NOTICE OF CLAIM

TO: City Clerk
City of Milwaukee
200 East Wells Street
Milwaukee, WI 53202

City Attorney's Office
City of Milwaukee
200 East Wells Street
Milwaukee, WI 53202

RE: November 5, 2006 incident in front of 820 N. Plankinton Avenue, Milwaukee, WI, involving Morgan Stencil, f/k/a Morgan Powell, and the City of Milwaukee.

PLEASE TAKE NOTICE that, Morgan Stencil, f/k/a Morgan Powell, the above-named claimant, sustained injuries and damages under the following circumstances that give rise to her claim against the City of Milwaukee pursuant to Section 893.80(1)(a) of the Wisconsin Statutes.

That on or about the 5th day of November, 2006, Morgan Stencil, f/k/a Morgan Powell, was dropped off for work at the Aids Resource Center located at 820 N. Plankinton Avenue, Milwaukee, Wisconsin, in the city of Milwaukee, County of Milwaukee. That as she exited her vehicle she immediately stepped into a 4' by 2' sewer hole in the street which was not covered by a sewer alarm system lid, which was broken. That the City of Milwaukee, through its agents, were negligent in its failure to repair said alarm system lid causing Morgan Stencil, f/k/a Morgan Powell, to injure her left ankle, causing her pain, discomfort, and permanent disability to her left ankle. Attached hereto are photocopies of photographs of the broken sewer alarm lid and the hole into which Ms. Stencil fell causing her injuries taken contemporaneous with the event. Also, attached hereto are copies of the Claimant's medical records relating to the treatment she received as a result of her injuries. In addition, attached hereto for reference is a copy of a Service Referral Record performed by a City of Milwaukee Sewer Maintenance Investigator.

As a direct result of the acts of the City of Milwaukee, Morgan Stencil, f/k/a Morgan Powell, sustained personal injuries as reflected above necessitating medical attention.

Attached hereto is claimant's Claim for Damages pursuant to Section 893.80(1)(b) of the Wisconsin Statutes.

Dated at Milwaukee, Wisconsin this 3rd day of January, 2007.

MARCUS LAW OFFICES
Attorneys for Claimant, Morgan Stencil, f/k/a Morgan Powell

By: _____
Robb A. Marcus
State Bar No.: 1006606

CLAIM FOR DAMAGES

TO: THE CITY CLERK IN AND FOR THE CITY OF MILWAUKEE, CITY OF MILWAUKEE ATTORNEY'S OFFICE

RE: November 5, 2004 incident in front of 820 N. Plankinton Avenue, Milwaukee, Wisconsin, involving Morgan Stencil, f/k/a Morgan Powell.

PLEASE TAKE NOTICE that, Morgan Stencil, f/k/a Morgan Powell, the above-named claimant, pursuant to Section 893.80(1)(b) of the Wisconsin Statutes, hereby makes claim to the City of Milwaukee for damages sustained by her on the 5th day of November, 2004, as a result of the negligence of the City of Milwaukee.

Morgan Stencil, f/k/a Morgan Powell, as claimant, is hereby demanding from the City of Milwaukee the sum of Fifty Thousand and 00/100 Dollars ($50,000.00) in satisfaction of personal injuries sustained by her as a result of the negligence and want of care of the City of Milwaukee as more particularly described in the attached Notice of Claim. Stencil has incurred medical expenses which are in the amount of $4,679.70, all as set forth on the attached Exhibit A (list of medical bills).

Dated at Milwaukee, Wisconsin this 3rd day of January, 2007.

MARCUS LAW OFFICES
Attorneys for Claimant, Morgan Stencil, f/k/a Morgan Powell

By: _____
Robb A. Marcus
State Bar No.: 1006606

MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT OF 11/05/2004
MEDICAL BILLINGS

PROVIDER	**DATE OF SERVICE**	**CHARGE**
St. Joseph's Emergency Physicians	11/05/04	183.00
St. Joseph's Hospital	11/05/04	857.20
Medpartners(ankle brace)	11/05/04	85.00
St. Francis Hospital	4/20/05-6/29/05	3,101.50
Mysore S. Shivram, M.D.	02/21/05-04/04/05	272.00
Lakeshore Medical Clinic	01/31/05	181.00
Total Medical Bills		**4,679.70**

ST JOSEPH'S EMER PHYS LLP
ST JOSEPH REGIONAL MEDICAL CTR
75 REMITT. DR #1574
CHICAGO IL 60675 1574

PHONE
800 219 9811

218001

MORGAN L POWELL
7801 W WINFIELD
MILWAUKEE WI 53218

343724

DATE
12/09/05
343724
ACCOUNT NUMBER

11/05/04

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT OF $_____

DATE MO DY YR	PHYSICIAN	TRANSACTION DESCRIPTION	PROC CODE	AMOUNT
***PATIENT NAME - MORGAN POWELL		343724		
11 05 04	HARIRIE	EMERGENCY DEPT VISIT	99283	183.00
		Dx1 84500		
01 14 05	HARIRIE	DENIAL RCVD-AETNA PPO	777	0.00
		ACCOUNT BALANCE		183.00

CLAIM STATUS
NOT COVERED ON DOS 183.00 SERVICE DATE 11/05/04
FILE DATE 12/20/04 AETNA PPO

Please make check payable to St. Joseph's Emergency Physicians, LLP..
Payment may be made by check, money order, or major credit card. This bill is for the Physician services--not for the hospital charges.
Notice: If you have already paid this bill, please disregard this statement. Thank you.
You can email your insurance information or billing questions to apollobilling@eci-med.com or call 1-800-219-9811.

We have filed this claim with your carrier, however, we have not yet received payment. Please contact your carrier to arrange for payment.
We would appreciate your prompt attention to this statement.
Please contact our office if you do not agree with the balance due.

ACCOUNT NUMBER	PREVIOUS BALANCE	PAYMENT/CREDIT	CHARGES	BALANCE DUE
343724		0.00	183.00	183.00

12/09/05 MAKE CHECK PAYABLE TO: ST JOSEPH'S EMER PHYS LLP

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS AND OVER
0.00	0.00	0.00	0.00	183.00

TAX ID 38-3420925 CBURGOS

ST. JOSEPH® REGIONAL MEDICAL CENTER

Covenant HEALTHCARE

P.O. Box 68-9510
Milwaukee, WI 53268-9510
Address Service Requested

PATIENT NAME	
POWELL, MORGAN L	
AMOUNT DUE	**PATIENT NUMBER**
857.20	71179892

STATEMENT DATE	SERVICE FROM	SERVICE THROUGH
12/20/04	11/05/04	11/05/04

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO:
ST. JOSEPH REGIONAL MEDICAL CENTER

AMOUNT ENCLOSED $

MORGAN POWELL
7801 W WINFIELD
MILWAUKEE, WI 53218-1153

ST. JOSEPH REGIONAL MEDICAL CENTER
BOX 68-9510
MILWAUKEE, WI 53268-9510

☐ IF ADDRESS OR INSURANCE COMPANY HAS CHANGED, PLEASE CHECK HERE AND COMPLETE INFORMATION REQUESTED ON REVERSE SIDE.

IMPORTANT: PLEASE DETACH & ENCLOSE THIS PORTION WITH YOUR PAYMENT

Questions Concerning this Statement can be e-mailed to:
covenantbusinessoffice@covhealth.org

CUSTOMER SERVICE: (414) 456-3000
(888) 553-5009

Thank you for choosing our facility for your health care needs.

The remaining AMOUNT DUE for hospital services referenced in this statement is your responsibility. AMOUNT DUE UPON RECEIPT. Please mail your payment today.

If you have already mailed your payment, please disregard this statement and accept our thanks for your prompt response.

DESCRIPTION	DEBITS	CREDITS
ADJUSTMENT	171.44	171.44-
EMERGENCY DEPT	564.25	0.00
PHARMACY	3.95	0.00
RADIOLOGY	289.00	0.00

THESE CREDIT CARDS ARE ACCEPTED. COMPLETE INFORMATION ON THE REVERSE SIDE.

VISA MasterCard OPTIMA DISCOVER NOVUS

BALANCE DUE FROM PATIENT 857.20

AS A COURTESY TO YOU, WE HAVE BILLED BOTH YOUR PRIMARY AND SECONDARY INSURANCE.

PATIENT NAME	PATIENT NUMBER	PRIMARY INSURANCE	SECONDARY INSURANCE
POWELL, MORGAN L	71179892	AETNA	

VISIT TYPE	SERVICE FROM	SERVICE THROUGH	TOTAL CHARGE	TOTAL PAYMENT / CREDIT	AMOUNT DUE
EMERGENCY MEDICINE	11/05/04	11/05/04	857.20	0.00	857.20

KEEP THIS PORTION FOR YOUR RECORDS.
See reverse side for credit card and patient financial information.
Please visit our website for answers to frequently asked questions at www.covhealth.org

ST. JOSEPH® REGIONAL MEDICAL CENTER

Covenant HEALTHCARE

P.O. Box 68-9510
Milwaukee, WI 53268-9510
Address Service Requested

PATIENT NAME	
POWELL, MORGAN L	
AMOUNT DUE	**PATIENT NUMBER**
857.20	71179892

STATEMENT DATE	SERVICE FROM	SERVICE THROUGH
12/14/04	11/05/04	11/05/04

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO:
ST. JOSEPH REGIONAL MEDICAL CENTER

AMOUNT ENCLOSED $

MORGAN POWELL
7801 W WINFIELD
MILWAUKEE, WI 53218-1153

ST. JOSEPH REGIONAL MEDICAL CENTER
BOX 68-9510
MILWAUKEE, WI 53268-9510

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IMPORTANT: PLEASE DETACH & ENCLOSE THIS PORTION WITH YOUR PAYMENT

Questions Concerning this Statement can be e-mailed to:
covenantbusinessoffice@covhealth.org

CUSTOMER SERVICE: (414) 456-3000
(888) 553-5009

The charges for hospital services referenced in this statement were submitted to your insurance company more than thirty (30) days ago. They have informed us that additional information was requested from you.

This claim will not be processed for payment by your insurance company until you provide the requested information.

The purpose of our letter is to make you aware of the situation. These charges are considered your responsibility until you comply with their request and payment is received.

Please contact your insurance company and provide the requested information.

Thank you.

DESCRIPTION	DEBITS	CREDITS
ADJUSTMENT	171.44	171.44-
EMERGENCY DEPT	564.25	0.00
PHARMACY	3.95	0.00
RADIOLOGY	289.00	0.00

HESE CREDIT CARDS ARE ACCEPTED. COMPLETE INFORMATION ON THE REVERSE SIDE.

VISA MasterCard OPTIMA DISCOVER NOVUS

BALANCE DUE FROM PATIENT 857.20

AS A COURTESY TO YOU, WE HAVE BILLED BOTH YOUR PRIMARY AND SECONDARY INSURANCE.

PATIENT NAME	PATIENT NUMBER	PRIMARY INSURANCE	SECONDARY INSURANCE
POWELL, MORGAN L	71179892	AETNA	

VISIT TYPE	SERVICE FROM	SERVICE THROUGH	TOTAL CHARGE	TOTAL PAYMENT / CREDIT	AMOUNT DUE
EMERGENCY MEDICINE	11/05/04	11/05/04	857.20	0.00	857.20

KEEP THIS PORTION FOR YOUR RECORDS.
See reverse side for credit card and patient financial information.
Please visit our website for answers to frequently asked questions at www.covhealth.org

MAKE CHECKS PAYABLE TO:

MEDPARTNERS, INC.
PO BOX 1410
BROOKFIELD, WI 53045

(414) 727-5940

16466-XE39

ADDRESS SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
12/21/04	**$85.00**	017987-00

PAGE: 1 of 1

SHOW AMOUNT PAID HERE $

100101

ADDRESSEE:

MORGAN L POWELL
7801 W WINFIELD
MILWAUKEE, WI 53218-1153

REMIT TO:

MEDPARTNERS
P O BOX 1410
BROOKFIELD, WI 53045

16466-XE39*1E00KZS71000046

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DR	PATIENT	DESCRIPTION	CHARGE	PAY/ADJ	BALANCE
11/05/04	me	Morgan	Ankle Brace Or Sprain KitD	85.00		
12/14/04			Plan Payment:000		0.00	
			pt not covered under plan			

ACCT: 017987-00	CURRENT	30-60 DAYS	60-90 DAYS	90-120 DAYS	OVER 120 DAYS
INS BALANCE	0.00	0.00	0.00	0.00	0.00
PATIENT BALANCE	85.00	0.00	0.00	0.00	0.00

PATIENT DUE $85.00

*Amounts pending with insurance are not included in the balance due. You will be billed once your insurance responds to our claim.

[redacted] MAKE CHECKS PAYABLE TO: [redacted]

MEDPARTNERS, INC.
PO BOX 1410
BROOKFIELD, WI 53045

(414) 727-5940

16466-XE39

ADDRESS SERVICE REQUESTED

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
12/21/04	**$85.00**	017987-00

PAGE: 1 of 1

SHOW AMOUNT PAID HERE $

100101

[redacted] ADDRESSEE:

MORGAN L POWELL
7801 W WINFIELD
MILWAUKEE, WI 53218-1153

[redacted] REMIT TO: [redacted]

MEDPARTNERS
P O BOX 1410
BROOKFIELD, WI 53045

16466-XE39*1EOOKZS71000046

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DR	PATIENT	DESCRIPTION	CHARGE	PAY/ADJ	BALANCE
11/05/04	me	Morgan	Ankle Brace Or Sprain KitD	85.00		
12/14/04			Plan Payment:000		0.00	
			pt not covered under plan			

ACCT: 017987-00	CURRENT	30-60 DAYS	60-90 DAYS	90-120 DAYS	OVER 120 DAYS
INS BALANCE	0.00	0.00	0.00	0.00	0.00
PATIENT BALANCE	85.00	0.00	0.00	0.00	0.00

PATIENT DUE $85.00

*Amounts pending with insurance are not included in the balance due. You will be billed once your insurance responds to our claim.

