

IN THE SUPREME COURT OF THE STATE OF NEVADA

ALBERT H. CAPANNA, M.D.,
Appellant/Cross-Respondent,

vs.

BEAU R. ORTH,
Respondent/Cross-Appellant.

ALBERT H. CAPANNA, M.D.,
Appellant,

vs.

BEAU R. ORTH,
Respondent.

Case No. 69935

District Court Case No. A648041

Electronically Filed
Aug 08 2017 11:49 a.m.
Elizabeth A. Brown
Clerk of Supreme Court

Case No. 70227

**APPENDIX TO RESPONDENT/CROSS-APPELLANT'S
COMBINED OPENING AND ANSWERING BRIEF**

VOL. 1 PART 2

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Pain Management Procedure Record

Time	B.P.	Pulse	SaO2	Time	Nurse's Notes
1032	113/67	58	92	1032	Rec'd pt. to Room via gurney. Pt. appears
1037	112/62	70	94-95	1037	VSS. No distress. Appears well. Vitals OK!
1042	131/70	68	98	1037	Hob up. VSS. H. Waking up. Denies needs.
1047	143/73	67	96	1042	1040. T.H. up. Ep. T.C.B. Tol. No fluids.
me	Meds	Sits	RN	1047	VSS. Dressed self. Status "feels good."
				1054	Stitch to chest. Tol Sore Throat.
				1115	R: status. Not ready to go. H. Stable. V. well.
					Steady diet + stable. Both vitals. Undisturbed.

DISCHARGE

Tol P.O. fluids well

D/C criteria met

Cleared for D/C by MD

☐ IV D/c'd

☐ Ambulatory

☐ Wheelchair

Injection Site Condition: good

Pain Level: 1/10

Time Discharged: 1115

RN: [Signature]

POST-PROCEDURE CONTACT REPORT

ate: 5/14/14 ☒ Letter Sent ☐ Phone

omplications: ☐ Yes ☒ No

N: [Signature]

POST-ASSESSMENT

ARDIOVASCULAR

Heart Sounds: audible, distant

Peripheral Pulses: equal, unequal, weak

bounding, absent

Veins: distended, flat

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent

Respirations: no distress, sob, labored, accessory muscles used

Cough: absent, non-productive, productive

EUROLOGICAL

CC: alert, lethargic, unresponsive

orientation: oriented, disoriented

pupils: equal, unequal, reactive, unreactive

INTEGUMENTARY

Skin Color: pink, pale, cyanotic, jaundice

Skin Temperature: warm, dry, cool, clammy, diaphoretic

Skin Turgor: loose, tight

Mucous Membrane: moist, dry, cracked

ASTROINTESTINAL

abdomen: soft, firm, hard, flat, distended

bowel Sounds: absent, present

BEHAVIOR

Cooperative: restless, withdrawn, crying, talkative, resistive

combative, calm & relaxed, anxious, fearful

Beau/Dustin

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117 • 702 933-3600

Patient Name:

Beau R Orth

956

DISCLOSURE AND CONSENT TO OPERATION OR OTHER SPECIAL PROCEDURES

To the patient: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping condition. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used to that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

GENERAL CONSENT & CONDITIONS: I (we) hereby authorize and understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize Anthony Mym C. Ruggieri MD surgeon, and/or such assistant(s) as may be selected by him/her to perform: Lumbar sacral facet with radiofrequency under
fluoroscopy

My physician has explained the procedure(s) necessary to treat my condition, possible risks and consequences associated with this/these procedure(s). I understand this explanation is not exhaustive and other risks and consequences may arise. No guarantee(s) or assurances have been made to me as to the result or cure. I feel comfortable with the information I have received and therefore give my informed consent.

If any presently unforeseen condition arises or is discovered during the course of this/these operation(s) or procedure(s), I authorize and request the performance of such operation(s) or procedure(s) in addition to or different from those now contemplated which my physician or associate(s) or designer(s) consider necessary or advisable in the exercise of his/her professional judgement.

In the event that a transfer is required to a local hospital, I understand and authorize Surgical Arts Center to release photocopies of Medical Records to that hospital. Photocopies will include but is not limited to, patient history, physical exam reports, physicians' and nurses' notes, lab and X-ray reports. I also give consent for the hospital to give Medical Records to Surgical Arts Center.

If it is necessary to remove any body material, I hereby authorize Surgical Arts Center to use their discretion in its disposal.

INDEPENDENT STATUS OF PHYSICIANS: I understand that physicians on the staff of this Center may be employees or independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients.

Surgical Arts Center is owned by Dr. Steven Thomas and Dr. Michael McKenna who also perform procedures at this facility.

ANESTHETICS: I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the anesthesia.

CONSENT TO DRAW BLOOD: I, the undersigned, do hereby consent to the withdrawal of a blood sample from my body in the event of a Medical Emergency or in the event that an employee or physician of Surgical Arts Center has had an accidental needle puncture or mucus membrane (eye, mouth, etc.) exposure to my blood or of a body fluid.

OBSERVERS: I consent for a health care representative to be present during the procedure as deemed necessary.

I understand that from time to time the Surgical Arts Center and its medical staff participate in medical training programs, under the supervision of a physician. For the purpose of advancing medical education. I consent to the admittance of medical observers to the operating room.

PHOTOGRAPHY: I understand that Surgical Arts Center and my physician may photograph certain parts of the procedure and use the negatives or prints for the purposes as may be deemed necessary. I consent to the photographing of the operation or procedure to be performed.

PERSONAL VALUABLES: I release the Surgical Arts Center from all responsibility relative to the loss and/or damage to property, money or valuables which are not deposited with the surgical center for safe keeping.

ADVANCE DIRECTIVES: I understand that it is my responsibility to share information with Surgical Arts Center concerning my Advance Directives if one exists.

DISCHARGE AGREEMENT: I have been informed and understand that it is absolutely necessary for someone to accompany me home after surgery. I understand that I cannot drive myself home and must be discharged into the care of and driven from the outpatient surgery center by another responsible adult.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Patient or other legally responsible person

Relationship

Witness to Signature

Date

Time

SAC-100 (5-2009)
1394

P00373
R.App. 000114

Patient Safety & Identity/Procedure/Site Verification/Check-List

Pre-operative:

- ☒ Preop area disinfected according to protocols
- ☒ Patient states two identifier's ☐ Name ☒ DOB ☐ Other: _____ ☐ G8916 IV Antibiotic
- ☒ Patient's responses match ID band
- ☒ Patient states procedure, site, side, and physically identifies same. ☒ G8918 No IV Antibiotic
- ☒ Consent matches patient stated responses, physician's orders, or schedule and H&P.
- ☒ Medical record relevant data, i.e. H&P, matches patient stated responses.
- ☒ Preop orders from physician were followed.
- ☒ Discharge instructions given to patient.
- ☒ Site is marked yes & initialed by Physician (N/A for Pain Management and Cosmetic Procedures)
- Discrepancy Noted: YES ☒ NO ☐ If Yes, Explain: _____
- Discrepancy Resolution _____
- Resolution Communicated to Team. R.N.: X Carson RN

Intra-operative:

- ☒ Confirm all Team members introduced themselves by name & role
- ☒ OR area disinfected according to protocols
- ☒ Confirmation of: patient identity, procedure, consent, site and positioning, and any patient concerns
- ☒ Radiographs / Implants / Special Equipment availability & concerns, sterility confirmed.
- ☒ "Time Out" @ 7:01 to Verify: any critical / unexpected steps / anticipated blood loss.
 - ☒ Correct patient ☒ Patient Allergies
 - ☒ Correct site ☒ Difficult Airway / Aspiration Risks yes/no
 - ☒ Correct procedure ☒ Risk of blood loss > 500ml yes/no
 - ☒ Appropriately displayed x-rays on correct patient
 - ☒ Staff Participating in "Time Out" are same Surgeon, Anesthesiologist, Circulating Nurse, and Scrub Tech documented on OR record
- ☒ Otherwise List: _____
- ☒ Antibiotics given within last 60 minutes
- Discrepancy Noted: YES ☒ NO ☐
- Explain: _____
- Discrepancy Resolution _____
- Resolution Communicated to Team. R.N.: [Signature]
- ☒ Name of procedure recorded
- ☒ Instrument, sponge, & needle count are correct (N/A)
- ☒ Surgeon, Anesthesiologist, & Nurse review key concerns for recovery and management of patient.

PACU:

- ☒ PACU area disinfected according to protocols ☒ G8907 No Adverse Event
- ☒ Confirm patient identity via arm band/chart ☐ Adverse Event
- ☒ Discharge instructions given to patient and hard copy sent home with patient ☐ G8908 Burn ☐ G8910 Fall
- ☒ Postoperative orders from Physician were followed. ☐ G8912 Wrong site. ☐ G8914 Hosp Txf
- ☒ Consent and procedure documented on OR record match within scope of related procedures. YES ☒ NO ☐
- If "No", Explain: _____
- Surgeon Notified of Discrepancy R.N.: [Signature]

s Notes Continued:

Pain Management Patient Care Plan

ing Diagnosis	Goal	Plan	Implementation	Comments
to lack je concerning Pain nent procedure	Patient will acknowledge understanding of proposed procedure prior to the performance of the procedure	Provide explanation regarding proposed procedure	Communicate with patient and family regarding specific procedure and answer any questions	Satisfactory
to lack pre- e preparation	Prepare patient for the procedure in the safest manner possible	Assess patient for drug allergies, NPO status, current medications (including blood thinners), smoking habits and alcohol consumption; check blood sugar on all diabetics and breath sounds on all thoracic patients, and any other pertinent information that could affect the outcome of the procedure	Patient interviewed and history taken; H&P reviewed; results of pre-operative testing reviewed when ordered	Unsatisfactory Satisfactory
	Reduce anxiety	Answer questions and provide comfort	Establish rapport with patient and family; answer questions and provide comfort measures	Unsatisfactory Satisfactory
or correct e site	Prevention of incorrect procedure site	Verify procedure site, check schedule and chart; obtain consent	Visually and verbally verify procedure site with patient; obtain written consent	Satisfactory Unsatisfactory
Discharge	Patient will possess sufficient discharge knowledge to ensure a smooth transition from Surgical Arts Center to home	Complete discharge instructions specific to procedure gone over with patient	Discharge instructions specific to procedure will be gone over allowing the patient to ask questions and restate the instructions	Satisfactory Unsatisfactory

PRE-OP NURSE SIGNATURE: _____

PERIPROCEDURE

ing Diagnosis	Goal	Plan	Implementation	Comments
Injury to patient	Pl. will not acquire injury perioperatively	Maintain patient safety and comfort	Greet pt; verify arm band, consent, site, allergies and any other pertinent information; encourage questions; position patient appropriately; monitor pt.	Satisfactory Unsatisfactory

PROCEDURE NURSE SIGNATURE: _____

PACU STANDARDS OF CARE

ing Diagnosis	Goal	Plan	Implementation	Comments
for Injury	Pl. will not acquire injury in PACU	Maintain patient safety and comfort	Pl. assessment; vs q 5 min x 3 or until stable using appropriate intervention if necessary; offer & encourage nourishment; maintain preop musculoskeletal system level of function; discharge after instructions given and criteria met.	Satisfactory Unsatisfactory

PACU NURSE SIGNATURE: _____

Surgical Arts Center
702-933-3600
fax 702-933-3601
9499 W. Charleston Blvd, Las Vegas, NV 89117

VALUABLES

These items have been taken from me and placed into the security envelope:

These items have been left in my possession:

cell phone

☐ I have no valuables/jewelry/money with me today

Patient Signature: [Signature]

Witness: [Signature]

Date: 5/19/14 Time: 09:20

I ACKNOWLEDGE RECEIPT OF THE ITEMS PLACED IN THE SECURITY ENVELOPE:

SIGNATURE: _____

RELATIONSHIP: _____

WITNESS: _____

Date: _____ Time: _____

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

05/14/2014

1407
P00376
R.App. 000117

Surgical Arts Center
9499 W. Charleston #250
Las Vegas, NV 89117
(702) 933-3500

Dr Ruggeroli
Pain Management Orders

Pre-Procedure Orders:

- noted
5/14/14*
1. Obtain appropriate consent
 2. Start hepllock unless patient requests no IV access
 3. Vital signs BP/P/SAO2
 4. O2 2-8L/min. nasal cannula or mask PRN
 5. Urine HCG if indicated
 6. Accucheck on all diabetic patients.
 7. Additional Orders:

Procedure Orders:

- Noted
5/14/14*
1. O2 2-8L/min nasal cannula or mask prn
 2. Versed 3 mg IV
 3. Fentanyl 150 mcg IV
 4. Propofol 50 mg IV
 5. Alfenta _____ mcg IV
 6. Romazicon _____ mg IV
 7. Additional Orders:

Post Procedure Orders:

- Noted
5/14/14*
1. Vital Signs q 5 minutes until stable
 2. Diet as tolerated
 3. DC IV or hepllock before discharge
 4. Provide and review written copy of post procedure instructions including medications and restrictions
 5. Discharge patient when all criteria met.
 6. Additional orders:

Physician Signature _____

Date 5/14/14

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

05/14/2014

DISCHARGE INSTRUCTIONS

The injection you received contained the local anesthetic and possibly a steroid medication (this type of steroid and dose amount helps to reduce inflammation resulting in the reduction of pain). THIS IS NOT A MUSCLE BUILDING KIND OF STEROID. You should experience a decrease in your everyday pain as well as some numbness due to the local anesthetic which can last from 2 to 8 hours, possibly longer. NOTE: You may have some pain at the injection site and/or a temporary increase in your everyday pain, however both should return to normal in 1-2 days. Most patients find that the use of an ice pack and heating pad along with resting will help to lower your pain symptoms. Please refer to your doctor's instructions for limitations of activities if any and any changes or additions with your medication(s). REMEMBER it may take up to a full week after the injection of steroid medication to note the effect/benefit. Therefore after the local anesthetic wears off, you most likely will experience your normal pain until the steroid medication has its effect.

- ☒ Keep your follow-up appointment as scheduled by your physician's office.
☒ Medication instructions. Take medications as prescribed or discussed with physician.
☒ Call your physician's office/answering service if you have an emergency related to the injection such as:
- Severe headache and/or seizures.
 - Loss of ability to feel or move your arms or legs.
 - Infection (redness, swelling, drainage or fever greater than 101.5F)
 - Heavy pressure over the chest or palpitations (rapid heart beat)
 - Bleeding at the injection site that is not stopped within 15 minutes of direct pressure
 - Difficulty breathing and/or speaking.
 - Adverse reaction to the medication given
 - Chills and/or sweating

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, GO TO THE NEAREST EMERGENCY ROOM. URGENT CARE OR CALL 911.

