( ) WNY PET-CT ( ) Windsong ( ) Other:

Best Test Date:
Best F/U Date:

Actual Test Date: 11/05/2014 @ 6:30pm
Actual F/U Date: 11/17/2014 @ 9:15am

Claustrophobic. Yes: ( ) / No: (X)
Large stature: Yes: (X) / No: ( )

This problem requires a specific diagnosis and/or treatment. It is on the basis of medical necessity that this investigation and/or treatment is needed.



Graham R. Huckell M.D.

Graham R Huckell
Electronic Signature

3065 Southwestern Boulevard, Suite 204
Orchard Park, New York 14127
Phone: (716) 675-9232
Fax: (716) 675-9217
www.wnypsychotherapy.com

WNY Psychotherapy Services

Fax

To: Mr. Matt Hilbert, Esq. **From:** KathyAnn Maiorana, LCSW

Fax: 716 608 1388 **Pages:** 7

Phone: **Date:** 2-29-16

Re: C. Townsend **cc:**

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

CONFIDENTIALITY NOTE:

The information being provided with this fax may contain protected health information as defined by Federal laws and regulations. This information is intended only for the use of the individual or entity named above. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties under Federal and State law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this fax in error, please notify the sender immediately, at the above phone number, to arrange for the return of these documents.

WESTERN NEW YORK PSYCHOTHERAPY SERVICES

INITIAL ASSESSMENT FORM/ GUIDED INTERVIEW

PATIENT NAME Christine Townsend DOB 5-15-73 SEX F

INSURANCE CO BCBS of WNY AGE 41

INITIAL VISIT DATE 10-30-14 MARITAL STATUS (CIRCLE): S M D/SEP W LW

ASSESSMENT INFORMATION

I. **Chief Complaint/Presenting Problem:**

"Quote" "I feel really unsafe"

A. History of Presenting Problem/Description:

This 41yr. old, single, mother of 1 (10yr. old) daughter presents with ↑ fear, stress and anxiety as it relates to a neg. experience with the Buff. police dept. She was "arrested" after calling the cops about some dogs in the neighborhood

B. Why Now?

↑ Awareness re: the need for Tx.

C. Significant Symptoms

↑ sx. of anxiety, stress, fear

II. **Patient Psychiatric Treatment History**

Denies

III. **Family Psychiatric History**

Is there a family history of psychiatric treatment/clear psychiatric disorders?

Yes X No____ Equivocal____ If equivocal, why?

mother = depression

father = PTSD, depression, anxiety & ETOH

XII. High Risk Factors (Check those that apply)

	Present	Past	Denied
A. Domestic Violence			X
B. Violent Behavior			X
C. Suicidal Ideation*			✓
D. Suicide Attempt			X
E. Child Abuse			X
F. Sexual Abuse			X
G. Eating Disorder			X
H. Evidence of Psychosis			X
I. Threat to Others*			X
J. Other ________			X

*If "C" _______ and/or "I" _______ (check those that apply) are current, but there is no present intent, is patient willing to agree to call you if he/she becomes seriously suicidal/homicidal?

Yes__________ No__________

If "No" what steps are taken to manage risk?

XIII. Current Mental Status (should correlate with diagnosis; rate all sections)

Within Normal Limits? Other?

- ☒ **Appearance:** well-groomed ✓ disheveled_____ bizarre_____ inappropriate_____
- ☒ **Speech:** delayed_____ soft_____ loud_____ slurred_____ excessive_____ pressured_____ perseverating_____ incoherent_____
- ☒ **Thought Content:**
  - **Delusions:** persecutory_____ being controlled_____ bizarre_____ grandiose_____ thought insertion/deletion_____
  - **Hallucinations:** auditory_____ visual_____ olfactory_____
- ☒ **Mood:** depressed X anxious X euphoric_____ hostile_____
- ☒ **Affect:** labile_____ expansive_____ constricted_____ blunted_____ flat_____
- ☒ **Orientation:** disoriented: sometimes_____ always_____ time_____ place_____ person_____
- ☒ **Memory:** impaired: immediate_____ recent_____ remote_____
- ☒ **Judgment:** impaired: minimal_____ moderate_____ severe_____
- ☒ **Insight:** impaired: minimal_____ moderate_____ severe_____
- ☒ **Attitude:** cooperative_____ guarded_____ suspicious_____ uncooperative_____ belligerent_____
- ☒ **Motor Activity:** calm_____ hyperactive_____ agitated_____ tremors/tics_____ muscle spasms_____ lethargic_____
- ☒ **Thought Process:** circumstantial_____ tangential_____ loosening of associations_____ flight of ideas_____ obsessive_____
- ☒ **Concentration:** diminished_____ poor_____
- ☒ **Appetite:** increased_____ decreased_____ duration_____
- ☒ **Weight change:** loss_____ gain_____ duration_____
- ☒ **Libido:** increased_____ decreased_____
- ☒ **Sleep Pattern:** hypersomnia_____ hyposomnia_____
  - **Insomnia:** initial_____ middle_____ terminal_____ start sleep _______ end sleep _______ total hours _____