MEDPARTNERS, INC.
PO BOX 1410
BROOKFIELD, WI 53045

(414) 727-5940

ST FRANCIS HOSPITAL
PO BOX 68-4007
MILWAUKEE, WI 53268-4007
Statement on: 12/14/05 at 05:57 PM

Guarantor: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE, WI 53218-0000

Patient: STENCIL MORGAN L
Visit #: 10836680
AR Seg: 04/20/05 to 04/20/05

Date	Svc Code	Description	Units	Debits	Credits
04/20/05	8512601	PT THERAPEUTIC EXER/U	1	105.00	
04/20/05	8512711	PT EVALUATION/UNIT	2	220.00	
04/26/05	9848172	ALLOW UNITEDHEALTHCAR	-1		130.00-
05/16/05	9848539	ALW UHC ADMIN	0		25.00-
09/29/05	9848475	ALLOW BAD DEBT WRITE	-1		170.00-
09/29/05	9848483	ALLOW RECEIVABLE OFFS	1	170.00	
				Balance:	170.00

* - Not posted

ST FRANCIS HOSPITAL
PO BOX 68-4007
MILWAUKEE, WI 53268-4007
Statement on: 12/14/05 at 05:56 PM

Guarantor: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE, WI 53218-0000

Patient: STENCIL MORGAN L
Visit #: 10842045
AR Seg: 04/21/05 to 04/30/05

Date	Svc Code	Description	Units	Debits	Credits
04/27/05	8512509	PT ULTRA/US ELECSTIM/	1	95.50	
04/27/05	8512601	PT THERAPEUTIC EXER/U	1	105.00	
04/27/05	61940328	PT HOT/COLD PACKS	1	70.00	
06/28/05	9848172	ALLOW UNITEDHEALTHCAR	-1		100.50-
07/27/05	9900101	PAY SELF PAY	-1		170.00-
				Balance:	0.00

* - Not posted

ST FRANCIS HOSPITAL
PO BOX 68-4007
MILWAUKEE, WI 53268-4007
Statement on: 12/14/05 at 05:56 PM

Guarantor: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE, WI 53218-0000

Patient: STENCIL MORGAN L
Visit #: 10842045
AR Seg: 05/01/05 to 05/31/05

Date	Svc Code	Description	Units	Debits	Credits
05/04/05	8512509	PT ULTRA/US ELECSTIM/	1	95.50	
05/04/05	8512601	PT THERAPEUTIC EXER/U	1	105.00	
05/04/05	61940328	PT HOT/COLD PACKS	1	70.00	
05/05/05	8512509	PT ULTRA/US ELECSTIM/	1	95.50	
05/09/05	8512509	PT ULTRA/US ELECSTIM/	1	95.50	
05/09/05	8512601	PT THERAPEUTIC EXER/U	1	105.00	
05/09/05	61940328	PT HOT/COLD PACKS	1	70.00	
05/16/05	8512601	PT THERAPEUTIC EXER/U	2	221.50	
05/20/05	8512509	PT ULTRA/US ELECSTIM/	1	100.75	
05/20/05	8512601	PT THERAPEUTIC EXER/U	1	110.75	
05/20/05	61940328	PT HOT/COLD PACKS	1	73.75	
06/28/05	9848172	ALLOW UNITEDHEALTHCAR	-1		293.25-
07/29/05	9900627	PAY UNITED HEALTHCARE	-1		92.40-
08/15/05	9848539	ALW UHC ADMIN	0		74.50-
12/01/05 *	9900627	PAY UNITED HEALTHCARE	1		59.60-
				Balance:	623.50

* - Not posted

ST FRANCIS HOSPITAL
PO BOX 68-4007
MILWAUKEE, WI 53268-4007
Statement on: 12/14/05 at 05:56 PM

Guarantor: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE, WI 53218-0000

Patient: STENCIL MORGAN L
Visit #: 10842045
AR Seg: 06/01/05 to 06/30/05

Date	Svc Code	Description	Units	Debits	Credits
06/08/05	8512601	PT THERAPEUTIC EXER/U	2	221.50	
06/14/05	8512601	PT THERAPEUTIC EXER/U	2	221.50	
06/16/05	8512509	PT ULTRA/US ELECSTIM/	1	100.75	
06/16/05	8512601	PT THERAPEUTIC EXER/U	1	110.75	
06/21/05	8512509	PT ULTRA/US ELECSTIM/	1	100.75	
06/21/05	8512601	PT THERAPEUTIC EXER/U	1	110.75	
06/23/05	8512509	PT ULTRA/US ELECSTIM/	1	100.75	
06/23/05	8512601	PT THERAPEUTIC EXER/U	1	110.75	
06/23/05	61940328	PT HOT/COLD PACKS	1	73.75	
06/29/05	8512509	PT ULTRA/US ELECSTIM/	1	100.75	
06/29/05	8512601	PT THERAPEUTIC EXER/U	1	110.75	
07/04/05	9848172	ALLOW UNITEDHEALTHCAR	-1		342.75-
08/05/05	9900627	PAY UNITED HEALTHCARE	-1		816.00-
				Balance:	204.00

* - Not posted

ST FRANCIS HOSPITAL
PO BOX 68-4007
MILWAUKEE, WI 53268-4007
Statement on: 12/14/05 at 05:56 PM

Guarantor: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE, WI 53218-0000

Patient: STENCIL MORGAN L
Visit #: 10842045
AR Seg: 07/01/05 to 07/05/05

Date	Svc Code	Description	Units	Debits	Credits

* - Not posted

Balance:	0.00

Date: 11-03-06 MYSORE S. SHIVARAM MD SC Page: 1
Time: 10:12:40 Patient History

Chart #19762 SSN# 387027121 MYSORE S. SHIVARAM MD SC
STENCIL,MORGAN DOB 08-22-82 4448 W LOOMIS ROAD
7801 W WINFIELD AVE SUITE 202
From
MILWAUKEE, WI 53218 To GREENFIELD, WI 53220
Home-(414)760-8743 Office-(414) (414)282-5555

T	Date	Code	Diagnosis	Prov	Amount	R	IB	Paid	Balance/ Susp. Amt	Carr
CA	10-04-05	CBD	– Bad Debt Write off	MSS	-25.00	N		0.00	0.00	
CA	05-10-05	CUH	No Pmt after 5 Stmts.	MSS	-25.82	N		0.00	0.00	
P	05-10-05	PUH		MSS	-33.18	N		0.00	0.00	UNIT
C	04-04-05	99213	84500	MSS	84.00	N	NY	84.00	0.00	
CA	04-04-05	CUH		MSS	-54.24	N		0.00	0.00	
P	04-04-05	PUH		MSS	-108.76	N		0.00	0.00	UNIT
P	02-21-05	PPAT		MSS	-25.00	N		0.00	0.00	PATNT
C	02-21-05	99243	84500	MSS	188.00	N	NY	188.00	0.00	

	Charges	Receipts	Debits	Credits	Balance
Patient:	50.00	-25.00	0.00	-25.00	0.00
Insurance:	222.00	-141.94	0.00	-80.06	0.00
TOTALS:	272.00	-166.94	0.00	-105.06	0.00

PLSPMAN

STATEMENT OF PHYSICIAN SERVICES

ACCOUNT NUMBER: 23081342

FOR APPOINTMENTS CALL: 414-541-7410

FOR BILLING QUESTIONS: 414-768-1845 OR 414-764-3766

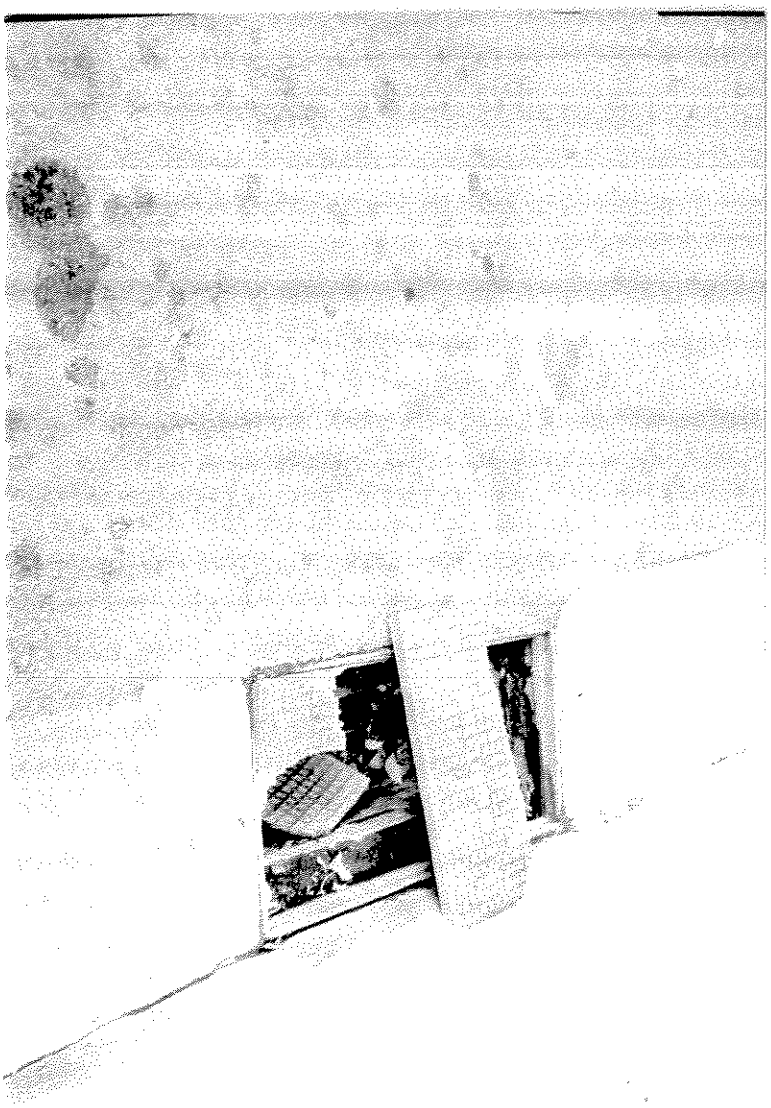
AMOUNT DUE: 0.00

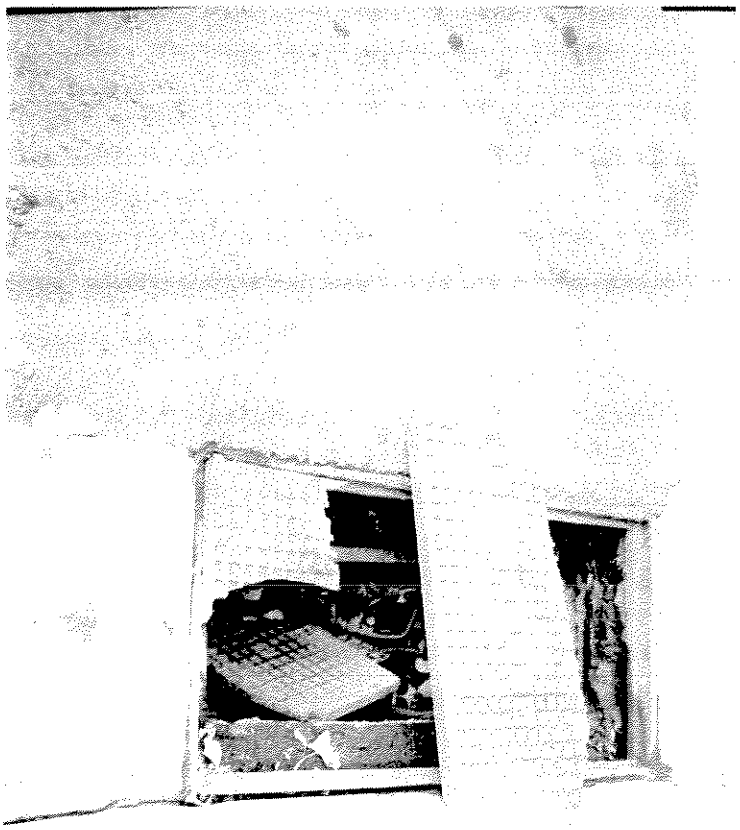
#23081342#
BETTY POWELL
1438 N 33RD ST
MILWAUKEE,WI 53208-2307

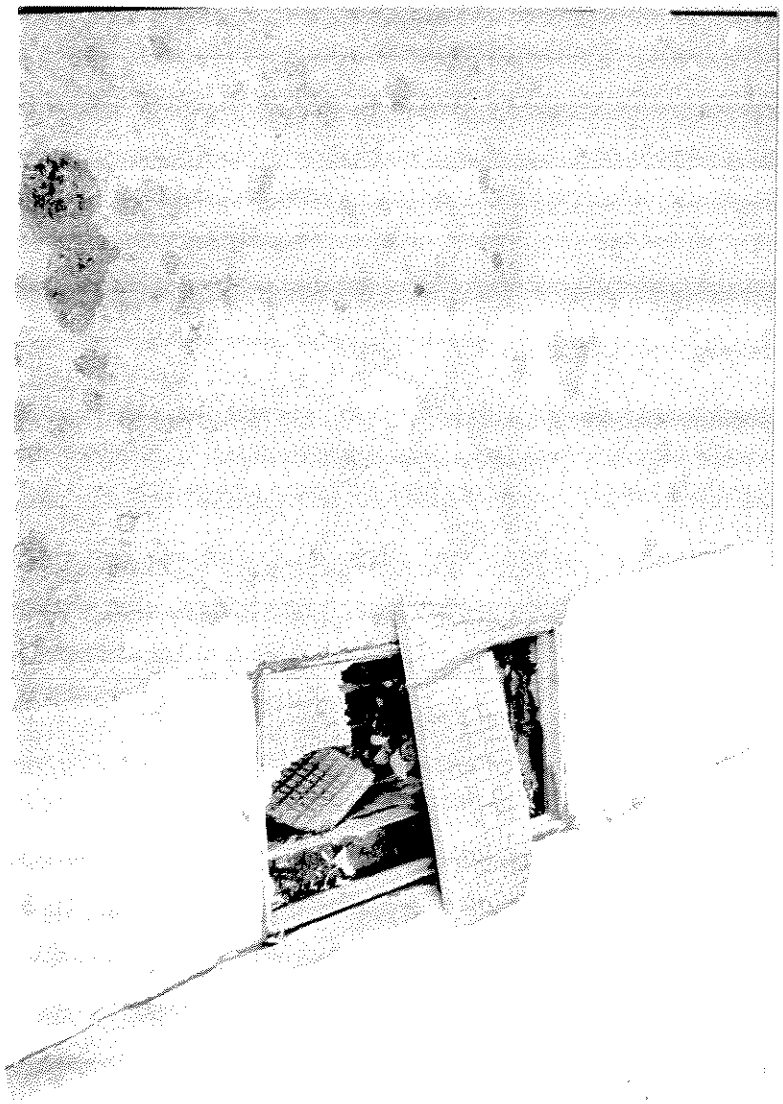
MAKE CHECKS PAYABLE TO:

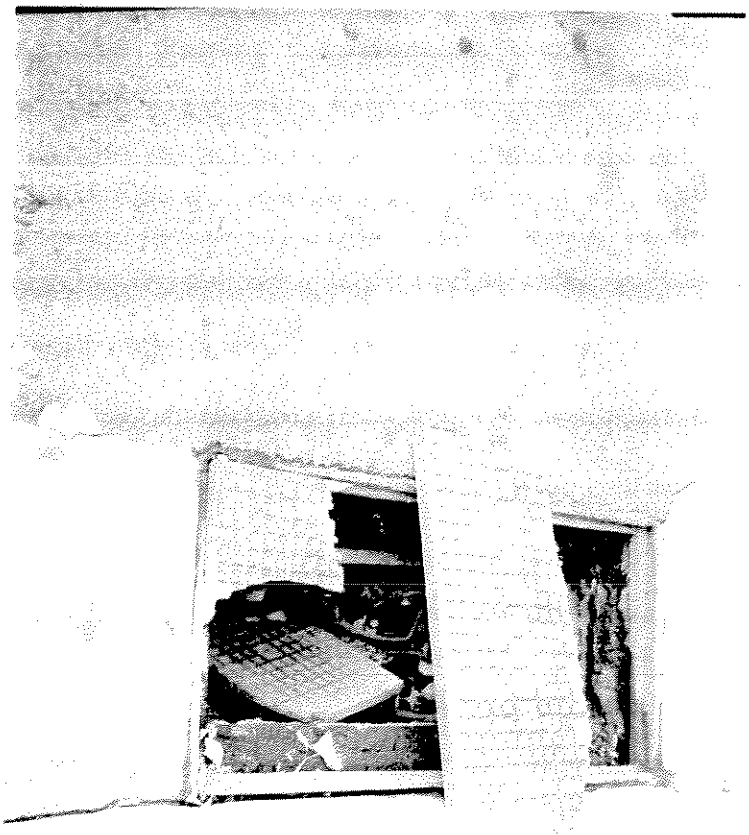
LAKESHORE MEDICAL CLINIC
PO BOX 371280
MILWAUKEE,WI 53237-2380