SPECIFIC INSTRUCTIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

- | | |
|---|--|
| <input type="checkbox"/> EPIDURAL INJECTION | <input type="checkbox"/> SELECTIVE NERVE ROOT BLOCK |
| <input type="checkbox"/> LUMBAR SYMPATHETIC BLOCK | <input type="checkbox"/> FACET JOINT AND/OR MEDICAL BRANCH BLOCK |
| <input type="checkbox"/> SACROILIAC JOINT INJECTION | <input type="checkbox"/> INTRATHECAL INJECTION |

You may experience some weakness in the arms or legs for several hours after the injection. Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities until the numbness has completely worn off and your full strength has returned.

☐ DISCOGRAM: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. You may experience soreness in the injection area. Ice will help to decrease inflammation. Take your pain medication as ordered by your physician. If a high fever (101.5 F or greater) occurs, please call your physician or go to the Emergency room or urgent care if you are unable to contact your doctor and/or the fever does not subside.

☐ STELLATE GANGLION BLOCK: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. It is normal for your eyelid to drop, to have blurred vision, hoarseness and/or to have numbness and weakness (to include your arm) on the side of the injection. These feelings should subside in 6 to 8 hours.

☐ TRIGGER POINT INJECTIONS ☐ INTERCOSTAL/PERIPHERAL NERVE BLOCK ☐ JOINT INJECTION
Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. The area where you have been experiencing pain will most likely be numb. Limit strenuous activity to avoid straining muscles which haven't been used in a while. It is good to stretch that muscle which will help the pain to stay away. If any shortness of breath occurs, please call your physician.

☒ RADIOFREQUENCY / RF OR ☐ TRIAL SPINAL CORD STIMULATOR / TSCS: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. You may experience more pain or discomfort after the procedure. It may take 2 to 3 weeks before you experience total relief of these symptoms.

☒ During your recovery period after your injection, to help reduce pain and increase mobility, try stretching exercises and/or apply heat or ice (or alternate heat and ice. Use ice for a maximum of 20 minutes at a time with at least 30 minutes before using ice again.)

SOME OF THE MEDICATIONS YOU RECEIVED MAY HAVE THE POTENTIAL FOR CAUSING DROWSINESS AFTER YOU LEAVE. DO NOT DRIVE A VEHICLE, OPERATE HEAVY MACHINERY, DRINK ANY ALCOHOLIC BEVERAGES OR SIGN ANY LEGAL DOCUMENTS FOR 24 HOURS. IN ADDITION, PLEASE USE CAUTION IN YOUR ACTIVITIES AT HOME.

☒ Copy given to patient

DATE: 5.14.14

TIME: 9:30 AM/PM

Patient Signature

Witness Signature

Discharged to:

SURGICAL ARTS CENTER
9499 W. Charleston, Suite 250
Las Vegas, Nevada 89117

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

05/14/2014

Pain Management Discharge Instructions

Surgical Arts Center
9499 W Charleston Blvd Suite 250 Las Vegas, NV 89117-7148
7029333800 Fax: 7029333801

April 22, 2014
Page 1
Chart Document

Beau R Orth

Male DOB:

10870

04/16/2014 - Operative Report
Provider: Anthony C Ruggeroli
Location of Care: Surgical Arts Center

Date of Procedure: 04/16/2014

Procedure Performed At: Surgical Arts Center

Patient: Orth, Beau

Preoperative Diagnosis: 1) LUMBAR SPONDYLOSIS/FACET BASED PAIN (ICD-721.3)

Postoperative Diagnosis: 1) **LUMBAR SPONDYLOSIS/FACET BASED PAIN (ICD-721.3)

Procedure(s):
1) left L4-5 facet joint injection
2) left L5-S1 facet joint injection
3) fluoroscopic needle localization / guidance and spinal exam
4) intravenous conscious sedation, moderate

Medications: lidocaine 1%, bupivacaine 0.75%, depomedrol 40mg/ml, Omnipaque 180, midazolam

Performing Physician: Anthony C. Ruggeroli, M.D.

Complications: NONE

Description of the procedure: After informed consent was verified, the patient was brought to the fluoroscopy suite, and was placed in the prone position. Triple betadine skin prep was accomplished over the lumbosacral area, and sterile drapes were applied. Non invasive monitoring was placed, including BP, pulse oximetry, and EKG, and was continued throughout the remainder of the case. Positioning comfort was verified with the patient and adjusted/modified as necessary.

Incremental doses of the sedative was administered intravenously for anxiolysis; the patient remained cooperative and responsive to voice throughout the remainder of the procedure. Refer to nursing record for total dose utilized.

C-arm fluoroscopy was then used to identify lumbar segments L4-5 and L5-S1, and angulated obliquely, and as necessary, to optimize image detail of the superficial aspects of the left L4-5 and L5-S1 facet joints. Skin wheals were then raised over the joint spaces using approximately 0.5 ml of 1% lidocaine per joint. Next, styletted 22ga needles were used to penetrate the skin, and were advanced towards the joint spaces. The capsules were penetrated and the needles were slightly advanced. Approximately 0.25ml of omipaque 180 was injected through each needle, where partial filling of the joints was observed without vascular uptake. Next, a solution was prepared comprising of a mixture of depomedrol 40mg/ml and 0.75% bupivacaine, one to one. 0.5ml of that solution was injected into each joint without patient complaint and the needles were removed intact.

Surgical Arts Center
8499 W Charleston Blvd Suite 250 Las Vegas, NV 89117-7148
7029333600 Fax: 7029333601

April 22, 2014
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Chart Document

Beau R Orth
Male DOB:

10870

****The patient was examined and questioned prior to discharge. His range of motion was restored and he noted none of the typical and presenting left lumbosacral pain.**

The patient tolerated the procedure well and was discharged without complication or incident.

The patient will see me back in follow up as scheduled and will track pain scores and function in the interim.

Anthony C. Ruggeroli, M.D.

CC to: Andrew Cash, MD

Electronically signed by Anthony C Ruggeroli on 04/21/2014 at 9:05 AM

McKenna, Ruggeroli and Helmi Pain Specialists
6070 S Fort Apache Road Suite 100 Las Vegas, NV 89148-5615
7023077700 Fax: 7023077942

April 15, 2014
Page 1
Chart Document

Beau R Orth
Male DOB:

10870

04/10/2014 - Office Visit: Follow up visit
Provider: Anthony C Ruggeroli
Location of Care: McKenna, Ruggeroli and Helmi Pain Specialists

History of Present Illness

Reason for visit: follow up from procedure
Chief Complaint: left lumbar and leg pain

Past Medical History

Back Problems
The patient denies any contributory past medical history.

Surgeries

Shoulders/Arms
low back surgery X2

Family History

The patient denies any contributory family medical history.
The patient denies any contributory family medical history.
Current Allergies (reviewed today):
PENICILLIN V POTASSIUM (PENICILLIN V POTASSIUM) (Critical)

Social History/Risk Factors

Work status: working
Daily activities: bending/squatting, lifting/pushing/pulling, repetitive movements, moderate to heavy physical labor/activity
Regular Exercise? yes
Alcohol use: 1-3 drinks per week
Tobacco use: never smoker
Drug use: no
Last bone density test: never
Prior treatment for bone density? no
Handedness: right
Height: 73
Weight: 230

Pain Follow-Up

Average pain since last visit: 6
Side effects from pain medications: no
New medication since last visit: no

Tobacco Use: never smoker

ADL

Present work status: regular, full time
Number of work days missed since last visit: 0
ER visit for pain since last visit: no

McKenna, Ruggeroli and Helmi Pain Specialists
6070 S Fort Apache Road Suite 100 Las Vegas, NV 89148-5615
7023077700 Fax: 7023077942

April 15, 2014
Page 2
Chart Document

Beau R Orth

Male DOB:

10870

Review of Systems

General: Complains of fatigue.

Ears/Nose/Throat: Denies decreased hearing, difficulty swallowing.

Cardiovascular: Denies chest discomfort, swelling of hands/feet, racing heart beat, weight gain, palpitations, blackouts/fainting, shortness of breath with exertion/activity, difficulty breathing while lying down.

Respiratory: Denies wheezing, coughing-up blood, cough.

Musculoskeletal: Complains of joint swelling, joint pain, stiffness, back pain.

Skin: Denies night sweats, dryness, suspicious lesions, changes in nail beds, changes in skin color, poor wound healing.

Neurologic: Complains of headaches, numbness, tingling.

Psychiatric: Denies anxiety, depression, claustrophobia.

Endocrine: Denies cold intolerance, heat intolerance, excessive thirst, excessive urination.

Heme/Lymphatic: Denies persistent infections, seasonal allergies.

Patient provided the above responses and/or history obtained.

Physical Exam

Vital Signs

Height: 73 inches

Weight: 230 pounds

Blood Pressure: 118/78 mm Hg

Calculations

Body Mass Index: 30.45

BMI out of Range, Nutritional Counseling given: yes

Lower Extremity Exam

Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsi flexion, knee extension, and hip flexion against resistance is without deficit bilaterally.

Deep Tendon Reflexes:

Knees: Right: normal Left: absent

Ankles: Right: normal Left: decreased

Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:

Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:

Right: normal; S1 / L5 / L4 / L3 dermatomes intact

Left: S1 diminished

Lumbosacral Exam

Gross Exam Lumbosacral: surgical scar or other scar present

McKenna, Ruggeroli and Helmi Pain Specialists
6070 S Fort Apache Road Suite 100 Las Vegas, NV 89148-5615
7023077700 Fax: 7023077942

April 15, 2014
Page 3
Chart Document

Beau R Orth

Male DOB:

10870

Palpation of Lumbosacral Soft Tissues:

Right: Lumbosacral tender

Left: Mid tender, Lumbosacral tender

Lumbar Range of Motion:

extension limited with pain, rotation limited with pain

Assessment:

New Problem(s) added today:

LUMBAR SPONDYLOSIS/FACET BASED PAIN (ICD-721.3)

New Problem(s) Assessed Today:

Status post left S1 and L5-S1 transforaminal epidural steroid injections; no significant benefit noted. He reports that the left lower extremity pain is much more tolerable vs the lumbar pain. The exam and diagnostic studies are consistent with posterior element pain, (facet joint related), and I think that for diagnostic and or therapeutic purposes, facet joint injections are reasonable and medically necessary at this time. If he has a clear positive response, but short lived, he would be a good candidate for radio frequency thermal coagulation. This is a reasonable non surgical option to treat his chronic pain condition, he has not responded to medications and physical therapy.

Current Medication List:

NEURONTIN 300 MG CAPS (GABAPENTIN) one PO TID for nerve pain as tolerated , start qhs
AMITRIPTYLINE HCL 10 MG TABS (AMITRIPTYLINE HCL) one to three PO qhs as needed for sleep

Plan:

left L5-S1 and L4-5 facet joint injections

DEPO

EXAM BY ME

follow up in office in two weeks for post injection and condition reassessment

patient to discuss condition with Dr. Cash, consider dorsal column stimulator trial if no improvement

Discontinued Medication(s):

NEURONTIN 300 MG CAPS (GABAPENTIN) one PO TID for nerve pain as tolerated , start qhs
AMITRIPTYLINE HCL 10 MG TABS (AMITRIPTYLINE HCL) one to three PO qhs as needed for sleep

Electronically signed by Anthony C Ruggeroli on 04/14/2014 at 4:50 PM

1415
P00383
R.App. 000124

PAIN MANAGEMENT CHART AUDIT

EACH CHART SHALL BE AUDITED FOR COMPLETENESS AND SHALL BE COMPLETE PRIOR TO BEING FILED FOR STORAGE

EACH ITEM SHALL BE CHECKED AS COMPLETE OR INDICATED AS N/A

LEFT SIDE OF CHART:

- A. PATIENT SUMMARY SHEET
- B. PATIENT FACE SHEET
- C. HIPAA RECEIPT ACKNOWLEDGMENT
- D. RESUSCITATIVE MEASURES

RIGHT SIDE OF CHART:

- E. CONSENT FOR PROCEDURE
- F. HISTORY & PHYSICAL
- G. OPERATIVE REPORT
- H. MEDICATION RECONCILIATION
- I. PROCEDURE RECORD
- J. SITE VERIFICATION
- K. VALUABLES SHEET
- L. PHYSICIAN'S ORDERS/ SIGNATURE
- M. LABORATORY REPORTS
- N. DISCHARGE INSTRUCTIONS
- O. INITIAL PRE-ANESTHETIC RECORD

SIGNATURE



DATE

4/26/14

☒ Check name sticker on chart to verify date currently seen

☒ Check Year sticker

25633 M
Anthony Mjm C Ruggeroll MD
Orth Beau R

04/16/2014

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117 • 702 933-3600

Patient Name:

beau R Orth

9:20

DISCLOSURE AND CONSENT TO OPERATION OR OTHER SPECIAL PROCEDURES

To the patient: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping condition. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

GENERAL CONSENT & CONDITIONS: I (we) hereby authorize and understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize Anthony M. C. Ruggeroli MD surgeon, and/or such assistant(s) as may be selected by him/her, to perform: lumbar sacral facet joint injection with steroid under fluoroscopy

My physician has explained the procedure(s) necessary to treat my condition, possible risks and consequences associated with this/these procedure(s). I understand this explanation is not exhaustive and other risks and consequences may arise. No guarantee(s) or assurances have been made to me as to the result or cure. I feel comfortable with the information I have received and therefore give my informed consent.

If any presently unforeseen condition arises or is discovered during the course of this/these operation(s) or procedure(s), I authorize and request the performance of such operation(s) or procedures(s) in addition to or different from those now contemplated which my physician or associate(s) or designee(s) consider necessary or advisable in the exercise of his/her professional judgment.

In the event that a transfer is required to a local hospital, I understand and authorize Surgical Arts Center to release photocopies of Medical Records to that hospital. Photocopies will include but is not limited to, patient history, physical exam reports, physicians' and nurses' notes, lab and x-ray reports. I also give consent for the hospital to give Medical Records to Surgical Arts Center.

If it is necessary to remove any body material, I hereby authorize Surgical Arts Center to use their discretion in its disposal.

INDEPENDENT STATUS OF PHYSICIANS: I understand that physicians on the staff of this Center may be employees or independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients.

Surgical Arts Center is owned by Dr. Steven Thomas and Dr. Michael McKenna who also perform procedures at this Facility.

ANESTHETICS: I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the anesthesia.

CONSENT TO DRAW BLOOD: I, the undersigned, do hereby consent to the withdrawal of a blood sample from my body in the event of a Medical Emergency or in the event that an employee or physician of Surgical Arts Center has had an accidental needle puncture or mucus membrane (eye, mouth, etc.) exposure to my blood or of a body fluid.

OBSERVERS: I consent for a health care representative to be present during the procedure as deemed necessary.

I understand that from time to time the Surgical Arts Center and its medical staff participate in medical training programs, under the supervision of a physician, for the purpose of advancing medical education. I consent to the admittance of medical observers to the operating room.