Comments:

FROM:WNY PSYCHOTHERAPY 7166759217 02/29/2016 15:27 #688 P.003/005

XVI. Initial Impressions of Treatment Focus and Intervention Strategy

A. Treatment Modality (check all that apply)

X Individual ______ Conjoint ______ Family ______ Group

B. Treatment Focus

- ↓ sx. of anxiety
- ↓ sx. of stress
- ↑ pos. self-esteem
- ↑ coping skills.

C. Treatment Objectives

Relaxation techniques
- workout
- listen to music
- Hobbies/crafts c̄ daughter

D. Estimate the number of sessions needed to complete treatment: U/K

E. Estimate the date by which treatment will be completed: U/K

IX. Reporting to Managed Care or HMO Primary Care Provider or Psychiatrist (check one)

______ Confidentiality issues have been discussed with patient/guardian

______ Copy of Initial Assessment

______ PCP Report - no release signed

Doctor's Name ______ Location ______

Psychiatrist's Name ______ Location ______

Is patient in agreement with this plan? Yes X No ______

Barriers to Plan none

Cancellation/Emergency Information Sheet given to Patient? Yes X No ______

Provider Signature [illegible signature] Date 10-30-14

Provider Name: Kathyann Maidcana Title: LCSW-R

THERAPY NOTES

Date: 11-11-14 Start Time: 10:00 Stop Time: 10:45

Total Face to Face time: 45 (minutes)

Patient: Christine Townsend Diagnosis: 308.3

Treatment Modality: Individual: X Family: ______

Current Symptoms and Present Concerns:

- "I have a lot of negative thoughts".
- "I have scared feelings".

Treatment Goals:

↓ sx. of Anxiety
↓ sx. of Stress
↑ coping skills
↑ pos. self-esteem

Session Notes: Current GAF: 60 **GAF Treatment Onset:** 60

Progress: Poor: ___ **Fair:** X **Good:** ___ **Excellent:** ___

Significant Interventions:

Discuss & developed Tx. plan

H-W: Anxiety & Phobia workbook
Ch. 1 & 2
start gathering "happy pictures".

Treatment/Termination Disposition:

P: Proceed per Tx. plan

Medication:

[illegible]

Therapist Signature: [signature], LCSW-R

Accession No. : 01315188
Patient Name / ID : TOWNSEND, CHRISTINE / 204520
Exam Date : 11/05/2014 18:33:28 (Approved)
Study Comment : TEACHANKLEOCDPB SPLIT
Sex / Age : F / 041Y

Creator : KARTHA, KRISH MD
Dictator : KARTHA, KRISH MD
Transcriber : Radecki, Laurie
Approver : KARTHA, KRISH MD
Approver2 :

Report Date : 11/06/2014 08:56:07
My Comment :
****

PATIENT NAME:
TOWNSEND , CHRISTINE

DOB:
05/15/1973 00:00:00
AGE/SEX:
041Y / F

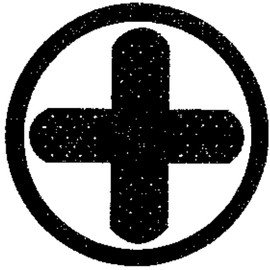
MRN #:
204520
ACC # :
01315188

EXAMINATION:
MRI ANKLE LT
CPT: 73721

STUDY DATE :
11/05/2014 18:33:28

Physician:
HUCKELL, GRAHAM MD
CC1:

700 MICHIGAN AVENUE
CC2:



CORPORATE OFFICE
6 Fountain Plaza
Buffalo, NY 14202
716.701.6331

January 12, 2016

Law Offices of Matthew Albert Esq
254 Richmond Ave, Bufflao NY 14222

REQUEST FOR COPY OF CHARTS

This is in response to your record request for Christine Townsend, date of birth 05/15/1973, seen at MASH Urgent Care.