PHYSICIAN / FACILITY	SERVICE DATE	SERVICE CODE	DESCRIPTION	TRANSACTION DATE	INSURANCE ACTIVITY	PATIENT ACTIVITY
MODY MD,RITA D			INVOICE: 25430228			
LAKESHORE OHIO BLDG			STENCIL,MORGAN			
	01/31/05		CREDIT CARD COPAY CLINIC 01/31/05		- 25.00	
			INSURANCE CONTRACT DISCOUNT AMOUNT:			
			PLSXGON VISA			
	01/31/05		CREDIT CARD COPAY CLINIC 02/10/05		25.00	
			TES Recon by Ext To Inv			
MODY MD,RITA D			INVOICE: 25595140			
LAKESHORE OHIO BLDG			STENCIL,MORGAN			
	01/31/05	99214	OFFICE/OUTPATIENT VISIT			181.00
	01/31/05		CREDIT CARD COPAY CLINIC 02/10/05			- 25.00
			INSURANCE CONTRACT DISCOUNT AMOUNT:			
			TES Recon by Ext From In			
			COMMERCIAL BILLED 02/10/05			
	01/31/05		UNITEDHEALTHCARE PAYMENT AMOUNT:03/08/05			- 65.98
			INSURANCE CONTRACT DISCOUNT AMOUNT:			- 90.02
MODY MD,RITA D			INVOICE: 25709877			

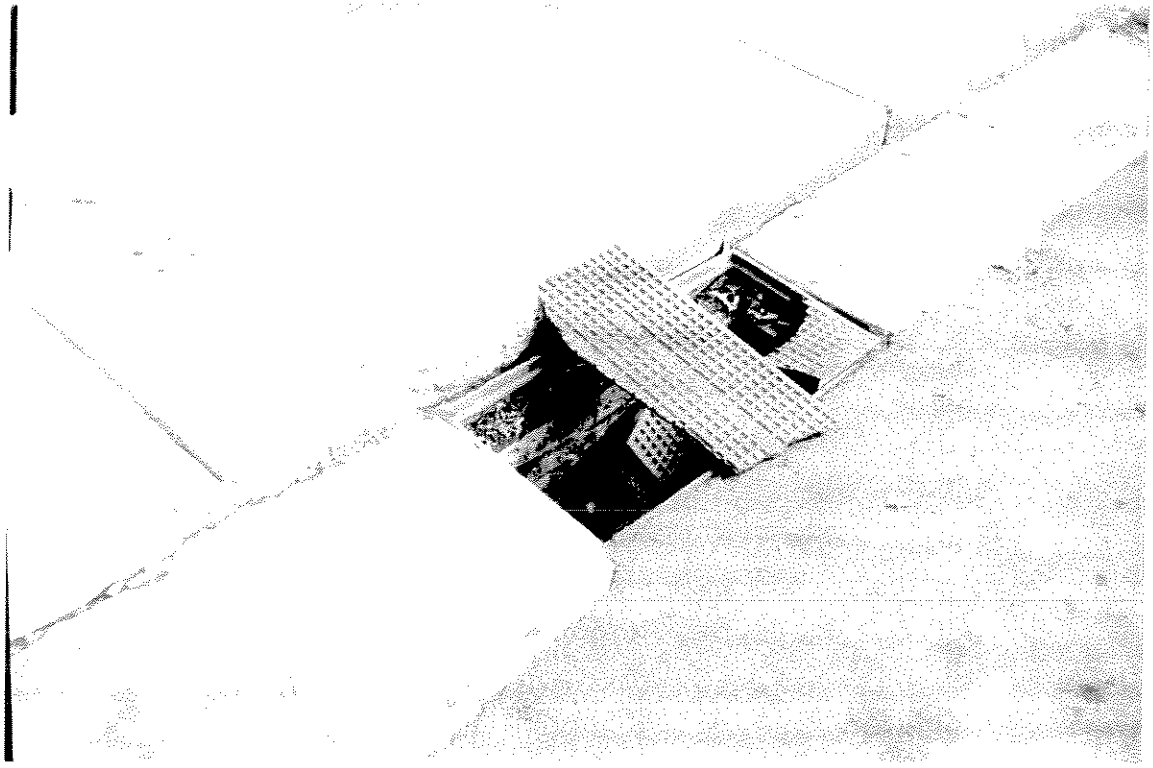




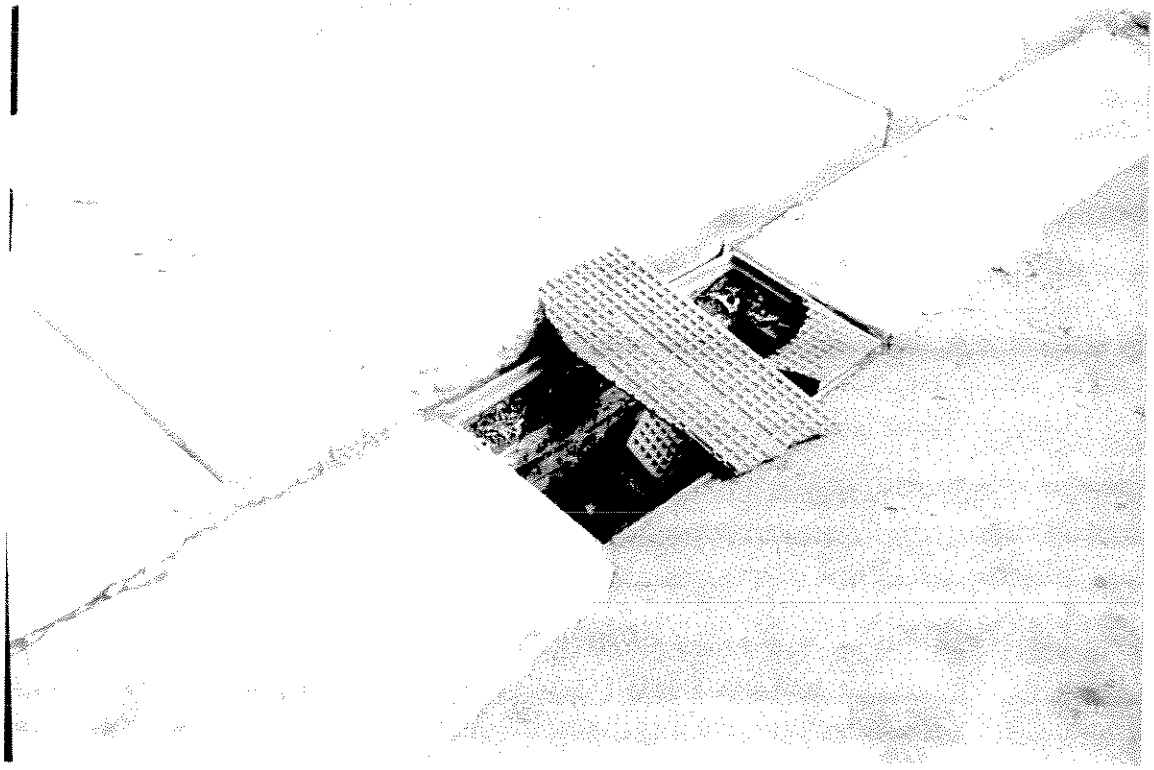





UNITED STATES
POSTAL SERVICE




UNITED STATES
POSTAL SERVICE



MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT 0F 11/05/2004
MEDICAL RECORDS

1. St. Joseph's Hospital
2. Lakeshore Medical Clinic
3. Mysore S. Shivram, M.D.
4. St. Francis Hospital

MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT 0F 11/05/2004
MEDICAL RECORDS

St. Joseph's Hospital

St JOSEPH'S HOSPITAL
5000 W. Chambers St. • Milwaukee, WI 53210-1688
A MEMBER OF Covenant HEALTHCARE
Covenant Healthcare is sponsored by
the Wheaton Franciscan and Felician Sisters.

December 19, 2005

MARCUS LAW OFFICES, S.C.
6290 NORTH PORT WASHINGTON ROAD

MILWAUKEE, WI 53217

CERTIFICATION OF MEDICAL RECORDS

Patient Name: MORGAN L STENCIL
Patient DOB: August 22, 1982
Patient MRN: 097-05-70

I, JILL KRUEGER, Record Custodian of hospital records at St. Joseph's Hospital, Milwaukee, Wisconsin, hereby certify that the documents annexed hereto and consisting of 8 pages and date(s) of service 11/5/04, constitutes an accurate, legible, and complete duplicate of the St. Joseph's Hospital medical record regarding the above named patient for the service date(s) requested.

Jill Krueger /SM
JILL KRUEGER, MS, RHIA, CCS
Director, Medical Records

097-05-70

MARCUS LAW OFFICES, S.C.

6300 N. PORT WASHINGTON ROAD
MILWAUKEE, WI 53217

ROBB A. MARCUS
ATTORNEY AT LAW

TELEPHONE: (414) 963-8990
FAX: (414) 964-7217

December 7, 2005

VIA FAX TO 874-4480
St. Joseph's Hospital
Att: Release of Information
5000 W. Chambers
Milwaukee, WI 53210

R44615

RECEIVED
DEC 15 2005

Re: My Client: **Morgan Powell**
Date of Birth: **08/22/82**
Case No.: **05CV1010**

Dear Sir or Madam:

Please be advised that we have been retained to represent Morgan Powell in connection with injuries she sustained in an accident that occurred on November 5, 2004. We understand that Ms. Powell received treatment at St. Joseph 's Hospital in connection with her injuries. Enclosed please find a medical authorization properly executed by our client, Ms. Powell. Please provide us with **certified copies** of any and all medical records relating to any treatment rendered to Ms. Powell on the date of the accident. If there is a charge for these services, please provide me with an invoice along with the billing statements and we will promptly remit payment of same.

Thank you in advance for your anticipated cooperation. Feel free to contact me should you have any questions.

Very truly yours,

Robb A. Marcus

RAM/rm
Enclosure
cc: Morgan Powell

12-19-05 Rm
11-5-04 Comp

8

ST. JOSEPH REGIONAL MEDICAL CENTER
A MEMBER OF COVENANT HEALTHCARE

Account No: 71179892 **MR#: 0970570**
Sched Date: 11/05/04 01:22 PM -

PATIENT INFORMATION

POWELL MORGAN L
7801 W WINFIELD
MILWAUKEE WI 53218

Phone: 414 760-8743
DOB: 08/22/1982 Age: 22
Gender: F MS: MARRIED
SS#: 387-02-7121
Religion: NONE
Employer: AIDS RESOURCE CTR OF WI
Phone #: 414 273-1991
Occupation:

NEAREST RELATIVE

Name: STENCIL KEVIN
Phone: 414 760-8743
Bus Phone:
Relat: SPOUSE
Notify: Y

ADDITIONAL CONTACT

Name: POWELL BETTY
Phone: 414 344-5280
Bus Phone:
Relat: PARENT
Notify: Y

VISIT INFORMATION

INTERPRETER NEEDED: NO
Language: ENGLISH

Admit Reason: RIGHT ANKLE PAIN
Comment: NK

Visit Type: E
Location: EMERGENCY DEPT MINOR#
Last Inp Date:
Last Outpt Date:

PHYSICIAN INFO

Adm:
Att: LACROSSE LARRY E
PCP: MODY RITA D

INSURANCE INFORMATION

PRIMARY: AETNA
Plan: STANDARD
PO BOX 981107
EL PASO TX 79998
Phone #: 800 872-3862
Subr: POWELL BETTY KAREN
Relat: CHILD/INS FIN RESP -
Policy#: 344421974
Group#: 100440-10
Group Name: NONE

GUARANTOR INFORMATION

Name: POWELL MORGAN L
7801 W WINFIELD
MILWAUKEE WI 53218-0000

Phone #: 414 760-8743
SS#: 387-02-7121
Employer: AIDS RESOURCE CTR OF WI
Phone #: 414 273-1991

FILE

NAME Powell, Morgan | ☐ M ☒ F | DOB 8-22-82 | AGE | DATE/TIME OF TRIAGE 11-5-04 1315 | 4 ☒ GREEN 5 ☐ BLUE

CHIEF COMPLAINT (REASON FOR SEEKING CARE) (R) ankle pain, fell today while getting out of the car fell into a hole in the street

PRIVATE PHYSICIAN ☒ ECI ☐ PMD

WORK COMP. EMPLOYER

DRUG SCREEN REQUIRED? ☐ YES ☐ NO

MODE OF ARRIVAL ☒ AMBULATORY ☐ W/C ☐ CARRIED

AMBULANCE

FAMILY WITH PATIENT ☒ YES ☐ NO

TRIAGE RN INIT. KB

PRE-HOSPITAL TREATMENT: ☒ NONE ☐ SPLINTING ☐ DRESSING ☐ MEDS ☐ ICE

VITAL SIGNS: TIME 1320 BP 108/81 P 52 RR 16 TEMP 97.7 O2SAT

ALLERGIES ☒ NONE ☐ LATEX | LMP/EDC Oct 20 | WT/KG | FINGERSTICK/DEVICE ∅

TETANUS ☒ UTD ☐ > 10YRS ☐ NEVER

ADV.DIRECTIVES ☐ YES ☒ NO ☐ INFO GIVEN

REFERRAL MADE ☐

MEDICATIONS ∅

HERBAL OR ALTERNATIVE MEDICATIONS ☐ ∅

MEDICAL HISTORY ☐ CARDIAC ☐ RESP. ☐ CANCER ☐ DIABETES ☐ HTN ∅ ☐ OTHER

ASSESSMENT	WNL	ABN.		WNL	ABN
NEURO	X		EENT	X	
CARDIAC	X		SKIN	X	
RESPIRATORY	X		MUSCULOSKELETAL		X
GI	X		PERIPHERAL/VASCULAR	X	
GU	X				

PAIN/COMFORT

PRE-TREATMENT RATING 7/10 (R) foot pain | POST-TREATMENT

PREGNANCY POS NEG SpGrav

VISUAL ACUITY OS OD OU

TIME	BP	P	R	T	O2SAT	ASSESSMENT/INTERVENTIONS/MEDS/EVALUATION	INITIALS
1350						Pt states having (R) ankle & foot pain after falling into a manhole today	T.V.
1410						Pt gone for x-ray	T.V.
1415						* Pt back from x-ray, Ultracet given which consists of 325 mg of Tylenol and 37.5mg tramadol, awaiting further eval	TV
1415						Applied an ace wrap to Pt. (R) ankle Pt. was also given air gel splint	KB
1510						Pt discharged in stable condition, pt states pain is now 4/10	TV

ORDERS LABS

☐ CBC ☐ BMP ☐ DRUG SCREEN ☐ RAPID STREP ☐ UA ☐ VOID ☐ CATH ☐ PREG ☐ DIP ☐ GC ☐ CHLAMYDIA ☐ WET MOUNT ☐ OTHER

FINDING RESULTS:

ORDERS XRAY

☐ FINGER	☐ RIGHT	☐ LEFT
☐ HAND	☐ RIGHT	☐ LEFT
☐ WRIST	☐ RIGHT	☐ LEFT
☐ ELBOW	☐ RIGHT	☐ LEFT
☐ SHOULDER	☐ RIGHT	☐ LEFT
☐ HIP	☐ RIGHT	☐ LEFT
☐ KNEE	☐ RIGHT	☐ LEFT
☒ ANKLE	☒ RIGHT	☐ LEFT
☐ FOOT	☐ RIGHT	☐ LEFT
☐ CXR		
☐ OTHER		

FINDINGS/RESULTS:

ORDERS MEDS/TREATMENTS ☐ TETANUS ☐ PT to see Patient

Ultracet i p.o. now

Gel splint

DISPOSITION

DISCHARGE: TIME ☐ AMA

☒ INSTRUCTIONS ☒ VERBAL ☒ WRITTEN

☒ VERBALIZES UNDERSTANDING

☒ REFERRED TO Mody

☒ LEFT WITH

CONDITION Stable, Improved

☒ SCRIPTS GIVEN Darvocet, Naprosyn

☒ AMBULATORY ☐ W/C ☐ CARRIED

DIAGONSIS: Acute (R) ankle & achilles strain

INITIALS/SIGNATURE/TITLE PHYSICIAN/PA [signature]

INITIALS/SIGNATURE/TITLE

RN/TECH KB/Kemba Banyard RN
T.V. / Nasser RN

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

FAST TRACK EMERGENCY DEPARTME

POWELL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 970570
EMERGENCY CONSULTANTS INC
ACCT#: 71179892

St. Joseph Regional Me[illegible]l Center | Emergency Dep[illegible]tment QualChart® | Page 1 of 1

ANKLE / FOOT PAIN

Fill in, circle pertinent positive findings. Complete all sections.