PHOTOGRAPHY: I understand that Surgical Arts Center and my physician may photograph certain parts of the procedure and use the negatives or prints for the purposes as may be deemed necessary. I consent to the photographing of the operation or procedure to be performed.

PERSONAL VALUABLES: I release Surgical Arts Center from all responsibility relative to the loss and/or damage to property, money or valuables which are not deposited with the surgical center for safe keeping.

ADVANCE DIRECTIVES: I understand that it is my responsibility to share information with Surgical Arts Center concerning my Advance Directives if one exists.

DISCHARGE AGREEMENT: I have been informed and understand that it is absolutely necessary for someone to accompany me home after surgery. I understand that I cannot drive myself home and must be discharged into the care of and driven from the outpatient surgery center by another responsible adult.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Patient or legally responsible person

Relationship

Witness to Signature

Date

Time

1411
P00385
R.App. 000126

Pain Management

Surgical Arts Center
9499 W. Charleston, Ste 250
Las Vegas, NV 89117

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

04/16/2014

See Medication Reconciliation form

Medications:

Allergies:

Medical Problems:

See Medication Reconciliation form

High blood pressure	Yes	No	Heart condition	Yes	No
Asthma/Lung problems:	Yes	No	Hepatitis	Yes	No
Diabetes:	Yes	No	Aids/HIV positive	Yes	No
Smoking:	Yes	No	Kidney disease	Yes	No
Coumadin:	Yes	No	Shortness of Breath	Yes	No
Aspirin:	Yes	No	Street drugs	Yes	No

If yes to any of above or any other medical problems, please describe:

Physical Examination:

Pain Description:

Blood Pressure: 136/75 Pulse: 64
Normal Other
HEENT: ☐
Cardiac: ☐
Pulmonary: ☐
Neuro: ☐

See HP notes

DIAGNOSIS: Lumbar-Radic (722.10) Cerv-Radic (722.0) Lumb-Disc (722.10) Cerv-Disc (722.4)
Lumb Spond (721.3) Cerv Spond (721.0) Sacroiliac Arthropathy (720.2)
CRPS 1 UE (337.21) CRPS 1LE (337.22) Cervical Strain (847.2) Lumbar Strain (847.0)
Other:

PLAN: Lumbar: TFED ILED/Caudal Z-jt Z-jt RF Disco Sympathetic
Cervical: TFED ILED Z-jt Z-jt RF Disco Sympathetic
SI joint Hip/Intra-articular Occipital Nerve Piriformis
ED Trial ITB Trial SCS Trial (total contacts) IDDS Implant
Other:

Physician Signature:

Date:

4-16-14

Pain Management Procedure Record

PRE-OP: Rida/Name: Victoria Waiting Y or N
 Phone: 778-1616
 Allergies: P.N. swelling
 Pain Level: 6/10

HISTORY: HCG: N/A
 Accucheck: n/a
 Anticoagulants: n/a
 P.T.: INR
 History: _____

Site: (12) hand #24
 Attempts: X 3
☒ Hep Lock w/ NS Flush
☐ IV
☐ Antibiotic

Time	B.P.	Pulse	SaO2
1010	136/75	64	98%

RN: Captal Drey

INTRA-OP: Time Start: 1020
 Time End: 1041

Position ☐ R Lateral ☒ Prone ☐ Sitting
☐ L Lateral ☐ Supine
 Prep ☐ Alcohol ☐ Duraprep ☐ Hibiclens ☒ Betadine

Time	B.P.	Pulse	SAO2	LOC
in 1033	138/77	108	96	2
out 1041	115/77	73	96	4

Time	Medications	Site	RN	Nurse's Notes
1033	Versed 2 mg	IV	2	<input type="checkbox"/> O2: <u>1/min/NVC</u>
	Fentanyl mcg	IV		<input type="checkbox"/> Celestone 6mg/cc
1032	Diprivan 80 mg	IV	2	<input checked="" type="checkbox"/> Depomedrol 80mg/cc
	Alfentanil mcg	IV		<input checked="" type="checkbox"/> Lidocaine 1% 2% 4%
	Romazicon mg	IV		<input checked="" type="checkbox"/> Isovue 300 / Isovue 180
1038	Diprivan 20 mg	IV	cel	<input type="checkbox"/> Marcaine 0.25% 0.5% .75%
				<input type="checkbox"/> Dexamethasone 10mg/ml
				<input type="checkbox"/> PFNS

Procedure: Free (L) 45 + (L) 45 Tol Procedure: free RN: S
 RN: S

ADMISSION/ASSESSMENT

CARDIOVASCULAR

Heart Sounds: audible, distant
 Peripheral Pulses: equal, unequal, weak
 strong bounding, absent
 Neck Veins: distended, flat

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent
 Respirations: no distress, sob, labored, accessory muscles
 used
 Cough: absent, non-productive, productive

NEUROLOGICAL

LOC: Alert, lethargic, unresponsive
 Orientation: oriented, disoriented
 Pupils: equal, unequal, reactive, unreactive

INTEGUMENTARY

Skin Color: pink, pale, cyanotic, jaundice
 Skin Temperature: warm, dry, cool, clammy, diaphoretic
 Skin Turgor: good, light
 Mucous Membrane: moist, dry, cracked

GASTROINTESTINAL

Abdomen: soft, firm, hard, flat, distended
 Bowel Sounds: absent, present

BEHAVIOR

Cooperative, restless, withdrawn, crying, talkative, resistive,
 combative, calm & relaxed, anxious, fearful

Level of Consciousness:

1: Agitated _____ 2: Alert _____ 3: Sedated _____
 4: Drowsy _____ 5: Sleeping: _____

25633 11/02/1989 M
 Anthony Mjm C Ruggeroli MD
 Orth Beau R

04/16/2014

Surgical Arts Center 9499 W Charleston, Suite 250 Las Vegas, NV 89117 (702) 933-3600

Pain Management Procedure Record

POST-OPERATION

Time	B.P.	Pulse	SaO2	Time	Nurse's Notes
1041	115/77	73	96	1041	Rec'd Pt to PPTU A APD. Demographics, w
1046	116/70	68	95		Cons contact Pt X3. IV d/c'd & bath
1051	115/70	73	96		contact D/C unit provid verbal ptnt
					ins site WNL. Pt OK to ing. Pt clean
					WLP steady. Pt to go straight out
					careless. Pt meets D/C criteria
					it is cleaned up and for D/C. Pt
					is to care site, w
Time	Meds	Site	RN		

DISCHARGE

☒ IV D/c'd ☒ Ambulatory ☒ w/responsible adult Pain Level: 0/10
☐ Tol P.O. fluids well ☐ Wheelchair RN: K. Monahan
☐ D/C criteria met Time Discharged: 1107
☒ Cleared for D/C by MD

POST-PROCEDURE CONTACT REPORT

Date: 4/16/14 ☐ Letter Sent ☐ Phone
 Complications: ☐ Yes ☒ No
 RN: K. Monahan

POST-OP ASSESSMENT

CARDIOVASCULAR

Heart Sounds: audible, distant
 Peripheral Pulses: equal/unequal, weak
 strong bounding, absent
 Neck Veins: distended, flat

NEUROLOGICAL

LOC: alert, lethargic, unresponsive
 Orientation: oriented, disoriented,
 Pupils: equal, unequal, reactive, unreactive

GASTROINTESTINAL

Abdomen: soft, firm, hard, flat, distended
 Bowel Sounds: absent, present

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent
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 Cough: absent, non-productive, productive

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Skin Color: pink, pale, cyanotic, jaundice
 Skin Temperature: warm, dry, cool, clammy, diaphoretic
 Skin Turgor: rose, light
 Mucous Membrane: moist, dry, cracked

BEHAVIOR

Cooperative, restless, withdrawn, crying, talkative, resistive,
 combative, calm & relaxed, anxious, fearful

Patient Safety & Identity/Procedure/Site Verification/Check-List

Pre-operative:

☒ Preop area disinfected according to protocols

☒ Patient states two identifier's ☒ Name ☒ DOB ☐ Other: _____

☐ G8916 IV Antibiotic

☒ Patient's responses match ID band

☒ Patient states procedure, site, side, and physically identifies same.

☒ G8918 No IV Antibiotic

☒ Consent matches patient stated responses, physician's orders, or schedule and H&P.

☒ Medical record relevant data, i.e. H&P, matches patient stated responses.

☒ Preop orders from physician were followed.

☒ Discharge instructions given to patient.

☒ Site is marked yes & initialed by Physician (N/A for Pain Management and Cosmetic Procedures)

Discrepancy Noted: YES NO If Yes, Explain: N/A

Discrepancy Resolution N/A

Resolution Communicated to Team. R.N.: Cynthia Blum

Intra-operative:

☒ Confirm all Team members introduced themselves by name & role

☒ OR area disinfected according to protocols

☒ Confirmation of: patient identity, procedure, consent, site and positioning, and any patient concerns

☒ Radiographs / Implants / Special Equipment availability & concerns, sterility confirmed.

☒ "Time Out" @ 1030 to Verify: any critical / unexpected steps / anticipated blood loss.

☒ Correct patient

☒ Patient Allergies

☒ Correct site

☒ Difficult Airway / Aspiration Risks yes no

☒ Correct procedure

☒ Risk of blood loss > 500ml yes no

☒ Appropriately displayed x-rays on correct patient

☒ Staff Participating in "Time Out" are same Surgeon, Anesthesiologist, Circulating Nurse,

and Scrub Tech documented on OR record

☒ Otherwise List:

☒ Antibiotics given within last 60 minutes

Discrepancy Noted: YES NO

Explain: _____

Discrepancy Resolution _____

Resolution Communicated to Team. R.N.: _____

☒ Name of procedure recorded

☒ Instrument, sponge, & needle count are correct (N/A)

☒ Surgeon, Anesthesiologist, & Nurse review key concerns for recovery and management of patient.

PACU:

☒ PACU area disinfected according to protocols

☒ G8907 No Adverse Event

☒ Confirm patient identity via arm band/chart

☐ Adverse Event

☒ Discharge instructions given to patient and hard copy sent home with patient

G8908 Burn G8910 Fall

☒ Postoperative orders from Physician were followed.

G8912 Wrong site G8914 Hosp Txr

☒ Consent and procedure documented on OR record match within scope of related procedures YES NO

If "No", Explain: _____

Surgeon Notified of Discrepancy R.N.: K. Osborn

Surgical Arts Center
9499 West Charleston, Suite 250
Las Vegas, NV 89117

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

04/16/2014

1421

P00390
R.App. 000131

Nurse's Notes Continued:

Pain Management Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential to lack knowledge concerning proposed Pain Management procedure	Patient will acknowledge understanding of proposed procedure prior to the performance of the procedure	Provide explanation regarding proposed procedure	Communicate with patient and family regarding specific procedure and answer any questions	Satisfactory Unsatisfactory
Potential to lack pre-procedure preparation	Prepare patient for the procedure in the safest manner possible	Assess patient for drug allergies, NPO status, current medications (including blood thinners), smoking habits and alcohol consumption; check blood sugar on all diabetics and breath sounds on all thoracic patients, and any other pertinent information that could affect the outcome of the procedure	Patient interviewed and history taken; H&P reviewed; results of pre-operative testing reviewed when ordered	Satisfactory Unsatisfactory
Anxiety	Reduce anxiety	Answer questions and provide comfort	Establish rapport with patient and family; answer questions and provide comfort measures	Satisfactory Unsatisfactory
Desire for correct procedure site	Prevention of incorrect procedure site	Verify procedure site, check schedule and chart; obtain consent	Visually and verbally verify procedure site with patient; obtain written consent	Satisfactory Unsatisfactory
Lack of discharge knowledge	Patient will possess sufficient discharge knowledge to ensure a smooth transition from Surgical Arts Center to home	Complete discharge instructions specific to procedure gone over with patient	Discharge instructions specific to procedure will be gone over allowing the patient to ask questions and restate the instructions	Satisfactory Unsatisfactory

PRE-OP NURSE SIGNATURE:

[Signature]

PERIPROCEDURE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient	PL will not acquire injury perioperatively	Maintain patient safety and comfort	Greet pt; verify arm band, consent, op site, allergies and any other pertinent information; encourage questions; position patient appropriately; monitor pt.	Satisfactory Unsatisfactory

PROCEDURE NURSE SIGNATURE:

[Signature]

PACU STANDARDS OF CARE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential for injury	Pt. will not acquire injury in PACU	Maintain patient safety and comfort	Pt. assessment; vs q 5 min x 3 or until stable using appropriate intervention if necessary; offer & encourage nourishment; maintain preop musculoskeletal system level of function; discharge after instructions given and criteria met.	Satisfactory Unsatisfactory

PACU NURSE SIGNATURE:

[Signature]

Surgical Arts Center
702-933-3600
fax 702-933-3601
9499 W. Charleston Blvd, Las Vegas, NV 89117

VALUABLES

These items have been taken from me and placed into the security envelope:

These items have been left in my possession:

wallet
phone

☒ I have no valuables/jewelry/money with me today

Patient Signature: _____

Witness: _____

[Signature]
Crystal [Signature]

Date: _____

7-16-14

Time: _____

100G

I ACKNOWLEDGE RECEIPT OF THE ITEMS PLACED IN THE SECURITY ENVELOPE:

SIGNATURE: _____

RELATIONSHIP: _____

WITNESS: _____

Date: _____

7-16-14

Time: _____

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

04/16/2014

1423

P00392
R.App. 000133

Surgical Arts Center
9499 W. Charleston #250
Las Vegas, NV 89117
(702) 933-3600

Dr Ruggeroli
Pain Management Orders

Pre-Procedure Orders:

1. Obtain appropriate consent
2. Start heplock unless patient requests no IV access
3. Vital signs BP/P/SAO2
4. O2 2-8L/min. nasal cannula or mask PRN
5. Urine HCG if indicated
6. Accucheck on all diabetic patients.
7. Additional Orders:

Procedure Orders:

1. O2 2-8L/min nasal cannula or mask prn
2. Versed 2 mg IV
3. Fentanyl mcg IV
4. Propofol 100 mg IV
5. Alfenta mcg IV
6. Romazicon mg IV
7. Additional Orders:

Post Procedure Orders:

1. Vital Signs q 5 minutes until stable
2. Diet as tolerated
3. DC IV or heplock before discharge
4. Provide and review written copy of post procedure instructions including medications and restrictions
5. Discharge patient when all criteria met.
6. Additional orders:

Physician Signature _____

Date _____

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

04/16/2014

1424

P00393
R.App. 000134

DISCHARGE INSTRUCTIONS

The injection you received contained the local anesthetic and possibly a steroid medication (this type of steroid and dose amount helps to reduce inflammation resulting in the reduction of pain). THIS IS NOT A MUSCLE BUILDING KIND OF STEROID. You should experience a decrease in your everyday pain as well as some numbness due to the local anesthetic which can last from 2 to 8 hours, possibly longer. NOTE: You may have some pain at the injection site and/or a temporary increase in your everyday pain, however both should return to normal in 1-2 days. Most patients find that the use of an ice pack and heating pad along with resting will help to lower your pain symptoms. Please refer to your doctor's instructions for limitations of activities if any and any changes or additions with your medication(s). REMEMBER it may take up to a full week after the injection of steroid medication to note the effect/benefit. Therefore after the local anesthetic wears off, you most likely will experience your normal pain until the steroid medication has its effect.