The cost of the copy chart is .75 per page. This chart has 6 pages. Please submit payment of $4.50 payable to ***MedFirst Urgent Care.*** Please forward your payment and a copy of this letter to 1751 Sheridan Dr, Tonawanda, NY 14223.

Upon receipt of your check, we will expedite the records to you.

If you have any questions please feel free to contact me at 176-844-7100.

Thank you.

Sincerely,

S Frisch

Susan Frisch
Office Manager

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MASH Urgent Care™ is a trademark of Innovative Health Services of America, Inc. and is licensed to independent medical treatment centers.

Kathy Ann Maiorana, L-CSW

Western New York Psychotherapy Services

315 Alberta Drive, Suite 211
Amherst, New York 14226
Telephone: (716) 837-6705
Fax: (716) 837-6759

January 11, 2016

Matthew Albert, Esq.
The Law Offices of Matthew Albert, Esq.
254 Richmond Avenue
Buffalo, NY 14222

RE: Christine Townsend
D.O.B.: 5/15/1973

Dear Mr. Albert:

Ms. Townsend presented for an initial visit on 10/30/2014; assessment completed 11/11/2014. Ms. Townsend self-terminated and did not return to treatment. Ms. Townsend cancelled 3 out of 5 scheduled appointments. The initial clinical impression was that of Acute Stress.

If you are in need of additional information, contact my office at (716) 837-6705.

Sincerely,

Kathy Maiorana, LCSW

RECEIVED 11/07/2014 10:10
From: 11/07/2014 10:11 #316 P.001/002

PATIENT NAME:
TOWNSEND , CHRISTINE

DOB:
05/15/1973 00:00:00
AGE/SEX:
041Y / F

MRN #:
204520
ACC # :
01315188

EXAMINATION:
MRI ANKLE LT
CPT: 73721

STUDY DATE :
11/05/2014 18:33:28

Physician:
HUCKELL, GRAHAM MD
CC1:

700 MICHIGAN AVENUE
CC2:

BUFFALO , NY 14203
CC3:

---------------- FINAL REPORT ---------------

torreMRI LEFT ANKLE

CLINICAL INDICATIONS: Injury 05/2014 with persistent ankle pain.

IMAGING SEQUENCES:Both spin echo and inversion recovery sequences were utilized to evaluate the ankle in the sagittal, axial, and coronal planes.

FINDINGS:There is a large (10 mm) osteochondral defect in the medial talar dome. This osteochondral fragment is undercut by fluid indicating a free fragment. This is best seen on the T2 coronal image #14. The remainder of the talus is intact. The distal tibia, distal fibula, and calcaneus are intact.

The medial and lateral ligaments are intact. The medial tendons are intact.

There is fluid in the peroneal tendon sheath. There is a longitudinal split-thickness tear of the peroneus brevis tendon at its crosses the lateral malleolus. The peroneus longus is intact. The Achilles tendon is intact.

There are small dorsal intertarsal marginal osteophytes. There are small tarsal metatarsal marginal osteophytes and subchondral cysts.

IMPRESSION:
1.LARGE OSTEOCHONDRAL DEFECT AT THE MEDIAL ASPECT OF THE TALAR DOME UNDERCUT BY FLUID INDICATING A FREE FRAGMENT.
2.PERONEAL TENOSYNOVITIS WITH A LONGITUDINAL SPLIT TEAR OF THE PERONEUS BREVISTENDON.
3.TARSAL METATARSAL AND INTERTARSAL OSTEOARTHRITIS.

Thank you.

Krishnan Kartha, MD

Dictated: KARTHA, KRISH MD 11/06/2014
Transcribed: Radecki, Laurie 11/06/2014 09:31:51 AM
Electronically signed: KARTHA, KRISH MD 11/06/2014 12:17:45 PM
2

Elizabeth King