Exam Time: 14:00 a.m. / p.m. | Mode of Arrival: EMS Other | Nurse's Triage Notes Reviewed: Yes No

VSS Except: BP _____ Pulse _____ Resp. Rate _____ Temp _____

Pulse Ox: NL Hypoxic ~~Not Applicable~~ _____ % on R/A or O_2 @ _____ L/min

Last Tetanus: _____ Unknown Last Menstrual Period: _____ Unknown

HISTORY:

HX from Pt Unobtainable due to: Dementia Altered MS Extremis HX from: Family / Caretaker EMS Interpreter

CHIEF COMPLAINT: This is a 22 year old male / female who presents with a chief complaint of pain at: Right / Left Ankle Foot _____ Toe

Mechanism of Injury: twisted it when stepped in a pothole No Known Trauma

Onset / Duration: _____ Min Hours Days Weeks Ago Severity: _____ (0-10) Mild Mod Severe Worse Since: _____

Aggravated By: Standing Ambulation _____ Nothing Alleviated By: Rest Elevation Ice OTC Meds _____ Nothing

Related HX: Able to Bear Weight: Yes No

Occupational Injury but limps

REVIEW OF SYSTEMS:

Motor Complaint: Negative ↓ ROM Swelling

Neurovascular Complaint: Negative Weakness Numbness / Tingling

Other Ortho Complaints: _____

PAST MEDICAL/FAMILY/SOCIAL HISTORY:

Previously Healthy

Patient: Prior Ankle or Foot Injury _____

Occupation: _____

Family Hx: _____ Lives: Alone With Family At Nursing Home

PHYSICAL EXAMINATION:

EXAM LIMITED DUE TO: Dementia Altered MS Extremis Other:

		Normal Findings:	Abnormal Findings:
Appearance	Normal	Well-Appearing	Ill-Appearing: Mild Mod Severe
		No Pain Distress	Pain Distress: Mild Mod Severe
		Well-Nourished	Obese / Thin / Cachectic
MS	Normal	Strength / ROM Intact	Limited @ ↓ 2° to pain
		No Edema	Edema @ _____
		No Calf Tenderness	Calf Tenderness
Skin	Normal	Warm & Dry	Pale / Diaphoretic
		Color Normal	Cyanosis @ _____
Neuro-Vascular	Normal	Pulses Normal	Abnormal @ _____
		A & O x 3	A V P U Disoriented
		NV Bundle Intact	Abnormal @ _____
		Distal to Injury	_____

Complaint-Specific Findings:

Swelling / Ecchymosis

Abnormal Contour / Rotation

Ligamentous Instability

Achilles Tendon Abnormality + tender

Laceration / Puncture Wound

Erythema / Warmth / Blisters

Foreign Body

Tenderness:

Medial / Lateral Malleolus

Heel / Achilles Insertion

Midfoot

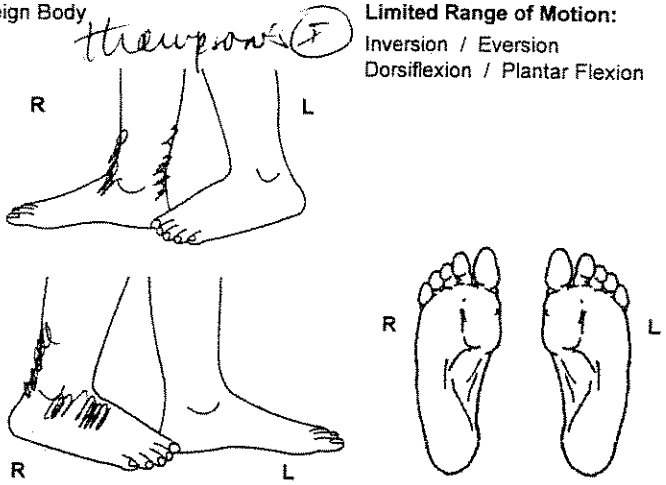
Metatarsals 1 2 3 4 5

Digits 1 2 3 4 5

Limited Range of Motion:

Inversion / Eversion

Dorsiflexion / Plantar Flexion



MEDICAL DECISION MAKING:

Consideration of the following circled conditions may be warranted for the presenting problem.

Burn / Localized	Fracture: Closed / Open	
Cellulitis / Infection	Gout	
Contusion	Puncture Wound	
Dislocation	Subungual Hematoma	
Foreign Body	Sprain / Strain	Tendonitis / Bursitis

Other: _____

Ancillary Tests and ED Treatment: See Orders Sheet

RE-EVALUATION:

Pain Scale (0 - 10)

Time: _____ Unch. Imp. Worse _____

Time: _____ Unch. Imp. Worse _____

PHYS. NOTIFICATION/CONSULTS:

Chart Copy Avail. to Addt'l Care Providers

Discussed case/management/disposition of patient with:

Name: _____ at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit OBS Transfer Consult Follow-up: _____

ED PHYSICIAN DIAGNOSES:

1 Acute R ankle / cellulitis

2 Sprain / strain

3

DISPOSITION:

RX: _____

Discharge to: Home Work Nursing Home OR Tele Floor Deceased AMA

Condition: Stable Unstable

Care Endorsed to: _____ @ _____ a.m. / p.m.

Transfer to: _____ Transfer Form Completed

Standard After-Care Instructions Given to Patient Upon Discharge From ED

Supervising / Management / Progress / Procedure Notes Attached Yes No

SIGNATURE:

_____ (Initials) I have reviewed the ancillary/nursing staff documentation. Physician attests performing History, Pertinent Physical Examination, and Medical Decision Making

_____ MD/DO

_____ MD/DO

_____ PA / NP / Resident

Chart / Addendum Dictated: Yes No

Disposition Time: 16:30 a.m. / p.m.

Jonathan F Hartle PAC 15651

POWELL MORGAN L

DOB: 08/22/82 22Y SEX: F MR: 970570

EMERGENCY CONSULTANTS INC

ACCT#: 71179892

  11/05/04 01:56 pm

QC2180011105040071

197 Larry E LaCrosse MD

Covenant

Elmbrook Memorial Hospital
19333 West North Avenue
Brookfield, WI 53045

St. Francis Hospital
3237 16th Street
Milwaukee, WI 53215

St. Joseph Regional Medical Center
5000 West Chambers
Milwaukee, WI 53210

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

RADIOLOGY

ORIGINAL
cc: RITA MODY, MD, Primary Care Physician
ORLANDO ALVAREZ, MD, Ordering Physician
LARRY LACROSSE, MD, Attending Physician

ORDERING PHYSICIAN: Dr. Orlando Alvarez
OCCURRENCE NUMBER: 64787228 **EXAM DATE:** 11/05/2004

EXAM: THREE-VIEW RIGHT ANKLE PLAIN FILM SERIES SUBMITTED WITHOUT PRIOR STUDIES FOR COMPARISON

INDICATION: Evaluate for fracture following trauma.

FINDINGS: No fractures, dislocations, radiopaque foreign bodies or focal bony defects demonstrated.

IMPRESSION: No acute bony disease demonstrated.

This document was electronically signed by JEFFREY M. HARTWICK, MD on behalf of ERNEST CONTI, MD on 11/07/2004 09:17:18.

Radiologist:_____
ERNEST CONTI, MD

EC/jah D.11/05/2004 15:38:08 T.11/05/2004 18:19:55
Doc ID #: 3811958 Voice ID #: 3696730

ST. JOSEPH REGIONAL MEDICAL CENTER
NAME: POWELL, MORGAN L **MRN:** 970570 **VISIT TYPE:** E
DOB: 08/22/1982 **ACCT #:** 71179892 **ROOM #:** EDM

RADIOLOGY

Covenant

Elmbrook Memorial Hospital
19333 West North Avenue
Brookfield, WI 53045

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Milwaukee, WI 53215

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Milwaukee, WI 53210

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

PROVISIONAL RADIOLOGY REPORT
ED-MINOR

THE FINAL REPORT WILL FOLLOW IN THE USUAL MANNER

Original Copy
cc:

OCCURRENCE NUMBER: 64787228

EXAM DATE: 11/05/2004

EXAM: ED-Ankle RT 3+ Views

RESULTS: Negative.

RADIOLOGIST:_____
MARK LAWTON, MD

ML/djk T. 11/05/2004 14:27:25

ST. JOSEPH REGIONAL MEDICAL CENTER
PATIENT NAME: POWELL, MORGAN L **MRN:** 970570 **DOB:** 08/22/1982
ACCT #: 71179892 **ROOM #:** EDM

THIS IS PART OF THE PERMANENT MEDICAL RECORD

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

☐ I. Aisiku, MD	☐ R. Skrupky, MD
☐ O. Alvarez, MD	☐ G. Walker, MD
☐ J. Faber, MD	☐ M. Bender, PA-C
☐ R. Keane, MD	☐ T. Damm, PA-C
☐ W. Kumprey, MD	☐ N. DeGrado, PA-C
☐ L. LaCrosse, MD	☐ K. Farnsworth, PA-C
☐ J. Lee, DO	☐ J. Harrie, PA-C
☐ J.B. Lindberg, MD	☐ J. McCommons, PA-C
☐ M. Mitchell, DO	☐ J. Robinson, PA-C

Patient Name [illegible] Date [illegible]

Rx [illegible]

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

☐ I. Aisiku, MD	☐ R. Skrupky, MD
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☐ J. Lee, DO	☐ J. Harrie, PA-C
☐ J.B. Lindberg, MD	☐ J. McCommons, PA-C
☐ M. Mitchell, DO	☐ J. Robinson, PA-C

Patient Name Date

Rx

Provisional Diagnosis _____ Physician who cared for you [illegible]

We have examined and treated you today on an emergency/urgent care/outpatient basis only. If symptoms or medical problem(s) fail to improve, call us at 447-2171, see your doctor, or return here.

☐ You must arrange for an exam with your physician in _____ days.

☐ You should arrange for an exam with your physician if your condition does not improve in [illegible] days.

☐ Physician [illegible]

Telephone [illegible]

Additional Instructions [illegible]

☐ You had _____ sutures/staples. They must be removed in _____ days.

☒ You were prescribed sedatives or pain medications that may make you drowsy. Do not drink alcohol, drive, or operate machinery while you are taking those medications.

☐ Cultures were done today. Results will not be available for 72 hours. We will call you if the culture is positive and additional treatment is required.

Please follow the instructions below as indicated for:

❑ Abdominal Complaint	❑ High Blood Pressure
❑ Animal Bite	❑ Neck Strain/Sprain
❑ Asthma	❑ Nosebleed
❑ Back Pain	❑ Otitis Media (Ear ache)
❑ Burn Care	❑ Pelvic Inflammatory Disease
❑ Cast Care	❑ Seizure
❑ Chest Pain	❑ Sore Throat
❑ Cold - Adult/Child	☑ Strain, Sprain, Fracture
❑ Crutch Walking/Crutches	❑ Tetanus
❑ Culture	❑ Threatened Miscarriage
❑ Eye Injury	❑ Urinary Tract Infection
❑ Fever - Child	❑ Venereal Disease
❑ Febrile Convulsion	❑ Vomiting/Diarrhea - Adult/Child
❑ Headache	❑ Wound Care/Suture After Care
❑ Head Injury - Adult/Child	❑ IV Conscious Sedation

Other _____

☑ If you received x-rays, they do not always show injury or disease. Fractures (breaks in the bones) are not always revealed on the initial x-rays but may be revealed on subsequent x-rays. **Your x-ray has been read on a preliminary basis.** Final reading will be made by the Radiologist. You or your referral physician will be notified of any additional findings through the Emergency Department.

☐ **If you received an EKG it has been read on a preliminary basis by the physician on duty.** A final reading will be made and you or your referral physician will be contacted if additional treatment is required.

I have received discharge instructions and understand that I have received emergency care only. I am to call or see my family physician for further care.

I also understand my primary care physician may receive a copy of my ED record

Patient signature: [illegible]

Work/School Release: _____ Today's date: [illegible]

_____ May return to work/school immediately with no limitations.

_____ Off work/school today, may return next scheduled shift/day.

_____ Off work/school for [illegible] days. Re-check by family/company doctor or preferred doctor prior to return recommended.

_____ May return to work/school with the following limitations: _____

ST. JOSEPH REGIONAL MEDICAL CENTER
A Covenant HOSPITAL
5000 W. Chambers Street
Milwaukee, WI 53210-1688

GENERAL DISCHARGE INSTRUCTIONS ED-SJRMC

POWELL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 970570
EMERGENCY CONSULTANTS INC.
ACCT#: 71179892

D. Assignment and Agreement to Pay: I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to Facility and the physicians and professionals associated with the Facility, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of the Facility, the physicians and/or the professionals associated with the Facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.

E. Valuables: Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.

F. Photographing: I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby, I give consent for my baby to be photographed for security and/or personal use.

G. Privacy Notice: I acknowledge that I was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

X _____ 11-5-4

Signature of Patient/Authorized Representative — Date

_____

Relationship of Authorized Representative

If unable to sign document, state reason: _____

Covenant HEALTHCARE

A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

St. Francis Hospital
St. Michael Hospital
Elmbrook Memorial Hospital
St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

POWELL MORGAN L
DOB 08/22/82 22Y SEX F MR 970570
EMERGENCY CONSULTANTS INC
ACCT# 71179892
RE
BOX APPEARS ON.

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

☐ St. Joseph Regional Medical Center
☐ St. Michael Hospital
☐ Elmbrook Memorial Hospital
☐ St. Francis Hospital

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

A. Consent for Treatment: I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.

B. General Acknowledgments: I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility, during regular business hours.

C. Medicare Payments: I acknowledge receipt of the "Important Message from Medicare," as applicable.

MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT 0F 11/05/2004
MEDICAL RECORDS

Lakeshore Medical Clinic

[illegible]
POWELL, MORGAN
[illegible]
[illegible] 0912AM
08/22/1982 34510697

LAKESHORE MEDICAL CLINIC — **PROGRESS NOTE**

Date:

Initials:

Name:

Chief Complaint:

DOB: 8/22/82 22 yrs.