- ☒ Keep your follow-up appointment as scheduled by your physician's office.
☒ Medication instructions. Take medications as prescribed or discussed with physician.
☒ Call your physician's office/answering service if you have an emergency related to the injection such as:
- Severe headache and/or seizures.
 - Difficulty breathing and/or speaking.
 - Loss of ability to feel or move your arms or legs.
 - Adverse reaction to the medication given
 - Infection (redness, swelling, drainage or fever greater than 101.5F)
 - Chills and/or sweating
 - Heavy pressure over the chest or palpitations (rapid heart beat)
 - Bleeding at the injection site that is not stopped within 15 minutes of direct pressure

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, GO TO THE NEAREST EMERGENCY ROOM. URGENT CARE OR CALL 911.

SPECIFIC INSTRUCTIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

- | | |
|---|---|
| <input type="checkbox"/> EPIDURAL INJECTION | <input type="checkbox"/> SELECTIVE NERVE ROOT BLOCK |
| <input type="checkbox"/> LUMBAR SYMPATHETIC BLOCK | <input checked="" type="checkbox"/> FACET JOINT AND/OR MEDICAL BRANCH BLOCK |
| <input type="checkbox"/> SACROILIAC JOINT INJECTION | <input checked="" type="checkbox"/> INTRATHECAL INJECTION |

You may experience some weakness in the arms or legs for several hours after the injection. Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities until the numbness has completely worn off and your full strength has returned.

☐ DISCOGRAM: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. You may experience soreness in the injection area. Ice will help to decrease inflammation. Take your pain medication as ordered by your physician. If a high fever (101.5 F or greater) occurs, please call your physician or go to the Emergency room or urgent care if you are unable to contact your doctor and/or the fever does not subside.

☐ STELLATE GANGLION BLOCK: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. It is normal for your eyelid to drop, to have blurred vision, hoarseness and/or to have numbness and weakness (to include your arm) on the side of the injection. These feelings should subside in 6 to 8 hours.

☐ TRIGGER POINT INJECTIONS ☐ INTERCOSTAL/PERIPHERAL NERVE BLOCK ☐ JOINT INJECTION
Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. The area where you have been experiencing pain will most likely be numb. Limit strenuous activity to avoid straining muscles which haven't been used in a while. It is good to stretch that muscle which will help the pain to stay away. If any shortness of breath occurs, please call your physician.

☐ RADIOFREQUENCY / RF OR ☐ TRIAL SPINAL CORD STIMULATOR / TSCS: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. You may experience more pain or discomfort after the procedure. It may take 2 to 3 weeks before you experience total relief of these symptoms.

☒ During your recovery period after your injection, to help reduce pain and increase mobility, try stretching exercises and/or apply heat or ice (or alternate heat and ice. Use ice for a maximum of 20 minutes at a time with at least 30 minutes before using ice again.)

SOME OF THE MEDICATIONS YOU RECEIVED MAY HAVE THE POTENTIAL FOR CAUSING DROWSINESS AFTER YOU LEAVE. DO NOT DRIVE A VEHICLE, OPERATE HEAVY MACHINERY, DRINK ANY ALCOHOLIC BEVERAGES OR SIGN ANY LEGAL DOCUMENTS FOR 24 HOURS. IN ADDITION, PLEASE USE CAUTION IN YOUR ACTIVITIES AT HOME.

1 Copy given to patient

DATE: 4 / 16 / 14

TIME: 10 : 05 AM / PM

Patient Signature

Witness Signature

Discharged to:

SURGICAL ARTS CENTER

9499 W. Charleston, Suite 250

Las Vegas, Nevada 89117

25633

M

04/16/2014

Anthony Mjm C Ruggeroli MD

Orth Beau R

Pain Management Discharge Instructions

Surgical Arts Center9499 W Charleston Blvd Suite 250 Las Vegas, NV 89117-7148
7029333600 Fax: 7029333601

March 28, 2014

Page 1

Chart Document

Beau R Orth

Male DOB:

10870

03/26/2014 - Operative Report

Provider: Anthony C Ruggeroli

Location of Care: Surgical Arts Center

Date of Procedure: 03/26/2014

Procedure Performed At: Surgical Arts Center

Patient: Orth, Beau

Preoperative Diagnosis: 1) LUMBAR DISC HERNIATION/PROTRUSION/BULGE (ICD-722.10)

Postoperative Diagnosis: 1) LUMBAR DISC HERNIATION/PROTRUSION/BULGE (ICD-722.10)

Procedure(s): 1) left L5-S1 transforaminal epidural steroid injection
2) left S1 transforaminal epidural steroid injection
3) fluoroscopic needle localization / guidance and spinal exam
4) Intravenous conscious sedation, moderate

Medications: lidocaine 1%, bupivacaine 0.75%, depomedrol 40mg/ml, Omnipaque 180, midazolam

Performing Physician: Anthony C. Ruggeroli, M.D.

Complications: NONE

Description of the procedure: After informed consent was verified, the patient was brought to the fluoroscopy suite, and was placed in the prone position. Triple betadine skin prep was accomplished over the lumbosacral area, and sterile drapes were applied. Non invasive monitoring was placed, including BP, pulse oximetry, and EKG, and was continued throughout the remainder of the case. Positioning comfort was verified with the patient and adjusted/modified as necessary.

Incremental doses of the sedative was administered intravenously for anxiolysis; the patient remained cooperative and responsive to voice throughout the remainder of the procedure. Refer to nursing record for total dose utilized.

C-arm fluoroscopy was used to identify lumbar segment L5-S1 and the left S1 dorsal foramen, and angulated obliquely, and as necessary, to optimize image detail of the left L5-S1 intervertebral foramen and the left S1 dorsal foramen. Skin wheals were then raised over the windows using approximately 0.5 ml of 1% lidocaine per wheal. Next, styletted 22ga needles were used to penetrate the skin, and were advanced; one towards the caudad aspect of the L5-S1 foramen, with the other needle directed towards the lateral aspect of the left S1 dorsal foramen. Multiple views were used, as necessary, including A/P and lateral views, to optimize final position of the needles during adjustments. No parathesias were reported during this process. Next, approximately 0.75ml of omnipaque 180 was injected through each needle, where an outline of the L5 and S1 roots was observed, indicating epidural distribution, without vascular uptake. Next, a solution was prepared comprising of a mixture of dexamethasone 10mg/ml and 0.75%

Surgical Arts Center

8499 W Charleston Blvd Suite 250 Las Vegas, NV 89117-7148
7029333600 Fax: 7029333601

March 28, 2014

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Beau R Orth

Male DOB:

10870

bupivacaine, two to one. 1.5ml of that solution was injected through each needle, two injections total, without patient complaint and the needle was removed intact.

The patient will see me back in follow up as scheduled and will track pain scores and function in the interim.

Anthony C. Ruggeroli, M.D.

CC to: Andrew Cash, MD

Electronically signed by Anthony C Ruggeroli on 03/28/2014 at 12:38 PM

McKenna, Ruggeroli and Helmi Pain Specialists
6070 S Fort Apache Road Suite 100 Las Vegas, NV 89148-5615
7023077700 Fax: 7023077942

March 25, 2014
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Beau R Orth

Male DOB:

10870

03/19/2014 - Consultation Report: New Patient Consultation
Provider: Anthony C Ruggeroli
Location of Care: McKenna, Ruggeroli and Helmi Pain Specialists

History of Present Illness

Reason for visit: new injury/problem

Referring physician: Dr. Cash

Prior visit to other physician: within the last month

Chief Complaint: lumbar and left leg pain

Pain onset two weeks ago, with no preceding event known. The pain is somewhat better at this time, following a medrol dosepak. The residual pain remains at a relatively high level, his physical activity is limited as such. Pain limited, primarily, to the left lumbosacral area, with radiation into the glute and posterior thigh and calf. There is a "numbness and tingling" character to the lower extremity pain as well. The pain is constant, and intensified with normal and usual physical activity. Recently evaluated by Dr. Cash, who recommended consideration of injection options.

His past surgical history is noted. He underwent a discectomy in 2010, followed by another decompressive procedure and had done fairly well, though he did experience daily moderate at least pain. This latest exacerbation was the worst pain that he has experienced for a long time.

The pain is described as continuous, aching, burning, exhausting, nagging, numb, sharp, shooting, stabbing, throbbing, tiring, and is worse in the morning, in the evening.

On AVERAGE, the pain is rated a 6 on a 0-10 scale (0 being no pain).

AT THIS TIME, the pain is rated a 3 on a 0-10 scale (0 being no pain).

Pain is made BETTER by: ice, laying down.

Pain is made WORSE by: driving, walking, weather, sitting for long periods of time, standing for long periods of time.

Attorney involved? no

Claiming as work related? no

Prior tests for current problem: MRI, Physical Therapy, X-ray

Past Medical History

Back Problems

The patient denies any contributory past medical history.

Surgeries

Shoulders/Arms

low back surgery X2

Family History

The patient denies any contributory family medical history.

The patient denies any contributory family medical history.

Current Allergies (reviewed today):

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Male DOB:

10870

PENICILLIN V POTASSIUM (PENICILLIN V POTASSIUM) (Critical)

Social History/Risk Factors

Work status: working

Daily activities: bending/squatting, lifting/pushing/pulling, repetitive movements, moderate to heavy physical labor/activity

Regular Exercise? yes

Alcohol use: 1-3 drinks per week

Tobacco use: never smoker

Drug use: no

Last bone density test: never

Prior treatment for bone density? no

Handedness: right

Height: 73

Weight: 230

Review of Systems

General: Complains of fatigue.

Ears/Nose/Throat: Denies decreased hearing, difficulty swallowing.

Cardiovascular: Denies chest discomfort, swelling of hands/feet, racing heart beat, weight gain, palpitations, blackouts/fainting, shortness of breath with exertion/activity, difficulty breathing while lying down.

Respiratory: Denies wheezing, coughing-up blood, cough.

Musculoskeletal: Complains of joint swelling, joint pain, stiffness, back pain.

Skin: Denies night sweats, dryness, suspicious lesions, changes in nail beds, changes in skin color, poor wound healing.

Neurologic: Complains of headaches, numbness, tingling.

Psychiatric: Denies anxiety, depression, claustrophobia.

Endocrine: Denies cold intolerance, heat intolerance, excessive thirst, excessive urination.

Heme/Lymphatic: Denies persistent infections, seasonal allergies.

Patient provided the above responses and/or history obtained.

Physical Exam

Vital Signs

Height: 73 inches

Weight: 230 pounds

Blood Pressure: 118/76 mm Hg

Calculations

Body Mass Index: 30.45

BMI out of Range, Nutritional Counseling given: yes

Lower Extremity Exam

Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

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March 25, 2014
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Beau R Orth

Male DOB:

10870

Motor/Strength: Plantar flexion, dorsi flexion, knee extension, and hip flexion against resistance is without deficit bilaterally.

Deep Tendon Reflexes:

Knees: Right: normal Left: absent

Ankles: Right: normal Left: decreased

Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:

Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:

Right: normal; S1 / L5 / L4 / L3 dermatomes intact

Left: S1 diminished

Lumbosacral Exam

Gross Exam Lumbosacral: surgical scar or other scar present

Palpation of Lumbosacral Soft Tissues:

Left: Mid tender

Lumbar Range of Motion:

extension limited with pain

Assessment:

Assessed LUMBAR DISC HERNIATION/PROTRUSION/BULGE as deteriorated - Anthony C Ruggeroli

Assessment of established problem(s):

The MRI shows a left eccentric protrusion at L5-S1, with S1 abutment/impingement, consistent with his pain description and exam. An injection to address this is reasonable and medically necessary, due to the high pain levels and functional impairment. I also discussed a gabapentin trial, as well as amitriptyline qhs, as the pain has caused a sleep disturbance. His options were offered, and he elects to proceed.

Plan:

left S1 and L5-S1 transforaminal epidural steroid injections

DEPO

ABOVE INTENDED FOR THERAPEUTIC PURPOSES

follow up in office in two weeks for post injection and condition reassessment

gabapentin trial in the interim, precautions discussed at length

amitriptyline trial for sleep enhancement

Increase physical activity as pain level improves, as tolerated

New Medication(s):

NEURONTIN 300 MG CAPS (GABAPENTIN) one PO TID for nerve pain as tolerated , start qhs

AMITRIPTYLINE HCL 10 MG TABS (AMITRIPTYLINE HCL) one to three PO qhs as needed for sleep

Medication List Upon Discharge Today:

NEURONTIN 300 MG CAPS (GABAPENTIN) one PO TID for nerve pain as tolerated , start qhs

AMITRIPTYLINE HCL 10 MG TABS (AMITRIPTYLINE HCL) one to three PO qhs as needed for sleep

Prescriptions:

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7023077700 Fax: 7023077942

March 25, 2014
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Chart Document

Beau R Orth

Male DOB:

10870

NEURONTIN 300 MG CAPS (GABAPENTIN) one PO TID for nerve pain as tolerated , start qhs
#90[capsule] x 2

Entered and Authorized by: Anthony C Ruggeroli
Electronically signed by: Anthony C Ruggeroli on 03/19/2014
Method used: Electronically to
CVS Pharmacy 8320* (retail)
8320 W Cheyenne Ave
Las Vegas, NV 89129
Ph: (702) 658-3834
Fax: (702) 658-3895

RxID: 1710859616156700

AMITRIPTYLINE HCL 10 MG TABS (AMITRIPTYLINE HCL) one to three PO qhs as needed for sleep
#90[tablet] x 1

Entered and Authorized by: Anthony C Ruggeroli
Electronically signed by: Anthony C Ruggeroli on 03/19/2014
Method used: Electronically to
CVS Pharmacy 8320* (retail)
8320 W Cheyenne Ave
Las Vegas, NV 89129
Ph: (702) 658-3834
Fax: (702) 658-3895

RxID: 1710859556156700

Handout requested.