LMP: 1/28/05

Meds: ☐ Updated, See Med List

Allergies: ☐ NKDA Updated, See Problem List

Updated, See Problem List For: (Initial)

PMSHx:☐ **SHx:** ☐ **FHx:** ☐

99212,99213,99202:0 99214,99203:1 99215,99204,99205:2

S) **Loc:**
Qual:
Severity:
Duration:
Timing:
Context:
ModFact:
Assoc S/S:

wants to discuss NovaRing.
Strained (R) ankle back in Nov.
Uses condom
Do not with BC pills as it caused Nausea
[illegible] fell in [illegible]
in Nov was seen in ER.
x-ray was neg. (St Joseph's)
(+) swelling and pain.
Brace was given
[illegible]

ROS: √ = Normal O= Abnormal

☐General ☐ ↓ ↑ Appetite ☐Wt loss ☐Fever ☐Chills ☐Sweats ☐Fatigue
☐Eyes ☐Blurry/Double Vision ☐Redness ☐Swelling ☐Discharge
☐HENT ☐H/A ☐Ear Ache ☐↓ Hearing ☐Tinnitus ☐Sinus ☐Sore Throat
☐Dentures ☐Scalp ☐Rhinorrhea ☐Glands ☐Annual Ophtho Exam
☐Resp ☐Cough ☐Colds ☐Sputum ☐SOB ☐Wheeze ☐Post Nasal Drip
☐CV ☐Chest Pain/Angina ☐SOB ☐DOE ☐Palpitations ☐Murmur ☐Edema
☐GI ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Pain
☐Dysphagia ☐Hemorrhoids ☐BRBPR ☐Melena ☐Ulcers
☐GU ☐Impotence ☐Dysuria ☐Hematuria ☐Urgency ☐Frequency
☐Prostate ☐Nocturia ☐Pelvic Pain ☐Discharge ☐Incontinence
☐Heme ☐Glands ☐Bleeding/Bruising Problems ☐Blood Disorders
☐MSK ☐Swelling ☐Joints ☐Weak ☐Symmetry ☐Low Back Pain ☐Pain
☐Skin ☐Rash ☐Insect Bites ☐Moles ☐Acne ☐Eczema ☐Itch ☐Hives
☐Neuro ☐Dizzy ☐Lightheaded ☐Syncope ☐Numbness ☐Weak ☐Tingling
☐Psych ☐Depressed ☐Anxious ☐Insomnia ☐Concentrate ☐Suicide
☐All/Imm ☐Urticaria ☐Sneezing ☐Conjunctivitis ☐Seasonal Allergies
☐Endo ☐Polyuria ☐Polydipsia ☐Polyphagia ☐Wt gain
☐Hot ☐Cold ☐Hair loss ☐Menopause ☐Wt loss

99212:0 99213,99202:1 99214,99203: 2-9 99204,99205: 10+

O) √ = Normal O= Abnormal B/P: 100/68 Pulse: 82 Temp: 98.0 RR: Ht: Wt: 119# BMI:

General ☑Well-nourished ☑Well-groomed ☑NAD ☐Cooperative
Eyes ☐Conjunctiva/Lids ☐PERRLA/EOMI ☐Fundus/Optic Discs
ENMT ☐Ears/Nose ☐Otoscopic Exam ☐Nasal Mucosa/Septum/Turbinates
☐Lips/Teeth/Gums ☐Oropharynx (6) ☐Hearing Test ☐Sinuses
Neck ☐Neck Exam ☑Thyroid Size/Shape/Consistency
Resp ☐Respiratory Effort ☑Auscultation ☐Chest Palpation ☐Chest Percussion
CV ☐Palpation of Heart ☑Auscultation ☐Carotid Artery ☐Abdominal Aorta
☐Femoral Pulses ☐Edema/Varicosities ☑Murmur/Rub/Gallop ☐DP/PT Pulse
Chest ☐Inspection ☐Palpation Breasts/Axillae
GI ☑Liver/Spleen ☑Mass ☑Tender ☐Guard/Rebound ☐BS ☐Anus/Perineum
GU MALE: ☐Scrotum ☐Testicles ☐Penis ☐Prostate
FEMALE: ☐External Gen ☐Vaginal Vault ☐Urethra ☐Bladder
☐Cervix ☐Uterus ☐Adnexa/Parametria ☐CVA
Lymph ☐Ant/Post Cervical ☐Auricular ☐Clavicular ☐Axillary ☐Groin
MS ☐Gait/Station ☐Digits/Nails
Circle: Head Neck Cervical Thoracic Lumbar Sacral Ribs Pelvis RU Ext LU Ext RL Ext LL Ext
☐Inspection ☐Palpation ☐R.O.M ☐Stability/Subluxation ☐Strength/Tone
Skin ☐Inspection of Skin/SQ Tissue ☐Palpation of Skin/SQ Tissue
Neuro ☐Cranial Nerves II-XII ☐DTR ☐Sensation ☐Cerebellar ☐Vibratory Sense
Psych ☐Judgment ☐Alert/Oriented (PPT) ☐Recent/Remote Memory ☐Mood/Affect

Rt ankle
Ø swelling
Mild tenderness +
lateral Malleoli
and Achilles Tendon
Movement Mildly painful
NV intact

99212:2-5 99213, 99202: 6-11 99214, 99203: 12-17 99215, 99204, 99205:18+ Counseling: 99212:10 min 99213: 15 min 99214: 25 min 99215: 40 min

A/P) **Stable Diagnoses** **New Diagnoses** **E/M Non-Stable**

Contraceptive Mgmt
Rt ankle sprain
To use backup method c 1st Month

d/w pt about NuvaRing [illegible]
Nuvaring Contraception prescribed. Risk and Inf. given to pt.
Pregnancy test stat
neg

99212,99202: 1 Diag Min data/risk 99213,99203: 2 Diag Lim data/risk 99214,99204: 3 Diag Mod data/risk 99215,99205: 4 Diag Ext data/risk

Rapid Strep Mono CBC dif PT/INR BMP CMP Liver Panel TSH Chol HgbA1C ESR B12/Folate (UA) micro CXR EKG

Education/Consults: needs to see orthopedic MD.

102703

MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT 0F 11/05/2004
MEDICAL RECORDS

Mysore S. Shivram, M.D.

MYSORE S. SHIVARAM, M.D.
Orthopaedic and Hand Surgeon

4448 W. Loomis Road, Suite 102
Greenfield, WI 53220
Telephone: (414) 282-5555
Fax: (414) 282-5588

April 4, 2005

Re: Morgan Stencil

Dear Dr. Rita Mody:

Morgan re-injured the right ankle when she twisted it. She is concerned about continued pain and feeling of weakness in the right ankle there is no instability of the right ankle. There is pain over the anterior tibiofibular ligament. She was sent to physical therapy for rehabilitation. I anticipate good recovery with physical therapy and she will return prn for recheck.

Thank you for the referral.

Sincerely,

Mysore S. Shivaram M. D.
MSS/jam

NAME: Morgan Stencil AGE:_____ PCP:_____

DATE: 04/04/05 CHIEF COMPLAINT: Rt √ Ankle

HISTORY OF PRESENT ILLNESS: had weakness (R) ankle. was swollen. Now has pain when steps. Able to walk

PAST/FAMILY/SOCIAL HISTORY (attached form): REVIEW BY:_____ ON:___/___/___

CONSTITUTIONAL: HT_____ WT_____ PULSE_____ RESP_____ B/P_____/_____

REVIEW SYSTEMS: ✓=NORMAL FINDINGS

~~☑ WELL DEVELOPED/WELL NOURISHED, ORIENTED x3~~

~~☑ SKIN~~ ☐ NECK ~~☐ EYES~~ ☐ EARS, NOSE, MOUTH

☐ CARDIOVASCULAR ☐ RESPIRATORY ☐ ABDOMEN

☐ ABNORMAL FINDINGS:_____

☐ NEUROLOGICAL:

KNEE JERK: R____ L____ BICEPS: R____ L____

ANKLE JERK: R____ L____ TRICEPS: R____ L____

BABINSKI: R____ L____ BRACHIORADIALIS: R____ L____

EXT HAL LONG: R____ L____ SENSORY: R____ L____

☐ MUSCULOSKELETAL:

INSEPCTION:

GAIT_____

SWELLING ⊖

DEFORMITY ⊖

EDEMA ⊖

CONTRACTURE ⊖

LISTING_____

PALPATION_____

TENDERNESS Over Anterior tibialis

SWELLING ⊖

INFLAMMATION ⊖

CREPITUS Present Medial

STABILITY OK – Non Palpable

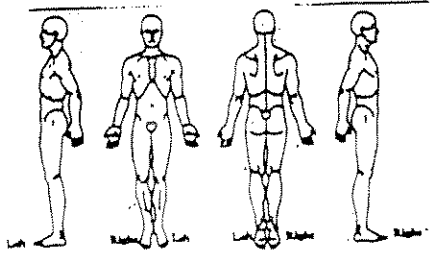
ROM: FLEXION_____

EXTENSION WNL

ABDUCTION_____ Pain

INT. ROT._____

EXT. ROT._____



REVIEWED: ☐ XRAYS ☐ MRI ☐ ARTHROGRAM ☐ CT SCAN ☐ BONE SCAN ☐ EMG

RESULTS:_____

Dr. Reinhard Mild Uncertain Rupture

TREATMENT PLAN: ☐ OBSERVE_____ ☐ CONSERVATIVE_____

☐ SURGERY_____

☑ THERAPY:_____ ☐ MEDICATION:_____

☐ OTHER_____

SIGNED:_____ DATE:___/___/___

MYSORE S. SHIVARAM, M.D.
Orthopaedic and Hand Surgeon

4448 W. Loomis Road, Suite 102
Greenfield, WI 53220
Telephone: (414) 282-5555
Fax: (414) 282-5588

February 21, 2005

Re: ~~Paula~~ Morgan Stencil

Dear Dr. Rita Mody:

Paula Morgan injured right ankle when she stepped out of the car in November, she continues to have right ankle pain particularly when she has been on her feet for awhile she has pain along the outer aspect of the right ankle. She complains of weakness in the right ankle. She denies any previous trauma to the right ankle.

Examination reveals no swelling or deformity of the right ankle.The range of motion is normal. She has pain over the anterior tib fib ligament. Right ankle is stable for examination.

She also has a vague clunk in the right ankle with range of motion this appears to be non-pathologic.

Diagnosis: Sprain right ankle with continued discomfort.

Treatment: Conservative care.
Supportive shoes.
Range of motion exercises to the right ankle.
Ice massage.

If she continues to be symptomatic I will repeat x-rays of the right ankle.

Thank you for the referral.

Sincerely,

Mysore S. Shivaram M. D.
MSS/jam

NAME: Morgan Stencil AGE: _____ PCP: Dr. Mody

DATE: 2/24/05 CHIEF COMPLAINT: NP (R) ankle

HISTORY OF PRESENT ILLNESS: (R) ankle pain, fall in the hole 11-5-05

PAST/FAMILY/SOCIAL HISTORY (attached form): REVIEW BY: _____ ON: ___/___/___

CONSTITUTIONAL: HT _____ WT _____ PULSE _____ RESP _____ B/P _____/_____

REVIEW SYSTEMS: ✓=NORMAL FINDINGS

☐ WELL DEVELOPED/WELL NOURISHED, ORIENTED x3

☐ SKIN ☐ NECK ☐ EYES ☐ EARS, NOSE, MOUTH

☐ CARDIOVASCULAR ☐ RESPIRATORY ☐ ABDOMEN

☐ ABNORMAL FINDINGS: _____

☐ NEUROLOGICAL: See 11

KNEE JERK: R ____ L ____ BICEPS: R ____ L ____

ANKLE JERK: R ____ L ____ TRICEPS: R ____ L ____

BABINSKI: R ____ L ____ BRACHIORADIALIS: R ____ L ____

EXT HAL LONG: R ____ L ____ SENSORY: R ____ L ____

☐ MUSCULOSKELETAL:

INSEPCTION:

GAIT _____ PALPATION _____

SWELLING _____ TENDERNESS _____

DEFORMITY _____ SWELLING _____

EDEMA _____ INFLAMMATION _____

CONTRACTURE _____ CREPITUS _____

LISTING _____ STABILITY _____

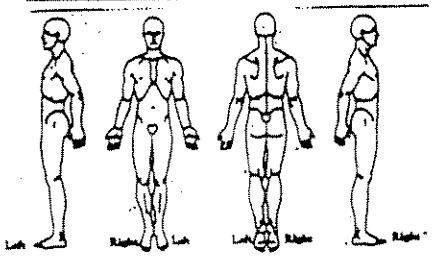
ROM: FLEXION _____

EXTENSION _____

ABDUCTION _____

INT. ROT. _____

EXT. ROT. _____



Rankle Pain

REVIEWED: ☐ XRAYS ☐ MRI ☐ ARTHROGRAM ☐ CT SCAN ☐ BONE SCAN ☐ EMG

RESULTS: _____ Rankle Xrays WNL

_____

TREATMENT PLAN: ☐ OBSERVE _____ ☐ CONSERVATIVE _____

☐ SURGERY _____

☐ THERAPY: _____ ☐ MEDICATION: _____

☐ OTHER _____

SIGNED: _____ DATE: ___/___/___

MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT 0F 11/05/2004
MEDICAL RECORDS

St. Francis Hospital

St. Francis Hospital
3237 S. 16TH STREET
MILWAUKEE, WI 53215
(414) 647-5358

December 14, 2005

MARCUS LAW OFFICES
6300 N. PORT WASHINGTON ROAD
MILW, WI 53217

CERTIFICATION OF MEDICAL RECORDS

PATIENT: MORGAN L STENCIL
DOB: August 22, 1982
MEDICAL RECORD #: 76-13-61
DATES OF SERVICE: 4-20-05 to 6-29-05

Mary Kaye Christensen, RHIT, Record Custodian of Hospital Records at St. Francis Hospital, Milwaukee, Wisconsin, hereby certify that the documents annexed hereto and consisting of 22 pages, constitute an accurate, legible, and complete duplicate of the St. Francis Hospital medical records regarding the above named patient for the Service Date(s) listed.

Mary Christensen

Mary Kaye Christensen, RHIT
Director of Health Information Management

REHABILITATION SERVICES - MEDICAL ARTS PAVILION

ORIGINAL
cc: MYSORE SHIVARAM, MD

THERAPY DISCHARGE SUMMARY
PERFORMANCE CENTERS AT THE MEDICAL ARTS PAVILION 647-7670

DIAGNOSIS: Right ankle sprain.
DATE OF ONSET: 11/05/2004
DATE OF EVALUATION: 04/20/2005
DATE OF DISCHARGE: 06/29/2005 TOTAL VISITS RECEIVED: 13.

TREATMENT/EDUCATION RECEIVED:

- Ultrasound, soft tissue message, range of motion, strengthening, stretching, provision of home exercise program, gait training, balance, reeducation.

FUNCTIONAL STATUS AT DISCHARGE:

-

CLINICAL STATUS AT DISCHARGE:

- Active range of motion: Dorsiflexion is 8 degrees. Plantar flexion is 64 degrees. Eversion is 15 degrees. Inversion is 30 degrees. Dorsiflexion strength is 4+; plantar flexion, eversion and inversion is 5 out of 5. Patient at times does have a tendency to ambulate on lateral border of right foot if ankle is sore. Her pain levels are 1 out of 10 with daily activity. If she does do more than usual walking, her foot does get sore but does not go beyond a 3 out of a 10. Stair climbing is still somewhat sore. She can take stairs reciprocally, but she needs to go slow at times. She is not able to tolerate wearing heels, however.

GOALS MET:

- Patient will achieve right ankle active range of motion to at least 5 degrees to allow for improved gait pattern.
- Patient will report decreased pain levels by at least 25% with daily activity.
- Patient will be independent with range of motion and stretching program to allow for progression towards long-term goals.
- Patient will report increased ease of stair climbing by at least 75%.
- Patient will achieve at least 4+ out of 5 strength throughout right ankle to promote stability of daily activities.

REHABILITATION SERVICES - MEDICAL ARTS PAVILION

GOALS NOT MET:

- Patient will achieve right ankle active range of motion to equal left ankle active range of motion to allow for return to driving and ambulation in the community including incline with pain no greater than a 3 out of 10 (this goal has not been met secondary to ankle active range of motion is not equal but is getting close to equal left ankle).

PLAN/FURTHER RECOMMENDATIONS:

- Plan is for the patient to continue with calf stretching, home exercise program as instructed. Patient is to followup with MD as she feels needed. Discontinue physical therapy at this time.

Kristen Brodzeller PT
KRISTEN E. BRODZELLER, PT

KEB/jsk D. 06/29/2005 12:23:29 T. 06/30/2005 07:03:44
Doc ID#: 4267972 Voice ID#: 4113482

ST. FRANCIS HOSPITAL
PROVIDER: KRISTEN E. BRODZELLER, PT
VISIT TYPE: R
ROOM #: SPME

NAME: STENCIL, MORGAN L
MRN: 761361
DOB: 08/22/1982

DATE: 04/21/2005
ACCT #: 10842045
AGE: 22Y

Mysore S. Shivaram, M.D.
Orthopedic and Hand Surgeon

PT/OT ORDER FORM

Patient Name: Morgan Stencil Date: 4-4-05

Diagnosis: Sprain Ankle

Treatment Frequency:

_____ Daily ✓ _____ Two times a week _____ Three times a week _____ Other

Treatment Duration: 1 2 (3) 4 5 6 7 8 9 10

_____ Days _____ Weeks _____ Sessions

_____ PT Only
_____ PT with concurrent or progression to OT

_____ Evaluation
_____ Evaluation and Treatment

_____ OT Only
_____ OT WCP (PT as needed)

_____ Evaluation
_____ Evaluation and Treatment
_____ FCE Only

Modalities/Procedures:

✓
_____ Ultrasound
_____ Phonophoresis
_____ Whirlpool/Contrast Bath
_____ Mobilization
_____ Massage/Myofascial Release
_____ Electrical Stimulation
_____ Hot Pack/Cold Pack
_____ Iontophoresis
_____ Mechanical Traction

Modalities/Procedures

_____ Desensitization/Massage
_____ Ultrasound
_____ Phonophoresis
_____ Fluidotherapy
_____ Paraffin
_____ Electrical Stimulation
_____ Hot Pack/Cold Pack
_____ Splint Fabrication
_____ Mobilization

Therapeutic Exercise:

✓ ✓
_____ ROM _____ AROM _____ AAROM _____ PROM
_____ Strengthening
_____ Stretching
_____ Lido Isokinetic Exercise/Testing
_____ Work Simulation

Educational Programs:

_____ Back Education
_____ Neck Education
✓
_____ Home Exercise Program

Precautions/Comments: _____

_____, M.D.

☑ PT ☐ OT ☐ ST ☑ PROGRESS REPORT ☐ DISCHARGE REPORT

Primary Diagnosis: (R) ankle strain Treatment Diagnosis: ↑ ROM, strength Precautions: ____

Provider Name ____ Provider NO. ____ Medicare: Y N HICN ____

Onset Date ____ SOC ____ VISITS FROM S.O.C. 7 Service Dates 4/2005 through 5/20/05

Patient reports: slow improvements

Range of pain, 0 – 10 Current: 4 Initially: 6-9/10 Subjective Pain Description:

Treatment / Education: US, STM, stretch, strengthening, HEP

Functional Status: - noted ↑'d soreness when walking too much
- unable to wear dress shoes
- Does not tolerate walking on uneven terrains
- stairs still difficult

Clinical Status: (R)

	(initial)	(today)	strength
DF	-10°	-18°	NT tenderness to touch along lat ankle border + Achilles tendon
PF	60°	60°	
EV	10°	5°	Gait: tendency to ambulate on lateral border of foot
INV	20°	25°	

Goals (Include met/not met/why as applicable)

STGs ① ↑ (R) ankle ROM DF to 5° to allow for improved gait - not met
② ↓ pain by 25% c̄ daily activity - sometimes met
③ I c̄ ROM / stretching program c̄ - met

LTG's have not been met

Plan / Recommendations: ☐ DC Therapy ☑ Continue: (Clarify necessity for continued skilled care). 2x / wk
x 3 weeks for cont'd ROM, gait trng, STM, strengthening

☑ Patient input solicited, plan discussed and agreed upon with patient / significant other.

Therapist Signature: [signature] PT Date: 5/25/05

Physician Reply / Orders:
☐ DC Therapy
☐ Continue Therapy: ____
☐ Special Instructions/Precautions: ____

I have reviewed this plan and recertify a continued need for services from ____ to ____

Physician Signature: [signature] Date: 5-29-05

Covenant REHABILITATION SERVICES
A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

PT / OT / ST
PROGRESS / DISCHARGE
REPORT

Facility

68577 3/05 R1

STENCIL MORGAN L
DOB: 08/22/82 22 Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT# 10842045

Distribution: White: Return to Clinic Yellow: ...

☑ PT ☐ OT ☐ ST ☑ PROGRESS REPORT ☐ DISCHARGE REPORT

Primary Diagnosis: R ankle strain Treatment Diagnosis: ↓ROM, ↓strength Precautions: _____

Provider Name _____ Provider NO. _____ Medicare: Y N HICN _____

Onset Date _____ SOC _____ VISITS FROM S.O.C. 7 Service Dates 4/20/05 through 5/20/05

Patient reports: slow improvements

Range of pain, 0 – 10 Current: 4 Initially: 6-9/10 Subjective Pain Description:

Treatment / Education: US, STM, stretch, strengthening, HEP

Functional Status: - Noted 1'd soreness when walking too much
- Unable to wear dress shoes
- Does not tolerate walking on uneven terrains
- Stairs still difficult

Clinical Status: (R)

	(initial)	(today)	strength
DF	-10°	-18°	NT
PF	60°	60°	
eve	10°	5°	
inv	20°	25°	

tenderness to touch along lat ankle border + Achilles tendon

Gait: tendency to ambulate on lateral border of foot

Goals (Include met/not met/why as applicable)

① ↑ R ankle ROM DF to 5° to allow for improved gait - not met
② ↓ pain by 25% to daily activity - sometimes
③ ↑ c ROM / Stretching program - not

UTCOs have not been met

Plan / Recommendations: ☐ DC Therapy ☑ Continue: (Clarify necessity for continued skilled care). 2 x/wk x 3 weeks for contd ROM, guarding, STM, strengthening

☑ Patient input solicited, plan discussed and agreed upon with patient / significant other.

Therapist Signature: Kristen Brorbeller P.T. Date: 5/25/05

Physician Reply / Orders:

☐ DC Therapy
☐ Continue Therapy: _____
☐ Special Instructions/Precautions: _____

I have reviewed this plan and recertify a continued need for services from _____ to _____.

Physician Signature: _____ Date: _____

Covenant REHABILITATION SERVICES
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Facility MAP

PT / OT / ST PROGRESS / DISCHARGE REPORT

68577 3/05 R1

STENCIL MORGAN L
DOB: 08/22/62 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#: 10842045

Distribution: White: Return to Clinic Yellow: Physician Copy Pink: Therapist

Diagnosis: ______________________ Next Physician Appointment: ______________________

What is the best way for the patient to learn? ☐ Read ☐ Listen ☐ Pictures ☐ Demo ☐ Video ☐ Other ______

Potential Learning Barriers identified by staff: ______ ☐ None

If barriers are identified, see Plan of Care on Initial Evaluation.

	Visit 13 of 20 authorized	Date 6/29/05	Visit ___ of ___ authorized	Date	Visit ___ of ___ authorized	Date
STATUS	Pre Tx pain rating/description: 1/10 Last Day		Pre Tx pain rating/description: ______		Pre Tx pain rating/description: ______	
SKILLED INTERVENTION Including SPECIFIC interventions that increase / decrease pain and modifications.	- U.S to lat ~~foot~~ ankle 8' (R) 50% 1.2 W/cm² - stand prustretch - SLS plyotoss on - ~~SL sens~~ floor - Tandem stance plyotoss - NT 2'					
EDUCATION	Taught: ☐ Patient ☐ Family ☐ Other ___ Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other ___ ☐ AV / TV Encourage cont of HEP - esp calf stretch Educ. Response: (Key Below) 1,2		Taught: ☐ Patient ☐ Family ☐ Other ___ Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other ___ ☐ AV / TV Educ. Response: (Key Below) ___		Taught: ☐ Patient ☐ Family ☐ Other ___ Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other ___ ☐ AV / TV Educ. Response: (Key Below) ___	
TREATMENT OUTCOME/RESPONSE	AROM DF 8° | 4+ PF 64 | 5 ev 15° | 5 inv 30° | 5 P: D/C PT Post Tx pain rating/description: 1/10		Post Tx pain rating/description: ______		Post Tx pain rating/description: ______	
Care Plan	☐ ~~Continue with plan~~ ☐ Revised as per above		☐ Continue with plan ☐ Revised as per above		☐ Continue with plan ☐ Revised as per above	
Time/ Initials	30'	KB				
Tx Charge	MPUES 8' MPTEX 22'					

Educ. Response Key: 1. Verbalized Understanding 2. Demonstrates Skill 3. Needs Further Instruction/Reinforcement 4. Offered and Refused 5. Unable to Meet

OTHER COMMENTS: D/C 4113482

Init.	Signature	Init.	Signature	Init.	Signature
KB	K Bempelly PT				

Covenant REHABILITATION SERVICES

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Facility ______

PT/OT/SP
Outpatient
Treatment Flowsheet

66831 11/03 R2

STENCIL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#:
10842045

Diagnosis: _____ Next Physician Appointment: _____

What is the best way for the patient to learn? ☐ Read ☐ Listen ☐ Pictures ☐ Demo ☐ Video ☐ Other _____

Potential Learning Barriers identified by staff: _____ ☐ None

If barriers are identified, see Plan of Care on Initial Evaluation.

	Visit 10 of 20 authorized	Date 6-16-05	Visit 11 of 20 authorized	Date 6/21/05	Visit 12 of ___ authorized	Date 6/23/05
STATUS	Pre Tx pain rating/description: 3/10 Actually sore yesterday better today (8/10)		Pre Tx pain rating/description: 3/10 Tolerable good pain VS Bad pain when I sit/stand		Pre Tx pain rating/description: 1/10 "warm air helping"	
SKILLED INTERVENTION Including SPECIFIC interventions that increase / decrease pain and modifications	- U.S 50% 8' to 1.2w/cm2 lat. side & ℞ foot - STM to above - Sitting towel calf stretch - Stand Baps 11 Bars L. 2 ⇆ X20 - Shuttle 30 x 4 c ℞ toe Rave - tandem stance - stand. calf stretch toss		- U.S 50% 8' to 1.2w/cm2 to 1 at ℞ foot, dorsum - STM to above 5' - Stand calf stretch - Stand Baps 11 Bars L. 2 ⇆ X20 - Shuttle 30 x 4 c ℞ toe Rave - SLS plyotoss - tandem plyotoss		- U.S 50% to 1.2w/cm2 to lat foot, dorsum & 5' - Sitting calf stretch - Stand Baps 11 Bars L. 2 ⇆ X20 - SLS plyotoss on foam, Floor - Plyotoss tandem - NT 2' - shuttle 4 c ℞ X20	
EDUCATION	Taught: ☑ Patient ☐ Family ☐ Other _____ Methods: ☑ Verbal ☐ Demo ☐ Written ☐ Other _____ ☐ AV / TV Cont HEP. Educ. Response: (Key Below) 1 2		Taught: ☑ Patient ☐ Family ☐ Other _____ Methods: ☑ Verbal ☑ Demo ☐ Written ☐ Other _____ ☐ AV / TV cont. calf stretching Educ. Response: (Key Below) 1 2		Taught: ☐ Patient ☐ Family ☐ Other _____ Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other _____ ☐ AV / TV ICE 10' Educ. Response: (Key Below) _____	
TREATMENT OUTCOME/RESPONSE	fol well - just fatigued p Rx Post Tx pain rating/description: 4/10		DF +5° - improve cont on fol Post Tx pain rating/description: 3/10		fol well cramps fatigued Post Tx pain rating/description: 1/10	
Care Plan	☑ Continue with plan ☐ Revised as per above		☑ Continue with plan ☐ Revised as per above		☑ Continue with plan ☐ Revised as per above	
Time/ Initials	30' KB		30' KB		30 tne KB	
Tx Charge	MPUE 8(8') MPTE X(22')		MPUE 8 MPTE X(22')		MPUE 8(8') MPTE X2' MP HP	

Educ. Response Key: 1. Verbalized Understanding 2. Demonstrates Skill 3. Needs Further Instruction/Reinforcement 4. Offered and Refused 5. Unable to Meet

OTHER COMMENTS: _____

Init.	Signature	Init.	Signature	Init.	Signature
KB	[signature] PT				

Covenant REHABILITATION SERVICES
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Facility _____

PT/OT/SP
Outpatient
Treatment Flowsheet

66831 11/03 R2

STENCIL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#: 10836680

Diagnosis: ______ Next Physician Appointment: ______

What is the best way for the patient to learn? ☐ Read ☐ Listen ☐ Pictures ☐ Demo ☐ Video ☐ Other ______

Potential Learning Barriers identified by staff: ______ ☐ None

If barriers are identified, see Plan of Care on Initial Evaluation.

	Visit 7 of ___ authorized · Date 5/20/05	Visit 8 of ___ authorized · Date 6/8/05	Visit 9 of 20 authorized · Date 6/14/05
STATUS	Pre Tx pain rating/description: 4/10 ↑ soreness today on feet most of day	Pre Tx pain rating/description: 1-2/10 Feels more flexible - pain more bearable	Pre Tx pain rating/description: 1½-2/10 Feeling better @ walking - can walk @ x3 hrs + then gets SV
SKILLED INTERVENTION Including SPECIFIC interventions that increase / decrease pain and modifications.	1.) US lat ankle/ant ankle 1.2w/cm² (50%) 7' 2.) attempted massage & mobs: very guarded & sensative to manual P.T. 3.) AROM DF/PF, INV/EV 4.) Belt stretch 60sec	U.S. lat/ant ankle joint 7' 50% 1.2w/cm² STM to above ~~gas[illegible]~~ gastroc stretch c̄ towel Gait trng c̄ VC's for heel toe gait Stand Baps c̄ 2 x 20 ea dir (wPWB)	U.S. lat ankle 50% 1.2w/cm² 7' - gastroc stretch c̄ towel - STAND Baps c̄ 2 x 20 ea dir - SLS plyotoss - tandem plyotoss - Shuttle 4c (B) heel Raise
EDUCATION	Taught: ☑ Patient ☐ Family ☐ Other ___ Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other ☐ AV / TV ~~Start~~ Cont ex's: 3,4,5 only. Educ. Response: (Key Below) ___	Taught: ☑ Patient ☐ Family ☐ Other Methods: ☑ Verbal ☐ Demo ☐ Written ☐ Other ☐ AV / TV - heel/toe - straight line - SLS plyotoss Ed pt to practice gait, Educ. Response: (Key Below)	Taught: ☑ Patient ☐ Family ☐ Other ___ Methods: ☑ Verbal ☐ Demo ☐ Written ☐ Other ☐ AV / TV Gait trng to ↓ extra push off on (R) LE Educ. Response: (Key Below) ___
TREATMENT OUTCOME/RESPONSE	5.) stand 2 by 4 stretch 1 min 6.) PWB pro stretch. ~~7.) Cryocuff 10'~~ Post Tx pain rating/description: 4/10	wearing high heels today, ed to not wear while learning gait) Declined ice Post Tx pain rating/description: 5/10	will ice if needed later Post Tx pain rating/description: 5/10
Care Plan	☑ Continue with plan ☐ Revised as per above	☑ Continue with plan ☐ Revised as per above	☑ Continue with plan ☐ Revised as per above
Time/ Initials	30 40 DPPT	23' of 7'US KB	25' KB
Tx Charge	1 PTGX, 1 PUES	2 MPTEX (23')	2 MPTEX