Electronically signed by Anthony C Ruggeroli on 03/19/2014 at 4:16 PM

SURGICAL ARTS CENTER
9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117
702 933-3600 fax 702 933-3601

Acct #: _____

PATIENT INFORMATION

Last Name: Orth (Jr, Sr, etc.) Sex: (M) or F Race: Caucasian
First Name: Beau Middle Initial: R Preferred Language: English
Street Address: _____ Apt. / Space: _____
City: LV State: NV Zip Code: _____
Home Telephone: _____ Cell Phone: Same Work Phone: Same
Date of Birth: _____ Age: _____ Social Security #: _____
Ethnicity: Hispanic (Non-Hispanic) Latino Non-Latino Refuse to Report Marital Status: M (S) D W
Email: _____ Patient's Employer: _____
Referring Physician: Andrew Cash
Patient's Employment Status: (Full-time) Part-Time Retired Self Employed Active Duty Not Employed Disabled
Patient's Student Status: Full-Time Part-Time (Not a Student)
Do you wish to receive your statements by: ☒ email ☐ mail

(If Patient is a minor)

Responsible Party: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Employer: _____
Email: _____

Part of Body being treated? RT or LT or Both (please circle) Back
How were you injured? Malpractice Date of Injury 10/10/10
On The Job Injury? ☐ Yes ☒ No Auto Accident? ☐ Yes ☒ No
Name: _____ Phone: _____ Claim #: _____
Do you have an Attorney pertaining to this injury? ☒ Yes ☐ No If yes, Attorney's Name: Dennis Prince Phone: _____

NEXT OF KIN INFORMATION OR EMERGENCY CONTACT

Name: Robert Orth Relationship: Father
Address: _____ Phone: _____ Home/Cell
I hereby authorize payment of medical benefits to SURGICAL ARTS CENTER for services furnished me. I also authorize the Surgical Arts Center to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have treatments, tests, and procedures that my physician deems advisable and necessary based on his judgement. I hereby consent to and authorize medical
Patient's Signature or Responsible Party Signature [Signature] Date 3/26/14

PAIN MANAGEMENT CHART AUDIT

EACH CHART SHALL BE AUDITED FOR COMPLETENESS AND SHALL BE COMPLETE PRIOR TO BEING FILED FOR STORAGE

EACH ITEM SHALL BE CHECKED AS COMPLETE OR INDICATED AS N/A

LEFT SIDE OF CHART:

- A. PATIENT SUMMARY SHEET
- B. PATIENT FACE SHEET
- C. HIPAA RECEIPT ACKNOWLEDGMENT
- D. RESUSCITATIVE MEASURES

✓
✓
✓
✓

RIGHT SIDE OF CHART:

- E. CONSENT FOR PROCEDURE
- F. HISTORY & PHYSICAL
- G. OPERATIVE REPORT
- H. MEDICATION RECONCILIATION
- I. PROCEDURE RECORD
- J. SITE VERIFICATION
- K. VALUABLES SHEET
- L. PHYSICIAN'S ORDERS/ SIGNATURE
- M. LABORATORY REPORTS
- N. DISCHARGE INSTRUCTIONS
- O. INITIAL PRE-ANESTHETIC RECORD

✓
✓
✓
✓
✓
✓
✓
✓
✓
✓
✓

SIGNATURE

[Signature]

DATE

4/4/14

Check name sticker on chart to verify date currently seen

Check Year sticker

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

03/26/2014

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 260 • LAS VEGAS, NV 89117 • 702 938-3600

Patient Name:

Beau R Orth

740

DISCLOSURE AND CONSENT TO OPERATION OR OTHER SPECIAL PROCEDURES

To the patient: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping condition. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

GENERAL CONSENT & CONDITIONS: I (we) hereby authorize and understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize Anthony Mim C Ruggeroli MD surgeon, and/or such assistant(s) as may be selected by him/her, to perform: Lumbar sacral transforaminal epidural with steroid injection under fluoroscopy

My physician has explained the procedure(s) necessary to treat my condition, possible risks and consequences associated with this/these procedure(s). I understand this explanation is not exhaustive and other risks and consequences may arise. No guarantee(s) or assurances have been made to me as to the result or cure. I feel comfortable with the information I have received and therefore give my informed consent.

If any presently unforeseen condition arises or is discovered during the course of this/these operation(s) or procedure(s), I authorize and request the performance of such operation(s) or procedure(s) in addition to or different from those now contemplated which my physician or associate(s) or designee(s) consider necessary or advisable in the exercise of his/her professional judgment.

In the event that a transfer is required to a local hospital, I understand and authorize Surgical Arts Center to release photocopies of Medical Records to that hospital. Photocopies will include but is not limited to, patient history, physical exam reports, physicians' and nurses' notes, lab and x-ray reports. I also give consent for the hospital to give Medical Records to Surgical Arts Center.

If it is necessary to remove any body material, I hereby authorize Surgical Arts Center to use their discretion in its disposal.

INDEPENDENT STATUS OF PHYSICIANS: I understand that physicians on the staff of this Center may be employees or independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients.

Surgical Arts Center is owned by Dr. Steven Thomas and Dr. Michael McKenna who also perform procedures at this Facility.

ANESTHETICS: I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the anesthesia.

CONSENT TO DRAW BLOOD: I, the undersigned, do hereby consent to the withdrawal of a blood sample from my body in the event of a Medical Emergency or in the event that an employee or physician of Surgical Arts Center has had an accidental needle puncture or mucus membrane (eye, mouth, etc.) exposure to my blood or of a body fluid.

OBSERVERS: I consent for a health care representative to be present during the procedure as deemed necessary.

I understand that from time to time the Surgical Arts Center and its medical staff participate in medical training programs, under the supervision of a physician, for the purpose of advancing medical education. I consent to the admittance of medical observers to the operating room.

PHOTOGRAPHY: I understand that Surgical Arts Center and my physician may photograph certain parts of the procedure and use the negatives or prints for the purposes as may be deemed necessary. I consent to the photographing of the operation or procedure to be performed.

PERSONAL VALUABLES: I release Surgical Arts Center from all responsibility relative to the loss and/or damage to property, money or valuables which are not deposited with the surgical center for safe keeping.

ADVANCE DIRECTIVES: I understand that it is my responsibility to share information with Surgical Arts Center concerning my Advance Directives if one exists.

DISCHARGE AGREEMENT: I have been informed and understand that it is absolutely necessary for someone to accompany me home after surgery. I understand that I cannot drive myself home and must be discharged into the care of and driven from the outpatient surgery center by another responsible adult.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

patient or legally responsible person

Relationship

3-26-14

Date

0748

Time

Witness to Signature

1427

P00403
R.App. 000144

Pain Management
Surgical Arts Center
9499 W. Charleston, Ste 250
Las Vegas, NV 89117

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

03/26/2014

Medications:

See Medication Reconciliation form

Allergies:

See Medication Reconciliation form

Medical Problems:

High blood pressure	Yes	No	Heart condition	Yes	No
Asthma/Lung problems:	Yes	No	Hepatitis	Yes	No
Diabetes:	Yes	No	Aids/HIV positive	Yes	No
Smoking:	Yes	No	Kidney disease	Yes	No
Coumadin:	Yes	No	Shortness of Breath	Yes	No
Aspirin:	Yes	No	Street drugs	Yes	No

If yes to any of above or any other medical problems, please describe:

Physical Examination:

Pain Description:

Blood Pressure: 137/83 Pulse: 72
Normal Other
HEENT: ☐
Cardiac: ☐
Pulmonary: ☐
Neuro: ☐

DIAGNOSIS: Lumbar Radic (722.10) Cerv Radic (722.0) Lumb Disc (722.10) Cerv Disc (722.4)
Lumb Spond (721.3) Cerv Spond (721.0) Sacroiliac Arthropathy (720.2)
CRPS 1 UE (337.21) CRPS 1LE (337.22) Cervical Strain (847.2) Lumbar Strain (847.0)
Other:

PLAN: Lumbar TLED ILED/Caudal Z-jt Z-jt RF Disco Sympathetic
Cervical: TLED ILED Z-jt Z-jt RF Disco Sympathetic
SI joint Hip/Intra-articular Occipital Nerve Piriformis
ED Trial ITB Trial SCS Trial(total contacts) IDDS implant
Other:

Physician Signature:

Date:

3-26-14

(Patient to complete shaded portion of form)

25633

M

03/26/2014

Anthony Mjm C Ruggeroli MD
Orth Beau R

Allergies: ☐ NKDA ☒ Verified ☐ See attached list for extensive allergies

Medication Penicillin Reaction N/A

Medication Information Obtained From:

☒ Patient ☐ Family member
 of patient ☐ Written list provided by patient

TO BE COMPLETED BY
NURSE/PHYSICIAN
ON DAY OF SURGERY

[illegible]

Patient Acknowledgement:

- I have provided as accurate a list as I can of my home medications. I will continue to follow the medication orders of the prescribing physician unless instructed to change. If I have questions about my home medications, I will call the doctor who prescribed them.
- I understand that my medication list may be shared with my other physicians unless I decline. ☐ I decline.

Patient (designee) Signature:

Date: 3/26/14

- Current home medication list has been reviewed with patient pre-operatively.

Staff Signature:

Date/Time: 3-26-14 00:50

NEW MEDICATIONS TO BEGIN TAKING

Medication/Dose	How Is It Taken	How Often Is It Taken	Rx Given at	Med Info Given
			<input type="checkbox"/> Pre-Op <input type="checkbox"/> DOS	<input type="checkbox"/> Yes
			<input type="checkbox"/> Pre-Op <input type="checkbox"/> DOS	<input type="checkbox"/> Yes
			<input type="checkbox"/> Pre-Op <input type="checkbox"/> DOS	<input type="checkbox"/> Yes

Physician Signature:

Date/Time: 3/20/11 0631

Staff Signature:

Date/Time: 5/26/19 0745

*Copy to be given to patient at discharge.

Pain Management Procedure Record

PRE-OP: Ride Name: Victor Waiting Y or N N HCG: N/A Site: L hand #22 #24
 Phone: 738-1016 Accucheck: N/A Attempts: X
 Allergies: penicillin Anticoagulants: N/A ☒ Hep Lock w/ NS Flush
 P.T.: _____ INR: _____
 History: adul ☐ IV _____
 Pain Level: 6 / 10 ☐ Antibiotic _____

Time	B.P.	Pulse	SaO2
0755	137/80	72	98%

RN: estringer

INTRA-OP: Time Start: 0835 Position: ☐ R Lateral ☐ Prone ☐ Sitting
 Time End: 0840 ☐ L Lateral ☐ Supine
 Prep: ☐ Alcohol ☐ Duraprep ☐ HibacLens ☒ Betadine

Time	B.P.	Pulse	SAO2	LOC
In: 0831	132/89	72	96	2
0836	137/82	70	98	6
Out: 0840	134/72	85		2

Time	Medications	Site	RN	Nurse's Notes
0831	Versed 2 mg	IV	S	<input type="checkbox"/> O2: _____ l/min/N/C
	Fentanyl mcg	IV		<input type="checkbox"/> Celestone 6mg/cc
0831	Dilprivan 70 mg	IV	S	<input checked="" type="checkbox"/> Depomedrol 80mg/cc
	Alfentanil mcg	IV		<input checked="" type="checkbox"/> Lidocaine 1% 2% 4%
	Romazicon mg	IV		<input checked="" type="checkbox"/> Isovue 300 / Isovue 180
0836	Diprivan 5 mg	IV	S	<input type="checkbox"/> Marcaine 0.25% 0.5% .75%
				<input type="checkbox"/> Dexamethasone 10mg/ml
				<input type="checkbox"/> PFNS

Procedure: Tyrod (D) S11 2551 Tol Procedure: gn RN: S
 RN: _____

ADMISSION/ASSESSMENT:

CARDIOVASCULAR Heart Sounds: <u>audible</u> distant Peripheral Pulses: <u>equal</u> , unequal, weak strong bounding, absent Neck Veins: <u>distended</u> , flat	RESPIRATORY Breath Sounds: <u>clear</u> , rales, rhonci, diminished, loud, absent Respirations: <u>no distress</u> , sob, labored, accessory muscles used Cough: <u>absent</u> , non-productive, productive
NEUROLOGICAL LOC: <u>alert</u> , lethargic, unresponsive Orientation: <u>oriented</u> , disoriented Pupils: <u>equal</u> , unequal, reactive, unreactive	INTEGUMENTARY Skin Color: <u>pink</u> , pale, cyanotic, jaundice Skin Temperature: <u>warm</u> , dry, cool, clammy, diaphoretic Skin Turgor: <u>loose</u> , tight Mucous Membrane: <u>moist</u> , dry, cracked
GASTROINTESTINAL: Abdomen: <u>soft</u> , firm, hard, flat, distended Bowel Sounds: <u>absent</u> , present	BEHAVIOR <u>Cooperative</u> : restless, withdrawn, crying, talkative, resistive, combative, calm & relaxed, <u>anxious</u> , fearful

Level of Consciousness:
 1: Agitated _____ 2: Alert _____ 3: Sedated _____
 4: Drowsy _____ 5: Sleeping: _____

25633 M
 Anthony Mjm C Ruggeroli MD
 Orth Beau R

03/26/2014

Surgical Arts Center 9499 W Charleston, Suite 250 Las Vegas, NV 89117 (702) 933-3600

P00406
 R.App. 000147

Pain Management Procedure Record

POST-OP

Time	B.P.	Pulse	SaO2	Time	Nurse's Notes
0840	134/72	85	95	0840	Rec'd pt to PACU. Pt awake and talking.
0845	133/74	88	95		V.S. Pt. drowsy, IV. IV d/c'd & cath.
0850	120/73	81	96		Intact. D/c inst rec'd. pt verbal, mobile.
					Written prov'd also pt to be flushed &
					cracked. Pt. still pain still left.
					Pt. nulls d/c inst. but is cleared by
					MD for Dr. A. Up to car, safely
					in O.R.

DISCHARGE

- ☒ IV D/c'd
☐ Tol P.O. fluids well
☒ Ambulatory
☐ D/C criteria met
☐ Wheelchair
☒ Cleared for D/C by MD

Injection Site Condition: WNL Pain Level: 6/10
☒ w/responsible adult Time Discharged: 0925
 RN: Klausen

POST-PROCEDURE CONTACT REPORT

Date: 3-26-14 Letter Sent ☐ Phone ☐

Complications: ☐ Yes ☒ No

RN: Klausen

POST-OP ASSESSMENT

CARDIOVASCULAR

Heart Sounds: audible, distant
 Peripheral Pulses: equal, unequal, weak
 strong bounding, absent
 Neck Veins: distended, flat

NEUROLOGICAL

LOC: Alert, lethargic, unresponsive
 Orientation: oriented, disoriented
 Pupils: equal, unequal, reactive, unreactive

GASTROINTESTINAL

Abdomen: soft, firm, hard, flat, distended
 Bowel Sounds: absent, present

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent
 Respirations: no distress, sob, labored, accessory muscles
 used
 Cough: absent, non-productive, productive

INTEGUMENTARY

Skin Color: pink, pale, cyanotic, jaundice
 Skin Temperature: warm, dry, cool, clammy, diaphoretic
 Skin Turgor: loose, tight
 Mucous Membrane: moist, dry, cracked

BEHAVIOR

Cooperative: restless, withdrawn, crying, talkative, resistive,
 combative, calm & relaxed, anxious, fearful

Patient Safety & Identity/Procedure/Site Verification/Check-List

Pre-operative:

☒ Preop area disinfected according to protocols

☒ Patient states two identifier's ☒ Name ☒ DOB ☐ Other: _____

☐ G8916 IV Antibiotic

☒ Patient's responses match ID band

☒ Patient states procedure, site, side, and physically identifies same.