Educ. Response Key: 1. Verbalized Understanding 2. Demonstrates Skill 3. Needs Further Instruction/Reinforcement 4. Offered and Refused 5. Unable to Meet

1 PHP

OTHER COMMENTS: 5/25/05 Faxed P.T. note; VO KB Kristen from Dr. Shivaram O.K. to cont P.T.; LM for pt to call + reschedule 6/10/05 KB

Init.	Signature	Init.	Signature	Init.	Signature
DP PT	D Passinault PT	KB	K Brozzelle, PT		

Covenant REHABILITATION SERVICES

A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

Facility MAP

PT/OT/SP
Outpatient
Treatment Flowsheet

66831 11/03 R2

STENCIL MORGAN L
DOB 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT# 10836680

Diagnosis: ____ Next Physician Appointment: ____

<table>
<tr><td colspan="4">What is the best way for the patient to learn? ☐ Read ☐ Listen ☐ Pictures ☐ Demo ☐ Video ☐ Other ____</td></tr>
<tr><td colspan="4">Potential Learning Barriers identified by staff: ____ ☐ None
If barriers are identified, see Plan of Care on Initial Evaluation.</td></tr>
<tr><td></td><td>Visit 4 of 10 authorized — Date 5/5/05</td><td>Visit 5 of ____ authorized — Date 5/9/05</td><td>Visit 6 of ____ authorized — Date 5/16/05</td></tr>
<tr><td>STATUS</td><td>Pre Tx pain rating/description: 3/4
sore 10'
still sore</td><td>Pre Tx pain rating/description: 6/10
- Did a lot of walking is sore today</td><td>Pre Tx pain rating/description: 1-2/10
- Rested
Bought Elliptical</td></tr>
<tr><td>SKILLED INTERVENTION Including SPECIFIC interventions that increase / decrease pain and modifications</td><td>US. 1.2w/cm² 50% to (R) lat ankle 6'
STM
PROM 4way
isometric 4way
towel curling
3 HEP</td><td>- U.S 50% 1.2w/cm² to (R) lat ankle 7'
- STM to lat ankle
- PROM 4way
HEP seated towel calf stretch
- yellow t-band 4-way 10x 3 HEP</td><td>- U.S. 50% 1.1w/cm² to (R) lat ankle 6'
- STM lat ankle
- PROM 4way
- <s>KAT</s> 3. Baps stand L2 (B) x20 ea
- WT (R) x2'
- Shuttle 4c (B) for curves</td></tr>
<tr><td>EDUCATION</td><td>Taught: ☑ Patient ☐ Family ☐ Other ____
Methods: ☑ Verbal ☑ Demo ☑ Written ☐ Other ☐ AV / TV
as above 1-2x/day
Educ. Response: (Key Below) 1,2</td><td>Taught: ☑ Patient ☑ Family ☐ Other ____
Methods: ☐ Verbal ☑ Demo ☑ Written ☐ Other ☐ AV / TV
Bike 5'
Ice 10'
Replace HEP c̄ + band ex
Educ. Response: (Key Below) gave Blue out of yellow</td><td>Taught: ☐ Patient ☐ Family ☐ Other ____
Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other ☐ AV / TV
- Standing calf stretch
- SLS plyotoss
Educ. Response: (Key Below) ____</td></tr>
<tr><td>TREATMENT OUTCOME/RESPONSE</td><td>Cont as tol
Post Tx pain rating/description: 3/10</td><td>Cont 2 more visits
Post Tx pain rating/description: 3/10</td><td>HEP: SLS
Declined ice
Post Tx pain rating/description: 2/10</td></tr>
<tr><td>Care Plan</td><td>☑ Continue with plan
☐ Revised as per above</td><td>☑ Continue with plan
☐ Revised as per above</td><td>☒ Continue with plan
☐ Revised as per above</td></tr>
<tr><td>Time/ Initials</td><td>20 — KB</td><td>30 + ice — KB</td><td>30 — KB</td></tr>
<tr><td>Tx Charge</td><td>MPUES</td><td>MPUES MPTEX MPHP</td><td>2MPTEX</td></tr>
</table>

Educ. Response Key: 1. Verbalized Understanding 2. Demonstrates Skill 3. Needs Further Instruction/Reinforcement 4. Offered and Refused 5. Unable to Meet

OTHER COMMENTS: 5-11-05 <s>KB</s> <s>5/11</s> called to reschedule - work

4/16

Init.	Signature	Init.	Signature	Init.	Signature
KB	[signature]				

Covenant REHABILITATION SERVICES
A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

Facility ____

PT/OT/SP
Outpatient
Treatment Flowsheet

66831 11/03 R2

STENCIL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#:
10842045

Diagnosis: _____ Next Physician Appointment: _____

What is the best way for the patient to learn? ☐ Read ☐ Listen ☐ Pictures ☐ Demo ☐ Video ☐ Other _____

Potential Learning Barriers identified by staff: _____ ☐ None

If barriers are identified, see Plan of Care on Initial Evaluation.

	Visit ___ of 20 authorized	Date 4/20/05	Visit 2 of 20 authorized	Date 4/27/05	Visit 3 of 20 authorized	Date 5/4/05
STATUS	Pre Tx pain rating/description: EVAL		Pre Tx pain rating/description: 2/10 - Depends on activity - pain 1+3 - still wearing tennis shoes		Pre Tx pain rating/description: 3 Had to wear brace ~~to~~ 2 days ago 2° ↑ of walking/dancing	
SKILLED INTERVENTION Including SPECIFIC interventions that increase / decrease pain and modifications.	HEP ankle calf stretch towel 4 way RLE RX U.S. 50% 1.2 w/cm² 6' to (R) lat. ankle		- U.S 50% 1.2 w/cm² 7' to lateral ankle - STM to glute & achilles - towel calf stretch - gentle ROM all directions		U.S. 50% 1.2 w/cm² to lat ankle 8' STM to ankle - Baps L1,2 ↔ x10 each dir - Standing calf stretch - Bike 3' - Ice 10'	
EDUCATION	Taught: ☑ Patient ☐ Family ☐ Other ____ Methods: ☑ Verbal ☐ Demo ☑ Written ☐ Other ____ ☐ AV / TV as above Educ. Response: (Key Below) 1,2		Taught: ☐ Patient ☐ Family ☐ Other ____ Methods: ☐ Verbal ☐ Demo ☐ Written ☐ Other ____ ☐ AV / TV Ice 10' no A & HEP Educ. Response: (Key Below) (1)		Taught: ☑ Patient ☐ Family ☐ Other ____ Methods: ☑ Verbal ☐ Demo ☐ Written ☐ Other ____ ☐ AV / TV Educ. Response: (Key Below) ____	
TREATMENT OUTCOME/RESPONSE	P: Cont US, ROM Post Tx pain rating/description: ____		Cont as tol Post Tx pain rating/description: 3		c/o difficulty c PF + DF 4th mtx P: TSmetrics Post Tx pain rating/description: 3/10 OK	
Care Plan	☑ Continue with plan ☐ Revised as per above		☑ Continue with plan ☐ Revised as per above		☑ Continue with plan ☐ Revised as per above	
Time/ Initials	30 KB		25+ice ICS		30+ice KB	
Tx Charge	2 MPEX MPTEX		3 MPUES MPTEX MPHP		MPTEX MPUES MPHP	

Educ. Response Key: 1. Verbalized Understanding 2. Demonstrates Skill 3. Needs Further Instruction/Reinforcement 4. Offered and Refused 5. Unable to Meet

OTHER COMMENTS: MD - nothing yet per PT 4/29/05 NS

Init.	Signature	Init.	Signature	Init.	Signature
KB	[signature]				

Covenant REHABILITATION SERVICES
A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

Facility _____

PT/OT/SP
Outpatient
Treatment Flowsheet

66831 11/03 R2

STENCIL MORGAN L.
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#: 10836680

Covenant

Elmbrook Memorial Hospital
19333 West North Avenue
Brookfield, WI 53045

St. Francis Hospital
3237 16th Street
Milwaukee, WI 53215

St. Joseph Regional Medical Center
5000 West Chambers
Milwaukee, WI 53210

St. Michael Hospital
2400 West Villard
Milwaukee, WI 53209

REHABILITATION SERVICES - MEDICAL ARTS PAVILION

ORIGINAL
cc: MYSORE SHIVARAM, MD

SUMMARY OF THERAPY EVALUATION
PERFORMANCE CENTERS AT THE MEDICAL ARTS PAVILION 647-7670

DIAGNOSIS: Right ankle strain.
DATE OF ONSET: 11/05/2004
DATE OF EVALUATION: 04/20/2005

FUNCTION/PAIN LIMITATIONS:

- The patient reports pain is along the inferior portion of the lateral malleolus on the right ankle and posteriorly along the Achilles tendon; 6 out of 10 is the current pain rating. Pain can get to a 9 out of 10, described as throbbing, sharp. Walking and stairs increase his pain. Elevating, rest, and ice decrease pain. Patient also reports a popping sensation in the right ankle. She is having difficulty driving and switching her foot from the brake to the gas pedals. She is only able to wear tennis shoes. Stair climbing is painful.

CLINICAL LIMITATIONS:

- The patient does not have any edema. She is ambulating stiffly. However, is able to demonstrate a heel-to-toe gait pattern. Range of motion actively on the right ankle is minus 10 degrees for dorsiflexion, 60 degrees for plantar flexion, 10 degrees for eversion, 20 degrees for inversion. Strength has not been tested at this time. Patient has tenderness along the lateral malleolar area on the right, as well as the Achilles tendon. The patient has bilateral rearfoot valgus.

GOALS:

Short term goals/time frame: Two weeks.

- Patient will achieve right ankle active range of motion to at least 5 degrees to allow for improved gait pattern.
- Patient will report decreased pain levels by at least 25% with daily activity. - not
- Patient will be independent with the range of motion and stretching program to allow for progression toward long-term goals.

Long term goals/time frame: Three to four weeks.

- Patient will achieve right ankle active range of motion to equal left ankle active range of motion to allow for return to driving and ambulation in the community, including inclines, with pain no greater than a 3 out of 10. - good
- Patient will report increased ease with stair climbing by at least 75%. - not

ST. FRANCIS HOSPITAL

PROVIDER: KRISTEN E. BRODZELLER, PT	**NAME**: STENCIL, MORGAN L	**DATE**: 04/20/2005
VISIT TYPE: C	**MRN**: 761361	**ACCT #**: 10836680
ROOM #: SPME	**DOB**: 08/22/1982	**AGE**: 22Y

REHABILITATION SERVICES - MEDICAL ARTS PAVILION

- Patient will achieve at least 4 plus out of 5 strength throughout right ankle to promote stability with daily activities. met

Patient/family goal:
- To reduce pain and strengthen ankle and the knee.

PLAN:
- To see patient two times a week for three weeks for range of motion, strengthening, ultrasound, stretching, provision of home exercise program, balance, proprioception, soft tissue massage.

REHAB PROGNOSIS: Good.

Kristen Brodzeller PT
KRISTEN E. BRODZELLER, PT

KEB/sas D. 04/20/2005 13:12:17 T. 04/20/2005 20:11:18
Doc ID#: 4133750 Voice ID#: 3992393

TREATMENT DIAGNOSIS	PRIMARY DIAGNOSIS	DATE OF ONSET / S.O.C
(R) ankle strain		11/05/04
TREATMENT ORDERED	**PRECAUTIONS/ALLERGIES**	
U.S. PRM, strengthening		
PROVIDER NAME	**PROVIDER NO.**	**MEDICARE** Y (N) **HICN**

MEDICAL HISTORY

MECHANISM OF INJURY / WORK RELATED Y (N)
Fell into a manhole - stepped backwards - manhole cover
CURRENT TESTS / RX / PAIN RX / RESULTS
X-rays (-) cast, used crutches (R) foot & ankle - twisted
still wears cast * wks ago rolled in going up stairs

SOCIAL STATUS

VOCATIONAL/AVOCATIONAL ACTIVITIES
Case Manager for AIDS resource Center
WORKING ☒ YES ☐ NO
PSYCHOSOCIAL FACTORS (SUBJECTIVE, I.E. HOME ENVIRONMENT, FAMILY SUPPORT, TRANSPORTATION, FEELINGS)
Part-time school - MBA Running, general ex

PAIN

LOCATION
inferior to lat malleoli - inside achilles
WHAT INCREASES PAIN?
walking, stairs
PAIN RATING SCALE
0/10 Current 9-10/10
WHAT DECREASES PAIN?
elevate, rest, ice
ONSET/DURATION
Throbbing → sharp up to knee
DESCRIPTION
Popping - hurts

FUNCTIONAL LIMITATIONS

FUNCTION/PAIN LIMITATIONS
- Driving - switch brake to gas - wearing tennis shoes
- stairs - climb painful
- limited

CLINICAL LIMITATIONS

CLINICAL LIMITATIONS
see Dictation
3992393

GOALS

SHORT TERM GOALS/TIME FRAME

LONG TERM GOALS/TIME FRAME

PATIENT / FAMILY GOAL (INCL. PAIN) ☐ GOALS DISCUSSED WITH PATIENT/FAMILY
REHAB PROGNOSIS

PLAN

PLAN (RX FREQ, DURATION, EDUCATIONAL PLAN)

CERTIFICATION DATES
FROM TO
THERAPIST'S SIGNATURE Kristin Bruggeman PT DATE 4/20/05

I have reviewed this plan of treatment and recertify a continued need of services _____ Physician _____ Date

Covenant REHABILITATION SERVICES
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Facility _____
White – Medical Records Yellow - Clinic

Summary of Physical Medicine Evaluation

512 3/05 R9

STENCIL MORGAN L
DOB: 08/22/82 22 Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#: 10836690

APPEARANCE

APPEARANCE – EDEMA/REDNESS/CALLOUSES

CIRCUMFERENCE (IN CM)	LEFT	RIGHT
Malleolus		
FIGURE 8		
MTP Joint 1-5		

GAIT

GAIT DEVIATION

↓ WBon (R) LE (in stance) shift

ASSISTIVE DEVICES

ROM STRENGTH

HIP DEFICITS – MMT

KNEE DEFICITS – MMT

HIP/KNEE FLEXIBILITY DEFICITS

ANKLE / FOOT

LEFT AROM	LEFT PROM	LEFT MMT	MOTION	RIGHT AROM	RIGHT PROM	RIGHT MMT
13°		~~5/5~~ 5/5	ANKLE: DORSIFLEXION	-10°		NT
72°		5/5	PLANTARFLEXION	60°		✓
91°		5/5	EVERSION	10°		
32°		5/5	INVERSION	20°		✓
			1ST MTP: FLEXION (MP)			
			EXTENSION (MP)			

PALPATION: tenderness along lateral malleolar area, Achilles

SENSATION: Intact

VASCULAR STATUS

LOWER EXTREMITY ALIGNMENT (CIRCLE IF POSITIVE)

Hip: anteversion	L	R	retroversion	L	R				
Knee: valgus	L	R	varus	L	R	recurvatum	L	R	
Rearfoot (wt. bearing)	valgus	(L)	(R)	varus	L	R			
1st Ray plantar flexed	L	R							
Other:									

LIGAMENTOUS TESTS (CIRCLE IF POSITIVE):

Inversion stress	L	R
Eversion stress	L	R
Ant. drawer	L	R

PROPRIOCEPTION / BALANCE (SINGLE LEG STANCE TIME IN SECONDS)

Eyes Opened L NT R NT

Eyes Closed L _____ R _____

THERAPIST'S SIGNATURE/DATE: Heather Bergeron P.T.

Covenant HEALTHCARE

Sponsored by the Wheaton Franciscan Sisters

Facility: NT

PHYSICAL MEDICINE
OBJECTIVE FINDINGS
ANKLE/FOOT – PART B

WHITE – MEDICAL RECORDS YELLOW – CLINIC

285 4/03 R2

STENCIL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#: 108366880

D. **Assignment and Agreement to Pay:** I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to Facility and the physicians and professionals associated with the Facility, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of the Facility, the physicians and/or the professionals associated with the Facility. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.

E. **Valuables:** Keeping valuables (such as cash, jewelry, documents) in the Facility is strongly discouraged. I understand that the Facility has a place where my valuables may be stored. If I choose to keep valuables in the Facility, I do so at my own risk and I understand and agree that Facility is not liable for loss or damage to any valuables that I do not turn over for storage.

F. **Photographing:** I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety. If my care involves the delivery of a baby, I give consent for my baby to be photographed for security and/or personal use.

G. **Privacy Notice:** I acknowledge that I was provided with a copy of Covenant Healthcare's Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

Morgan Stencil — 4-20-05

Signature of Patient/Authorized Representative — Date

Relationship of Authorized Representative

If unable to sign document, state reason: _____

Covenant HEALTHCARE

A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

St. Francis Hospital
St. Michael Hospital
Elmbrook Memorial Hospital
St. Joseph Regional Medical Center

Inpatient and Outpatient Consent for Treatment & Financial Agreement

1820 2/03 R8

STENCIL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#: 10836680

BOX APPEARS ON.

Covenant Healthcare

Inpatient and Outpatient Consent for Treatment & Financial Agreement

☐ St. Joseph Regional Medical Center
☐ Elmbrook Memorial Hospital
☐ St. Michael Hospital
☐ St. Francis Hospital

Covenant Healthcare Hospitals have a number of ambulatory/outpatient sites that are covered by this Agreement.

A. **Consent for Treatment:** I am entering the above named facility (the "Facility") for the purpose of medical and/or surgical treatment or diagnosis. I consent to my physician, other attending, consulting and/or referring physicians and their assistants and designees, and other Facility personnel, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate by my physician. This consent includes my consent for hospital services, diagnostic procedures and all medical treatment rendered under the instructions of my physician(s) including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.

B. **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments in the Facility. I understand that many of the physicians on the Facility's staff are not employees or agents of the Facility but, rather, are independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients. I understand that the Facility is not liable for any actions or omission of, or the instructions given by, such independent contractors who treat me while I am in the Facility. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at the Facility. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care. I understand that I may review and obtain a copy my medical record, at my own expense, and that this review shall take place in the Facility, during regular business hours.

C. **Medicare Payments:** I acknowledge receipt of the "Important Message from Medicare," as applicable.

PATIENT LABELS MUST BE PLACED HERE ON ALL PAGES (PARTS) – SIDES OR FOLD-OUT (PANELS) THAT THIS BOX APPEARS ON.

REHABILITATION INTAKE

MEDICAL HISTORY

Do **YOU** have a history of: (Check, if yes)	Comments/Date
☐ Vision Problems (Do you wear glasses or contact lenses?)	
☐ Cancer	
☐ Diabetes	
☐ Low Blood Sugar	
☐ Heart Disease	
☐ Angina or Chest Pain	
☐ Pacemaker ☐ Implanted Stimulator ☐ Defibrillator	
☐ Shortness of Breath	
☐ Stroke	
☐ Osteoporosis	
☐ Asthma	
☐ Polio	
☐ Migraine Headaches	
☐ Arthritis	
☐ Hypertension or High Blood Pressure	
☐ Parkinson's Disease	
☐ Dizziness	
☐ Falls or Balance Problems	
☒ Fainting spells	
☐ Implanted metal	
☐ Bladder or bowel control issues	
☐ Are you pregnant now?	
☐ Other	

Please list all medications you are currently taking: none/

Please list any surgeries, hospitalization, and/or broken bones and the year they occurred: none

ALLERGIES

Are you allergic to: (circle those that apply)

Latex Bee Stings Shellfish Cortisone

Please list any allergies not listed above: _____

OTHER

Do you have an Advanced Directive? ☐ Yes ☒ No

if no, do you want information? ☒ Yes ☐ No

Advance Directive information given? (therapist to complete) ☐ Yes ☐ No

What is the best way for you to learn?

☐ Reading ☐ Listening ☐ Pictures ☒ Demonstration ☐ Video

☐ Other: _____

What is your goal regarding therapy? What do you hope to achieve? To reduce pain - strengthen ankle & knee

Therapist Signature: Kristen Brunelle PT Date: 4/29/05

Covenant REHABILITATION SERVICES

A member of Covenant Healthcare, which is sponsored by the Wheaton Franciscan and Felician Sisters

Rehabilitation Intake

81258 12/03

Facility: _____

STENCIL MORGAN L
DOB 08/22/82 22Y SEX F MR: 761361
SHIVARAM MYSORE S
ACCT# 10836680

FL ...TIONAL LIMITS/OUTCOME TOOL

Covenant REHABILITATION SERVICES

You have been referred to therapy for _____
Please look at the activity list below. Indicate how your condition affects your ability to perform these activities. Please circle the number that best applies to your ability.

1-No problem with activity
2-Can do with some difficulty
3-Can do with great difficulty
4-Cannot do

ACTIVITY	DATE: INITIAL Ability to Function	DATE: PROGRESS/DISCHARGE Ability to Function	DATE: PROGRESS/DISCHARGE Ability to Function
Sitting	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Standing	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Squatting	NA 1 (2) 3 4	NA 1 (2) 3 4	NA 1 2 3 4
Going Up or Down Stairs	NA 1 2 (3) 4	NA 1 (2) 3 4	NA 1 2 3 4
Walking	NA 1 2 (3) 4	NA 1 2 3 4	NA 1 2 3 4
Transferring Positions (Sitting to Standing, etc.)	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Sports/Recreation (Running, golfing, etc.)	NA 1 2 3 (4)	NA 1 2 3 (4)	NA 1 2 3 4
Driving a Vehicle	NA 1 (2) 3 4	NA (1) 2 3 4	NA 1 2 3 4
Lying Down	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Sleeping at Night	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Lifting/Carrying (Groceries, briefcase, etc.)	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Getting Dressed	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Daily Job Activities	NA 1 (2) 3 4	NA (1) 2 3 4	NA 1 2 3 4
Housework/Yard work	NA 1 (2) 3 4	NA (1) 2 3 4	NA 1 2 3 4
Reaching (Overhead, behind back, etc.)	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Gripping	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Flexing or Extending Arm/Elbow	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Fine Hand Activity	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Bathing	NA (1) 2 3 4	NA (1) 2 3 4	NA 1 2 3 4
Other No High heels	NA 1 2 3 (4)	NA 1 2 3 4	NA 1 2 3 4

TOTAL GOALS: 10 TOTAL MET: 5

Goals not achieved due to __ Attendance __ Continued Pain __ Further Medical Care __ Other _____

DIAGNOSIS (CHECK ALL THAT APPLY)

CERVICAL NS __ Srg __ LUMBAR NS __ Srg __ SHOULDER NS __ Srg __ HIP NS __ Srg __
KNEE NS __ Srg __ ELBOW/HAND NS __ Srg __ THORACIC NS __ Srg __ ANKLE/FOOT NS X Srg __
CVA __ STUDY DIAG __ OTHER NS __ Srg __

VISITS: 13

SITE: MAP __ RAWSON __ SMH __ SMBD __ VILLARD __ ELM __ ELM-WAUKESHA __ SJRMC __ SJOC __ OTHER

Therapist Signature Date

STENCIL MORGAN L
DOB: 08/22/82 22Y SEX: F MR: 761361
SHIVARAM MYSORE S
ACCT#:

0605574131 10/06/2003 03:11:22 PM #80990

ST. FRANCIS HOSPITAL
A MEMBER OF COVENANT HEALTHCARE

Account No: 10842045
Sched Date: 04/21/05 08:00 AM

MR#: 0761361

PATIENT INFORMATION

STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE WI 53218

Phone: 414 760-8743
DOB: 08/22/1982 Age: 22
Gender: F MS: MARRIED
SS#: 387-02-7121
Religion: NONE
Employer: AIDS RESOURCE CTR OF WI
Phone #: 414 273-1991
Occupation:

NEAREST RELATIVE

Name: STENCIL KEVIN
Phone: 414 760-8743
Bus Phone:
Relat: SPOUSE
Notify: Y

ADDITIONAL CONTACT

Name: POWELL BETTY
Phone: 414 344-5280
Bus Phone:
Relat: PARENT
Notify: Y

VISIT INFORMATION

Admit Reason: RIGHT ANKLE
Comment: KFS

Visit Type: R
Location: SPORTS MEDICINE#
Last Inp Date:
Last Outpt Date: 04/20/05

INTERPRETER NEEDED: NO
Language: ENGLISH

PHYSICIAN INFO

Adm:
Att: SHIVARAM MYSORE S
PCP: MODY RITA D

INSURANCE INFORMATION

PRIMARY: UNITED HEALTHCARE
Plan: STANDARD
PO BOX 740800
ATLANTA GA 30374
Phone #: 877 842-3210
Subr: STENCIL MORGAN L
Relat: PATIENT IS INSURED -
Policy#: 941429779
Group#: 4R8097
Group Name: AIDS RESCOURCE

GUARANTOR INFORMATION

Name: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE WI 53218-0000

Phone #: 414 760-8743
SS#: 387-02-7121
Employer: AIDS RESOURCE CTR OF WI
Phone #: 414 273-1991

PRINTED COPY Date: 06/27/05 Time: 01:54 PM

C

Mysore S. Shivaram, M.D.
Orthopedic and Hand Surgeon

PT/OT ORDER FORM

Patient Name: Morgan Stencil Date: 4-4-05

Diagnosis: Shoulder Rainkle

Treatment Frequency:

_____ Daily ✓ Two times a week _____ Three times a week _____ Other

Treatment Duration: 1 2 (3) 4 5 6 7 8 9 10

_____ Days _____ Weeks _____ Sessions

_____ PT Only
_____ PT with concurrent or progression to OT

_____ Evaluation
_____ Evaluation and Treatment

_____ OT Only
_____ OT WCP (PT as needed)

_____ Evaluation
_____ Evaluation and Treatment
_____ FCE Only

Modalities/Procedures:

✓ Ultrasound
_____ Phonophoresis
_____ Whirlpool/Contrast Bath
_____ Mobilization
_____ Massage/Myofascial Release
_____ Electrical Stimulation
_____ Hot Pack/Cold Pack
_____ Iontophoresis
_____ Mechanical Traction

Modalities/Procedures

_____ Desensitization/Massage
_____ Ultrasound
_____ Phonophoresis
_____ Fluidotherapy
_____ Paraffin
_____ Electrical Stimulation
_____ Hot Pack/Cold Pack
_____ Splint Fabrication
_____ Mobilization

Therapeutic Exercise:

✓ ROM _____ AROM _____ AAROM _____ PROM
✓ Strengthening
_____ Stretching
_____ Lido Isokinetic Exercise/Testing
_____ Work Simulation

Educational Programs:

_____ Back Education
_____ Neck Education
✓ Home Exercise Program

Precautions/Comments: _____

_____, M.D.

A1766 1M X9433 (Rev. 3/96)

ST. FRANCIS HOSPITAL
A MEMBER OF COVENANT HEALTHCARE

Account No: 10836680
Sched Date: 04/20/05 11:15 AM

MR#: 0761361

PATIENT INFORMATION

STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE WI 53218

Phone: 414 760-8743
DOB: 08/22/1982 Age: 22
Gender: F MS: MARRIED
SS#: 387-02-7121
Religion: NONE
Employer: AIDS RESOURCE CTR OF WI
Phone #: 414 273-1991
Occupation:

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Last Outpt Date:

INTERPRETER NEEDED: NO
Language: ENGLISH

PHYSICIAN INFO

Adm:
Att: SHIVARAM MYSORE S
PCP: MODY RITA D

INSURANCE INFORMATION

PRIMARY: UNITED HEALTHCARE
Plan: STANDARD
PO BOX 740800
ATLANTA GA 30374
Phone #: 877 842-3210
Subr: STENCIL MORGAN L
Relat: PATIENT IS INSURED -
Policy#: 941429779
Group#: 4R8097
Group Name: NONE

GUARANTOR INFORMATION

Name: STENCIL MORGAN L
7801 W WINFIELD
MILWAUKEE WI 53218-0000

Phone #: 414 760-8743
SS#: 387-02-7121
Employer: AIDS RESOURCE CTR OF WI
Phone #: 414 273-1991

PRINTED COPY Date: 04/14/05 Time: 04:28 PM

C

MORGAN STENCIL, f/k/a MORGAN POWELL
ACCIDENT OF 11/05/2004
CITY OF MILWAUKEE SERVICE REFERRAL

CITY OF MILWAUKEE
INFRASTRUCTURE
ENVIRONMENTAL ENGINEERING
SEWER MAINTENANCE

SERVICE REFERRAL RECORD

Dispatched Location: 820 N. PLANKINGTON Ave
Received:(Date): 11-5-04 (Time): 11:40 (From): HALL
Contact:(Person): KARI BAKER Phone #: 225-1565

FIELD INVESTIGATION

Time Arrived: 11:20 Am Crew #: 2 Investigator: DUCK Assisted by: STIBBE
Dispatched Location: 820 N. PLANKINGTON Ave
(circle one)

Subject: (LIDS & GRATES) LOST ITEMS CHECK CONNECTION ODOR
CAVE-IN (Dye Test: Pos Neg) OTHER (explain in Action Required below)

LOCATION

Street Location (NW NE SW SE) Corner On: _____
At (Address or Intersecting Street): _____
Alley Location: (BEHIND ALONGSIDE) Of: _____

Action Required: BARRICADES, Comm. Lids - BROKEN ON SITE
Barricaded: (YES) NO SITE IS BARRICADED

REFERRED TO (circle one)

Large Crew Hand Crew Mason CCTV Jet Jet-Vac Rodder Vac-All Crane Bucke

FOLLOW-UP INFORMATION

SEWER MAIN WORK

(circle one)
SEWER TYPE: SAN STORM COMB Size: _____ Depth: _____
CCTV Exam # _____ CCTV Video # _____ Microfiche # _____
Section Requiring Work: From Manhole # _____ to Manhole # _____

CLEANED by Cleaning Crew # _____
Start Date: _____ Footage Cleaned: _____
Debris: _____ Complete Date: _____

REPAIR by Large Digging Crew # _____
Start Date: _____ Backfilled: _____
Closed: _____ Type of Repair: _____

STRUCTURE WORK

(circle one)
Structure Type: Catch Basin Storm Inlet Sewer Manhole Drain Communications Manhole

CLEANED by Cleaning Crew # _____
Start Date: _____ Number Cleaned: _____
Debris: _____ Complete Date: _____

REPAIR by Crew # _____ & Mason Crew # _____
Start Date: _____ Backfilled: _____
Closed: _____ Type of Repair: _____

HOTLINE INFORMATION

Start Date: _____ Start Time: _____ Ticket Number: # _____
Marking Instructions: _____

Comments: A 4'x2' ALARM SYSTEM L/D [redacted] BROKE BY CURB LINE. A PERSON WAS INJURED. SHE SPRAINED HER ANKLE. HER NAME IS MORGAN POWELL PH 225-1524 SHE TALKED TO STEVE SITBURGER AND HE COULD DROP FOR[illegible]
ALARM FUELS FOR FAMILY