☒ G8918 No IV Antibiotic

☒ Consent matches patient stated responses, physician's orders, or schedule and H&P.

☒ Medical record relevant data, i.e. H&P, matches patient stated responses.

☒ Preop orders from physician were followed.

☒ Discharge instructions given to patient.

☒ Site is marked yes & initialed by Physician (N/A for Pain Management and Cosmetic Procedures)

Discrepancy Noted: YES ☒ NO ☐ If Yes, Explain: _____

Discrepancy Resolution _____

Resolution Communicated to Team. R.N.: Christina J. P.

Intra-operative:

☒ Confirm all Team members introduced themselves by name & role

☒ OR area disinfected according to protocols

☒ Confirmation of: patient identity, procedure, consent, site and positioning, and any patient concerns

☒ Radiographs / Implants / Special Equipment availability & concerns, sterility confirmed.

☒ "Time Out" @ 0830 to Verify: any critical / unexpected steps / anticipated blood loss.

☒ Correct patient

☒ Patient Allergies

☒ Correct site

☒ Difficult Airway / Aspiration Risks yes / no

☒ Correct procedure

☒ Risk of blood loss > 500ml yes / no

☒ Appropriately displayed x-rays on correct patient

☒ Staff Participating in "Time Out" are same Surgeon, Anesthesiologist, Circulating Nurse,

and Scrub Tech documented on OR record

Otherwise List: _____

☒ Antibiotics given within last 60 minutes

Discrepancy Noted: YES ☐ NO ☒

Explain: _____

Discrepancy Resolution _____

Resolution Communicated to Team. R.N.: [Signature]

☒ Name of procedure recorded

☒ Instrument, sponge, & needle count are correct (N/A)

☒ Surgeon, Anesthesiologist, & Nurse review key concerns for recovery and management of patient.

PACU:

☒ PACU area disinfected according to protocols

☒ G8907 No Adverse Event

☒ Confirm patient identity via arm band/chart.

☐ _____ Adverse Event

☒ Discharge instructions given to patient and hard copy sent home with patient.

G8908 Burn

G8910 Fall

☒ Postoperative orders from Physician were followed.

G8912 Wrong site

G8914 Hosp Txfr

☒ Consent and procedure documented on OR record match within scope of related procedures YES ☒ NO ☐

If "No", Explain: _____

Surgeon Notified of Discrepancy _____

R.N.: [Signature]

Nurse's Notes Continued:

Pain Management Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential to lack knowledge concerning proposed Pain Management procedure	Patient will acknowledge understanding of proposed procedure prior to the performance of the procedure	Provide explanation regarding proposed procedure	Communicate with patient and family regarding specific procedure and answer any questions	Satisfactory
Potential to lack pre-procedure preparation	Prepare patient for the procedure in the safest manner possible	Assess patient for drug allergies, NPO status, current medications (including blood thinners), smoking habits and alcohol consumption; check blood sugar on all diabetics and breath sounds on all thoracic patients, and any other pertinent information that could affect the outcome of the procedure	Patient interviewed and history taken; H&P reviewed; results of pre-operative testing reviewed when ordered	Unsatisfactory
Anxiety	Reduce anxiety	Answer questions and provide comfort	Establish rapport with patient and family; answer questions and provide comfort measures	Satisfactory
Desire for correct procedure site	Prevention of incorrect procedure site	Verify procedure site, check schedule and chart; obtain consent	Visually and verbally verify procedure site with patient; obtain written consent	Unsatisfactory
Lack of discharge knowledge	Patient will possess sufficient discharge knowledge to ensure a smooth transition from Surgical Arts Center to home	Complete discharge instructions specific to procedure gone over with patient	Discharge instructions specific to procedure will be gone over allowing the patient to ask questions and restate the instructions	Satisfactory

PRE-OP NURSE SIGNATURE: 

PERIPROCEDURE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient	PT. will not acquire injury perioperatively	Maintain patient safety and comfort	Greet pt; verify arm band, consent, op. site, allergies and any other pertinent information; encourage questions; position patient appropriately; monitor pt.	Satisfactory
				Unsatisfactory

PROCEDURE NURSE SIGNATURE: 

PACU STANDARDS OF CARE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential for injury	PT. will not acquire injury in PACU	Maintain patient safety and comfort	PT. assessment; vs q 5 min x 3 or until stable using appropriate intervention if necessary; offer & encourage nourishment; maintain preop musculoskeletal system level of function; discharge after instructions given and criteria met.	Satisfactory
				Unsatisfactory

PACU NURSE SIGNATURE: 

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702-933-3600
fax 702-933-3601
9499 W. Charleston Blvd, Las Vegas, NV 89117

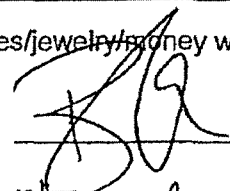
VALUABLES

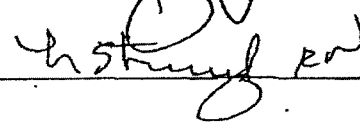
These items have been taken from me and placed into the security envelope:

These items have been left in my possession:

Wallet
phone

☐ I have no valuables/jewelry/money with me today

Patient Signature: 

Witness: 

Date: 3-26-14

Time: 0748

I ACKNOWLEDGE RECEIPT OF THE ITEMS PLACED IN THE SECURITY ENVELOPE:

SIGNATURE: _____

RELATIONSHIP: _____

WITNESS: _____

Date: _____ Time: _____

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

03/26/2014

1440

P00410
R.App. 000151

Surgical Arts Center
9499 W. Charleston #250
Las Vegas, NV 89117
(702) 933-3600

Dr Ruggeroli Pain Management Orders

Pre-Procedure Orders:

- 3-26-14
G. Ruggeroli
1. Obtain appropriate consent
 2. Start heplock unless patient requests no IV access
 3. Vital signs BP/P/SAO2
 4. O2 2-8L/min. nasal cannula or mask PRN
 5. Urine HCG if indicated
 6. Accucheck on all diabetic patients.
 7. Additional Orders:

Procedure Orders:

- meds
3/26/14
1. O2 2-8L/min nasal cannula or mask prn
 2. Versed 2 mg IV
 3. Fentanyl mcg IV
 4. Propofol 120 mg IV
 5. Alfenta mcg IV
 6. Romazicon mg IV
 7. Additional Orders:

Post Procedure Orders:

- mt
3/26/14
1. Vital Signs q 5 minutes until stable
 2. Diet as tolerated
 3. DC IV or heplock before discharge
 4. Provide and review written copy of post procedure instructions including medications and restrictions
 5. Discharge patient when all criteria met.
 6. Additional orders:

Physician Signature

Date

3-26-14

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

03/26/2014

1441

P00411
R.App. 000152

DISCHARGE INSTRUCTIONS

The injection you received contained the local anesthetic and possibly a steroid medication (this type of steroid and dose amount helps to reduce inflammation resulting in the reduction of pain). THIS IS NOT A MUSCLE BUILDING KIND OF STEROID. You should experience a decrease in your everyday pain as well as some numbness due to the local anesthetic which can last from 2 to 8 hours, possibly longer. NOTE: You may have some pain at the injection site and/or a temporary increase in your everyday pain, however both should return to normal in 1-2 days. Most patients find that the use of an ice pack and heating pad along with resting will help to lower your pain symptoms. Please refer to your doctor's instructions for limitations of activities if any and any changes or additions with your medication(s). REMEMBER it may take up to a full week after the injection of steroid medication to note the effect/benefit. Therefore after the local anesthetic wears off, you most likely will experience your normal pain until the steroid medication has its effect.

- ☒ Keep your follow-up appointment as scheduled by your physician's office.
- ☒ Medication instructions. Take medications as prescribed or discussed with physician.
- ☒ Call your physician's office/answering service if you have an emergency related to the injection such as:
 - Severe headache and/or seizures.
 - Loss of ability to feel or move your arms or legs.
 - Infection (redness, swelling, drainage or fever greater than 101.5F)
 - Heavy pressure over the chest or palpitations (rapid heart beat)
 - Bleeding at the injection site that is not stopped within 15 minutes of direct pressure
 - Difficulty breathing and/or speaking.
 - Adverse reaction to the medication given
 - Chills and/or sweating

IF YOU ARE UNABLE TO REACH YOUR DOCTOR AND ARE EXPERIENCING ANY OF THE SYMPTOMS LISTED ABOVE OR FEEL YOU NEED IMMEDIATE MEDICAL ATTENTION, GO TO THE NEAREST EMERGENCY ROOM. URGENT CARE OR CALL 911.

SPECIFIC INSTRUCTIONS FOR YOUR PROCEDURE ARE NOTED BELOW (SEE ALL THAT ARE CHECKED)

- | | |
|--|--|
| <input checked="" type="checkbox"/> EPIDURAL INJECTION | <input type="checkbox"/> SELECTIVE NERVE ROOT BLOCK |
| <input type="checkbox"/> LUMBAR SYMPATHETIC BLOCK | <input type="checkbox"/> FACET JOINT AND/OR MEDICAL BRANCH BLOCK |
| <input type="checkbox"/> SACROILIAC JOINT INJECTION | <input type="checkbox"/> INTRATHECAL INJECTION |

You may experience some weakness in the arms or legs for several hours after the injection. Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities until the numbness has completely worn off and your full strength has returned.

☐ DISCOGRAM: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. You may experience soreness in the injection area. Ice will help to decrease inflammation. Take your pain medication as ordered by your physician. If a high fever (101.5 F or greater) occurs, please call your physician or go to the Emergency room or urgent care if you are unable to contact your doctor and/or the fever does not subside.

☐ STELLATE GANGLION BLOCK: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. It is normal for your eyelid to drop, to have blurred vision, hoarseness and/or to have numbness and weakness (to include your arm) on the side of the injection. These feelings should subside in 6 to 8 hours.

☐ TRIGGER POINT INJECTIONS ☐ INTERCOSTAL/PERIPHERAL NERVE BLOCK ☐ JOINT INJECTION
Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. The area where you have been experiencing pain will most likely be numb. Limit strenuous activity to avoid straining muscles which haven't been used in a while. It is good to stretch that muscle which will help the pain to stay away. If any shortness of breath occurs, please call your physician.

☐ RADIOFREQUENCY / RF OR ☐ TRIAL SPINAL CORD STIMULATOR / TSCS: Do not operate machinery, drive a vehicle, use stairs or engage in any strenuous activities. You may experience more pain or discomfort after the procedure. It may take 2 to 3 weeks before you experience total relief of these symptoms.

☒ During your recovery period after your injection, to help reduce pain and increase mobility, try stretching exercises and/or apply heat or ice (or alternate heat and ice. Use ice for a maximum of 20 minutes at a time with at least 30 minutes before using ice again.)

SOME OF THE MEDICATIONS YOU RECEIVED MAY HAVE THE POTENTIAL FOR CAUSING DROWSINESS AFTER YOU LEAVE. DO NOT DRIVE A VEHICLE, OPERATE HEAVY MACHINERY, DRINK ANY ALCOHOLIC BEVERAGES OR SIGN ANY LEGAL DOCUMENTS FOR 24 HOURS. IN ADDITION, PLEASE USE CAUTION IN YOUR ACTIVITIES AT HOME.

Copy given to patient: ☒ DATE: 3.26.14 TIME: 07:40 AM/PM
Patient Signature: Victoria Witness Signature: Anthony Mjm C Ruggeroli MD
Discharged to: Victoria

SURGICAL ARTS CENTER
9499 W. Charleston, Suite 250
Las Vegas, Nevada 89117

25633 M 03/26/2014
Anthony Mjm C Ruggeroli MD
Orth Beau R

Pain Management Discharge Instructions

1442
P00412
R.App. 000153

INSTRUCTION TO PATIENT: Please print or indicate by a check mark (✓) your answer to each question. These answers will greatly help your anesthesiologist to give you the best possible care during your operation. If you do not understand any question (or your answer is uncertain) simply place a question mark (?) next to the answer column.

Name Beau Orth Age 24 Sex M

Height 6'2 Weight 230 lbs. Right Handed ☐ Left Handed ☐

1. List all previous surgeries (and when).

Shoulder Surgery 12/07
Back Surgery 9/10
Back Surgery 10/10

HAVE YOU OR HAVE YOU HAD... YES NO

- | | | |
|------------------------------|-------------------------------------|-------------------------------------|
| 10. Glaucoma | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Stiff Jaw or Neck | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. A Cold in the past month | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. Shortness of Breath | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Chronic Cough | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15. Asthma | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 16. Heart Attack | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 17. Chest Pain; Angina | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 18. Palpitations | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19. High Blood Pressure | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20. Hepatitis | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21. Hiatal Hernia | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 22. Rheumatic Fever | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 23. Ulcers | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 24. Stroke | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 25. Seizures | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 26. Blackouts | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 27. Back Problems | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 28. Muscle Disease | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 29. Arthritis | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 30. Diabetes | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 31. Thyroid Problems | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 32. Bleeding Tendencies | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 33. Sickle Cell Anemia | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 34. Blood Transfusions | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 35. Kidney Disease | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 36. Aids/HIV Positive | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 37. Any Others | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

2. Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery? YES ☐ NO ☒

3. Have you or your family had any unusual reaction to anesthesia? ☒ YES ☐ NO

4. Have or are you taking "street drugs"? ☐ YES ☒ NO

5. Have you had recent weight change? (Significant amount).... ☐ YES ☒ NO

6. Are you pregnant? ☐ YES ☒ NO

7. Do you smoke? If yes, _____ cigarettes per day ☐ YES ☒ NO

8. Do you have caps, false teeth, or contact lenses? ☐ YES ☒ NO

9. Do you drink alcoholic beverages How much? twice a week ☒ YES ☐ NO

Remarks:

Patient Label

3/26/14
Date

[Signature]
Signature (Patient or Person filling Out Form)

SURGICAL ARTS CENTER
 9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NEVADA 89117
 702 933-3600 fax 702 933-3601

Pre-Anesthesia Record

SAC-203 (Rev 12/2013)

1443

P00413
 R.App. 000154

25633 M
 Anthony Mjm C Ruggeroli MD
 Orth Beau R

03/26/2014

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117
702 933-3600 fax 702 933-3601

FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, & DISCLOSURE OF OWNERSHIP

All fees for medical care are based on the usual, reasonable, and customary fee charged in this area by physicians of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. This means that you will be expected to pay your payment / at each visit. There will be a \$25.00 service charge for any checks returned to our office. Unpaid balances will be assessed at 12% APR (1% per month) or a \$5.00 surcharge, whichever is greater, on any unpaid balances after 120 days. These balances may include balances that have not been paid by your company. ALL ACCOUNTS 90 DAYS PAST DUE MAY BE ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. In the event of collection proceedings due to lack of payment on my part or my I gree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor or group.

Our office verifies eligibility and benefits with your company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your however, is a contract between you and your Final responsibility for payment of your account rests with you. The exception is for those patients with injuries that are work-related and are covered by Those patients are not responsible for their bills unless their is denied.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payments but rather are based on medical necessity. Claims are subject to policy provisions, and determines final payment. A deposit is required if you are being scheduled for surgery. If an assistant is required at the time of surgery to improve the quality of your surgical outcome, the assistant's fee is in addition to the surgeon's fee.

Having read the above, I hereby authorize payment by my or other designated payor of medical benefits to SURGICAL ARTS CENTER, for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have A photocopy of the assignment is considered as valid as the original.

I also authorize SURGICAL ARTS CENTER to release to my other designated payors of medical benefits, or their agents, any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests, and procedures performed in the surgery center that my physician deems advisable and necessary based on his judgement. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

SURGICAL ARTS CENTER is owned by Dr. Steven Thomas and Dr. Michael McKenna who also perform procedures at this facility.

Patient's or Responsible Party's Signature

Date

3/26/14

Patient's or Responsible Party's Printed Name

Dean Orth

SAC-101 (8/2011)

1387

P00414
R.App. 000155

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117 • 702 933-3600 • fax 702 933-3601

NOTICE TO PATIENT, AND GUARANTORS HEALTH PLAN DENIALS

Your Health Plan will only pay the Surgical Center for the services you receive if they are covered under the terms and conditions of the Health Plan. If you are a member of a preferred provider organization, health maintenance organization or other managed care plan, your Health Plan may reduce or deny your benefits if:

- The services are not Medically Necessary;
- The services are not provided in a Health Plan surgical center;
- The services are not approved, ordered or performed by a Health Plan physician; or
- The services is not a covered service.

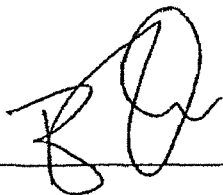
Health Plans review surgery centers services to determine if the services are Medically Necessary. Generally, Medically Necessary means services, which are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition;
- Within recognized standards of medical practice;
- Not primarily for the convenience of the Health Plan member, the member's family or the Health Plan physician; and
- The least costly of alternative supplies or levels of services which can be safely and effectively provided to the patient.

The Surgical Center cannot accept financial risk for services which you request, or your physician orders, which are subsequently determined to not be Medically Necessary. Your financial agreement with the Surgical Center is to pay for all services you receive whether or not the Health Plan determines the services to be a covered service or Medically Necessary.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's agent, or guarantor, and accepts its terms.

Patient



Witness



Date

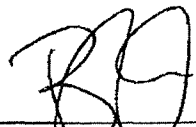
3/26/14

Surgical Arts Center
9499 W. Charleston Blvd. Suite #250
Las Vegas, NV. 89117
(702)933-3600

I acknowledge that I have received verbal and written instructions prior to the date of my procedure of the Surgical Arts Center's policies on:

- Advanced Directives
- HIPPA Privacy policies
- Patient's Rights
- Patient's Responsibilities
- Grievance Procedures

In signing below, I fully understand these policies and have no further questions.




Signature of patient or legal representative

3/26/14
Date

Beau Osth

Printed Name of patient or legal representative



Witness signature

3/26/14
Date

SURGICAL ARTS CENTER
9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117
702 933-3600 fax 702 933-3601

AMBULATORY SURGERY CENTER PATIENT CONSENT TO
RESUSCITATIVE MEASURES

Not A Revocation Of Advance Directives Or Medical Powers Of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This surgery center respects and upholds those rights.

However, unlike in an acute care hospital setting, the surgery center does not routinely perform "High Risk" procedures. Most procedures performed in this facility are considered to be on minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, our expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directives or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directives or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO RESCHEDULE THE PROCEDURE.

Please check the appropriate box in answer to these questions. Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make health care decisions for you?

☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.

If you checked the first box "Yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

☒ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.

☐ I would like to have information on Advance Directives. Please go to www.nvlivingwill.com.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.

By: _____

(Patient's Signature)

Witnessed By: _____

(Witness Signature)

Patient's Last Name:

Orth

Patient's First Name:

Beau

Date:

3/26/14

If consent to the procedure is provided by anyone other than the Patient,
this form must be signed by the person providing the consent or authorization.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED:

By: _____

(Signature)

(Print Name)

Relationship to Patient:

☐ Court Appointed Guardian

☐ Attorney-in-Fact

☐ Health Care Surrogate

☐ Other _____

1390
P00417
R.App. 000158

Surgical Arts Center

9499 W. Charleston, Suite 250, Las Vegas, NV 89117

Phone (702) 933-3600 Fax (702) 933-3601

HIPPA NOTICE OF PRIVACY PRACTICES

Effective: May 15, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The following notice is the privacy policy of Surgical Arts Center (SAC) as described in the Portability and Accountability
Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. We are required by law to maintain the privacy of your
personal health information and to provide you with this notice of our legal duties, privacy practices, your rights with respect to your personal
health information and to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and
enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that
is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities,
including health care providers, such as physicians and hospitals, as well as, companies or plans. The law specifically
protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify
you as the individual patient who is associated with that health information.

Uses and Disclosures of Your Personal Health Information

The following are the circumstances under which we are permitted by law to use and disclose your personal health information:

- **Treatment:** *Examples of treatment activities include:* (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.
- **Payment:** *Examples of payment activities include:* (a) billing and collection activities and related data processing; (b) actions by a health plan or to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or agreement, determinations of eligibility or, adjudication or; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.
- **Healthcare Operations:** *Examples of healthcare operations include:* (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and give your address, phone number, company name, and part of body being treated. We may also call you by name in the waiting room when your physician is ready to see you.
- **Persons Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. If you are in the hospital, we may also tell your family or friends your condition and that you are in a hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Your Authorization:** Except as otherwise permitted or required as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining other law provides the with the right to contest a
- **As Required by Law:** We may use or disclose your health information when we are required to do so by law.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

- **Right to Request Restrictions on Use or Disclosure:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by your agreement (except in an emergency or as required by law).
- **Right to Receive Confidential Communications:** You have the right to receive confidential communications of your personal health information. You must make your request in writing. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.
- **Right to Inspect and Copy Your Personal Health Information:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance.
- **Right to Amend Your Personal Health Information:** You have the right to request that we amend your personal health information. Your request must be in writing and it must explain why the information should be amended. We have the right to deny your request for amendment under certain circumstances.
- **Right to Receive an Accounting of Disclosures of Your Personal Health Information:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Right to a Paper Copy of This Notice:** You have a right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one from our Privacy Officer.

Complaints

You may file a complaint with us and with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may submit your complaint in writing to our Privacy Officer at the address listed above. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will always have available the current notice at or near the front desk. The notice will contain, on the first page, the effective date.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to SAC. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our Privacy Officer, at the address and telephone number listed above.

I acknowledge that I have received, read and understand Surgical Arts Center's Notice of Privacy Practices.

Signature of Patient or Legal Representative

3/26/14
Date

Beau Oath
Printed Name of Patient or Legal Representative

Witness Signature

3/26/14
Date

PAIN MANAGEMENT CHART AUDIT

EACH CHART SHALL BE AUDITED FOR COMPLETENESS AND SHALL BE COMPLETE PRIOR TO BEING FILED FOR STORAGE

EACH ITEM SHALL BE CHECKED AS COMPLETE OR INDICATED AS N/A

A. PATIENT SUMMARY SHEET	<input checked="" type="checkbox"/>
B. PATIENT FACE SHEET	<input checked="" type="checkbox"/>
C. HIPAA RECEIPT ACKNOWLEDGMENT	<input checked="" type="checkbox"/>
D. RESUSCITATIVE MEASURES	<input checked="" type="checkbox"/>
E. CONSENT FOR PROCEDURE	<input checked="" type="checkbox"/>
F. HISTORY & PHYSICAL	<input checked="" type="checkbox"/>
G. OPERATIVE REPORT	<input checked="" type="checkbox"/>
H. PERI-OPERATIVE RECORD/FOLLOW-UP	<input checked="" type="checkbox"/>
I. SITE VERIFICATION	<input checked="" type="checkbox"/>
J. VALUABLES SHEET	<input checked="" type="checkbox"/>
K. PHYSICIAN'S ORDERS	<input checked="" type="checkbox"/>
L. LABORATORY REPORTS	<input checked="" type="checkbox"/>
M. DISCHARGE INSTRUCTIONS	<input checked="" type="checkbox"/>
N. INITIAL PRE-ANESTHETIC RECORD	<input checked="" type="checkbox"/>

SIGNATURE Anthony Mjm C Ruggeroli MD

DATE 08/24/2010

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

08/13/2010

1444

P00420
R.App. 000161

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117 • 702 933-3600

Patient Name:

Beau Otm

DISCLOSURE AND CONSENT TO OPERATION OR OTHER SPECIAL PROCEDURES

To the patient: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping condition. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

GENERAL CONSENT & CONDITIONS: I (we) hereby authorize and understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize Dr. Anthony C. Ruggieri surgeon, and/or such assistant(s)

as may be selected by him/her to perform: lumbar sacral transforaminal epidural with steroid injection under fluoroscopy.

My physician has explained the procedure(s) necessary to treat my condition, possible risks and consequences associated with this/these procedure(s). I understand this explanation is not exhaustive and other risks and consequences may arise. No guarantee(s) or assurances have been made to me as to the result or cure. I feel comfortable with the information I have received and therefore give my informed consent.

If any presently unforeseen condition arises or is discovered during the course of this/these operation(s) or procedure(s), I authorize and request the performance of such operation(s) or procedure(s) in addition to or different from those now contemplated which my physician or associate(s) or designer(s) consider necessary or advisable in the exercise of his/her professional judgement.

In the event that a transfer is required to a local hospital, I understand and authorize Surgical Arts Center to release photocopies of Medical Records to that hospital. Photocopies will include but is not limited to, patient history, physical exam reports, physicians' and nurses' notes, lab and X-ray reports. I also give consent for the hospital to give Medical Records to Surgical Arts Center.

If it is necessary to remove any body material, I hereby authorize Surgical Arts Center to use their discretion in its disposal.

INDEPENDENT STATUS OF PHYSICIANS: I understand that physicians on the staff of this Center may be employees or independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients.

Surgical Arts Center is owned by Dr. Steven Thomas and Dr. Michael McKenna who also perform procedures at this facility.

ANESTHETICS: I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the anesthesia.

CONSENT TO DRAW BLOOD: I, the undersigned, do hereby consent to the withdrawal of a blood sample from my body in the event of a Medical Emergency or in the event that an employee or physician of Surgical Arts Center has had an accidental needle puncture or mucus membrane (eye, mouth, etc.) exposure to my blood or of a body fluid.

OBSERVERS: I consent for a health care representative to be present during the procedure as deemed necessary.

I understand that from time to time the Surgical Arts Center and its medical staff participate in medical training programs, under the supervision of a physician. For the purpose of advancing medical education. I consent to the admittance of medical observers to the operating room.

PHOTOGRAPHY: I understand that Surgical Arts Center and my physician may photograph certain parts of the procedure and use the negatives or prints for the purposes as may be deemed necessary. I consent to the photographing of the operation or procedure to be performed.

PERSONAL VALUABLES: I release the Surgical Arts Center from all responsibility relative to the loss and/or damage to property, money or valuables which are not deposited with the surgical center for safe keeping.

ADVANCE DIRECTIVES: I understand that it is my responsibility to share information with Surgical Arts Center concerning my Advance Directives if one exists.

DISCHARGE AGREEMENT: I have been informed and understand that it is absolutely necessary for someone to accompany me home after surgery. I understand that I cannot drive myself home and must be discharged into the care of and driven from the outpatient surgery center by another responsible adult.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

Patient or other legally responsible person

Self
Relationship

Witness to Signature

8-13-10
Date

6:45
Time

SAC-100 (5-2009)

1445

P00421
R.App. 000162

Pain Management

Surgical Arts Center
9499 W. Charleston, Ste 250
Las Vegas, NV 89117

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

08/13/2010

Medications:

None

Allergies:

Penicillin

Medical Problems:

High blood pressure

Yes

No

Heart condition

Yes

No

Asthma/Lung problems:

Yes

No

Hepatitis

Yes

No

Diabetes:

Yes

No

Aids/HIV positive

Yes

No

Smoking:

Yes

No

Kidney disease

Yes

No

Coumadin:

Yes

No

Shortness of Breath

Yes

No

Aspirin:

Yes

No

Street drugs

Yes

No

If yes to any of above or any other medical problems, please describe:

Physical Examination:

Pain Description:

Pain & Numbness in leg & lower back

Blood Pressure: 125/75

Pulse: 61

Normal

Other

HEENT:

☐

Cardiac:

☐

Pulmonary:

☐

Neuro:

☐

DIAGNOSIS: Lumbar Radic (722.10) Cerv Radic (722.0) Lumb Disc (722.10) Cerv Disc (722.4)
Lumb Spond (721.3) Cerv Spond (721.0) Sacroiliac Arthropathy (720.2)
CRPS I UE (337.21) CRPS ILE (337.22) Cervical Strain (847.2) Lumbar Strain (847.0)

Other:

PLAN:

Lumbar: TFED ILED/Caudal Z-jt Z-jt RF Disco Sympathetic

Cervical: TFED ILED Z-jt Z-jt RF Disco Sympathetic

SI joint Hip/Intra-articular Occipital Nerve Piriformis

ED Trial ITB Trial SCS Trial(total contacts) IDDS implant

Other:

Physician Signature:

Date: 8-13-10

Surgical Arts Center

9499 W Charleston Blvd Suite 250 Las Vegas, NV 89117
702-933-3600 Fax: 702-933-3601

Beau R Orth

Male DOB: ()

08/13/2010 - Operative Report**Provider: Anthony C. Ruggeroli, MD****Location of Care: Surgical Arts Center**

Date of Procedure: 08/13/2010

Procedure Performed At: Surgical Arts Center

Patient: Orth, Beau

Preoperative Diagnosis: 1) LUMBAR DISC HERNIATION/PROTRUSION/BULGE (ICD-722.10)

Postoperative Diagnosis: 1) LUMBAR DISC HERNIATION/PROTRUSION/BULGE (ICD-722.10)

Procedure(s): 1) left L5-S1 transforaminal epidural steroid injection
2) left S1 transforaminal epidural steroid injection
3) fluoroscopic needle localization / guidance and spinal exam
4) intravenous conscious sedation, moderate

Medications: lidocaine 1%, bupivacaine 0.75%, depomedrol 40mg/ml, Omnipaque 180,
midazolam

Performing Physician: Anthony C. Ruggeroli, M.D.

Complications: NONE

Description of the procedure: After informed consent was verified, the patient was brought to the fluoroscopy suite, and was placed in the prone position. Triple alcohol skin prep was accomplished over the lumbosacral area, and sterile drapes were applied. Non invasive monitoring was placed, including BP, pulse oximetry, and EKG, and was continued throughout the remainder of the case. Positioning comfort was verified with the patient and adjusted/modified as necessary.

Incremental doses of midazolam was administered intravenously for anxiolysis; the patient remained cooperative and responsive to voice throughout the remainder of the procedure. Refer to nursing record for total dose utilized.

C-arm fluoroscopy was used to identify lumbar segment L5-S1 and the left S1 dorsal foramen, and angulated obliquely, and as necessary, to optimize image detail of the left L5-S1 intervertebral foramen and the left S1 dorsal foramen. Skin wheals were then raised over the windows using approximately 0.5 ml of 1% lidocaine per wheal. Next, styletted 22ga needles were used to penetrate the skin, and were advanced; one towards the caudad aspect of the L5-S1 foramen, with the other needle directed towards the lateral aspect of the left S1 dorsal foramen. Multiple views were used, as necessary, including A/P and lateral views, to optimize final position of the needles during adjustments. No parathesias were reported during this process. Next, approximately 0.75ml of omnipaque 180 was injected through each needle, where an outline of the roots and mesial aspects of the pedicles, L5 and S1, was observed, indicating epidural distribution, without vascular uptake. Next, a solution was prepared comprising of a mixture of

08/13/2010 15:04

7023077842

P.002/002

Surgical Arts Center

9499 W Charleston Blvd Suite 250 Las Vegas, NV 89117
702-933-3600 Fax: 702-933-3601

Beau R Orth

Male DOB:

depomedrol 40mg/ml and 0.75% bupivacaine, two to one. 1.5ml of that solution was injected through each needle, two injections total, without patient complaint and the needle was removed intact.

The patient will see me back in follow up as scheduled and will track pain scores and function in the interim.

Anthony C. Ruggeroli, M.D.

CC to: Michael Milligan, MD

Signed by Anthony C. Ruggeroli, MD on 08/13/2010 at 10:00 AM

Pain Management Procedure Record

PRE-OP: Ride/Name: Robert Waiting Y or N father
 Phone:
 Allergies: PCN
 Pain Level: 7 / 10

HISTORY: HCG: (N/A)
 Accucheck: DIA
 Anticoagulants: DIA
 P.T. DIA INR DIA
 History:

IV: Site: Lt Hup #22 #24
 Attempts: 1
☒ Hep Lock w/ NS Flush
☐ IV
☐ Antibiotic

Time	B.P.	Pulse	SaO2
0650	125/75	61	99

RN: R. Kachas

INTRA-OP: Time Start: 0700 Position ☐ R Lateral ☒ Prone ☐ Sitting
 Time End: 0705 ☐ L Lateral ☐ Supine
 Prep ☐ Alcohol ☐ Duraprep ☐ Hibiclens ☐ Betadine

Time	B.P.	Pulse	SAO2	LOC
In 0700	124/72	64	98	3
Out 0705	140/80	63	97	2

Time	Medications	Site	RN	Nurse's Notes
0700	Versed 4 mg	IV	<u> </u>	<input type="checkbox"/> O2: <u> </u> /min/N/C
	Fentanyl mcg	IV		<input type="checkbox"/> Celestone 6mg/cc
	Diprivan mg	IV		<input type="checkbox"/> Depomedrol 80mg/cc
	Alfentanil mcg	IV		<input type="checkbox"/> Lidocaine 1% 2% 4%
	Romazicon mg	IV		<input type="checkbox"/> Isovue 300 / Isovue 180
				<input type="checkbox"/> Marcaine 0.25% 0.5% .75%
				<input type="checkbox"/> Dexamethasone 10mg/ml
				<input type="checkbox"/> PFNS

Procedure: ① TREN ④ L5 Tol Procedure: RN:
 RN:

ADMISSION ASSESSMENT:

CARDIOVASCULAR
 Heart Sounds: audible, distant
 Peripheral Pulses: equal, unequal, weak
strong bounding, absent
 Neck Veins: distended, flat

RESPIRATORY
 Breath Sounds: clear, rales, rhonci, diminished, loud, absent
 Respirations: no distress, sob, labored, accessory muscles used
 Cough: absent, non-productive, productive

NEUROLOGICAL
 LOC: alert, lethargic, unresponsive
 Orientation: oriented, disoriented,
 Pupils: equal, unequal, reactive, unreactive

INTEGUMENTARY
 Skin Color: pink, pale, cyanotic, jaundice
 Skin Temperature: warm, dry, cool, clammy, diaphoretic
 Skin Turgor: good, tight
 Mucous Membrane: moist, dry, cracked

GASTROINTESTINAL
 Abdomen: soft, firm, hard, flat, distended
 Bowel Sounds: absent, present

BEHAVIOR
 Cooperative: restless, withdrawn, crying, talkative, resistive,
 combative, calm & relaxed, anxious, fearful

Level of Consciousness:
 1: Agitated 2: Alert 3: Sedated
 4: Drowsy 5: Sleeping:

25633 11/02/1989 M 08/13/201
 Anthony Mjm C Ruggeroli MD
 Orth Beau R

Surgical Arts Center 9499 W Charleston, Suite 250 Las Vegas, NV 89117 (702) 933-3600

Pain Management Procedure Record

POST-OP

Time	B.P.	Pulse	SaO2	Time	Nurse's Notes
0705	118/81	63	77	0705	Received patient into recovery on gurney side rails
0710	136/75	65	76		x2. Patient alert & oriented. VSS. Post-op at
0715	131/70	63	76	0710	Patient tolerating fluids. Discharge instructions given. Verbalized understanding.
Time	Meds	Site	RN	0710	IV D/C'd intact. Dressing ambulated safely to vehicle chair. Tolerated well.
				0720	Discharge criteria met & patient discharged by RN.
					Ambulated safely to vehicle.

DISCHARGE

☒ Tol P.O. fluids well

☒ D/C criteria met

☒ Cleared for D/C by MD

☒ IV D/C'd

☒ Ambulatory

☐ Wheelchair

Injection Site Condition: WNL Pain Level: 4.5 / 10

☒ w/responsible adult

Time Discharged: 0720

RN: [Signature]

POST-PROCEDURE CONTACT REPORT

Date: 8-13-10 ☐ Letter Sent ☐ Phone

Complications: ☐ Yes ☒ No

RN: [Signature]

POST-OP ASSESSMENT

CARDIOVASCULAR

Heart Sounds: audible, distant

Peripheral Pulses: equal, unequal, weak

strong bounding, absent

Neck Veins: distended, flat

NEUROLOGICAL

LOC: alert, lethargic, unresponsive

Orientation: oriented, disoriented,

Pupils: equal, unequal; reactive, unreactive

GASTROINTESTINAL

Abdomen: soft, firm, hard, flat, distended

Bowel Sounds: absent, present

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent

Respirations: no distress, sob, labored, accessory muscles used

Cough: absent, non-productive, productive

INTEGUMENTARY

Skin Color: pink, pale, cyanotic, jaundice

Skin Temperature: warm, dry, cool, clammy, diaphoretic

Skin Turgor: loose, tight

Mucous Membrane: moist, dry, cracked

BEHAVIOR

Cooperative: restless, withdrawn, crying, talkative, resistive, combative, calm & relaxed, anxious, fearful

Identity/Procedure/Site Verification

Pre-operative:

- ☒ Patient states first identifier (list) NAME
- ☒ Patient states second identifier (list) DOB
- ☒ Patient's responses match ID band
- ☒ Patient states procedure, site, side, and physically identifies same.
- ☒ Consent matches patient stated responses.
- ☒ Medical record relevant data, i.e. H&P, matches patient stated responses.
- ☒ OR schedule is consistent with patient responses and H&P.
- N/A Site is marked yes (N/A for Pain Management and Cosmetic Procedures)
- N/A Site initialed by Physician (N/A for Pain Management and Cosmetic Procedures)

Discrepancy Noted: Yes No

Explain: _____

Discrepancy Resolution _____

____ Resolution Communicated to Team.

R.N.: Judy D. Kuehner

Intra-operative:

- ☒ Confirmation of patient identity, procedure, consent, site and positioning.
- ☒ Radiographs / Implants / Special Equipment available
- ☒ "Time Out" @ 0700 to Verify:
 - ☒ Correct patient
 - ☒ Correct site
 - ☒ Correct procedure
 - ☒ Appropriately displayed x-rays on correct patient
 - ☒ Staff Participating in "Time Out" are same Surgeon, Anesthesiologist, Circulating Nurse, and Scrub Tech documented on OR record
- Otherwise List: _____

Discrepancy Noted: Yes No

Explain: _____

Discrepancy Resolution _____

____ Resolution Communicated to Team.

R.N.: [Signature]

PACU:

- ☒ Confirm patient identity via arm band/chart.

Yes No Consent and procedure documented on OR record match within scope of related procedures.

If "No", Explain: _____

____ Surgeon Notified of Discrepancy

R.N.: [Signature]

Surgical Arts Center
9499 West Charleston, Suite 250
Las Vegas, NV 89117

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

08/13/2011

1451

P00427
R.App. 000168

Nurse's Notes Continued:

Pain Management Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential to lack knowledge concerning proposed Pain Management procedure	Patient will acknowledge understanding of proposed procedure prior to the performance of the procedure	Provide explanation regarding proposed procedure	Communicate with patient and family regarding specific procedure and answer any questions	Satisfactory Unsatisfactory
Potential to lack pre-procedure preparation	Prepare patient for the procedure in the safest manner possible	Assess patient for drug allergies, NPO status, current medications (including blood thinners), smoking habits and alcohol consumption; check blood sugar on all diabetics and breath sounds on all thoracic patients, and any other pertinent information that could affect the outcome of the procedure	Patient interviewed and history taken; H&P reviewed; results of pre-operative testing reviewed when ordered	Satisfactory Unsatisfactory
Anxiety	Reduce anxiety	Answer questions and provide comfort	Establish rapport with patient and family; answer questions and provide comfort measures	Satisfactory Unsatisfactory
Desire for correct procedure site	Prevention of incorrect procedure site	Verify procedure site, check schedule and chart; obtain consent	Visually and verbally verify procedure site with patient; obtain written consent	Satisfactory Unsatisfactory
Lack of discharge knowledge	Patient will possess sufficient discharge knowledge to ensure a smooth transition from Surgical Arts Center to home	Complete discharge instructions specific to procedure gone over with patient	Discharge instructions specific to procedure will be gone over allowing the patient to ask questions and restate the instructions	Satisfactory Unsatisfactory

PRE-OP NURSE SIGNATURE: _____

[Signature]

PERIPROCEDURE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential injury to patient	Pl. will not acquire injury perioperatively	Maintain patient safety and comfort	Greet pt; verify arm band, consent, op site, allergies and any other pertinent information; encourage questions; position patient appropriately; monitor pt.	Satisfactory Unsatisfactory

PROCEDURE NURSE SIGNATURE: _____

[Signature]

PACU STANDARDS OF CARE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential for injury	Pl. will not acquire injury in PACU	Maintain patient safety and comfort	Pl. assessment; vs q 5 min x 3 or until stable using appropriate intervention if necessary; offer & encourage nourishment; maintain preop musculoskeletal system level of function; discharge after instructions given and criteria met.	Satisfactory Unsatisfactory

PACU NURSE SIGNATURE: _____

[Signature]

Surgical Arts Center
702-933-3600
fax 702-933-3601
9499 W. Charleston Blvd, Las Vegas, NV 89117

VALUABLES

These items have been taken from me and placed into the security envelope:

These items have been left in my possession:

Clothing

☒ I have no valuables/jewelry/money with me today

Patient Signature: _____

Witness: _____

Linda S. Kaulas RN MSN

Date: 8-13-10

Time: 0645

I ACKNOWLEDGE RECEIPT OF THE ITEMS PLACED IN THE SECURITY ENVELOPE:

SIGNATURE: _____

RELATIONSHIP: _____

WITNESS: _____

Date: _____ Time: _____

25633
Anthony Mjm C Ruggeroli MD
Orth Beau R

08/13/2010

1453

P00429
R.App. 000170

Surgical Arts Center
9499 W. Charleston #250
Las Vegas, NV 89117
(702) 933-3600

25633 M
Anthony Mjm C Ruggeroli MD
Orth Beau R

08/13/2013

Dr Ruggeroli Pain Management Orders

Pre-Procedure Orders:

- Noted
SS Kachas*
1. Obtain appropriate consent
 2. Start heplock unless patient requests no IV access
 3. Vital signs BP/P/SAO2
 4. O2 2-8L/min. nasal cannula or mask PRN
 5. Urine HCG if indicated
 6. Accucheck on all diabetic patients.
 7. Additional Orders:

Procedure Orders:

- not
all*
1. O2 2-8L/min nasal cannula or mask prn
 2. Versed 4 mg IV
 3. Fentanyl mcg IV
 4. Propofol mg IV
 5. Alfenta mcg IV
 6. Romazicon mg IV
 7. Additional Orders:

Post Procedure Orders:

- Wm
8/13/13
over*
1. Vital Signs q 5 minutes until stable
 2. Diet as tolerated
 3. DC IV or heplock before discharge
 4. Provide and review written copy of post procedure instructions including medications and restrictions
 5. Discharge patient when all criteria met.
 6. Additional orders:

Physician Signature _____

Date 8-13-13

Surgical Arts Center
9499 W. Charleston, Ste 250
Las Vegas, NV 89117

25633
Anthony Mjm C Ruggeroli MD
Orth Beau R

08/13/2011

DISCHARGE INSTRUCTIONS

The injection you received contained the local anesthetic and possibly some steroid medication (to reduce inflammation and pain, not the muscle-building kind of steroid). You should have decreased or no pain from four to eight hours due to the local anesthetic. Some pain at the injection site may be present tonight, but should be gone within 24 hours.

If you have an emergency question or problems concerning the injection, call Dr. McKenna or Dr. Ruggeroli at 307-7700. If you cannot contact Dr. McKenna or Dr. Ruggeroli and feel it is an emergency, go to the nearest emergency room for treatment.

EPIDURAL INJECTION

Do not drive an automobile, use stairs or engage in strenuous activities until the numbness has completely worn off and full strength has returned to your arms and legs. Your arms and/or legs may be weaker than they feel for up to eight hours after the injection.

FACET INJECTION/LUMBAR SYMPATHETIC BLOCK/SELECTIVE NERVE ROOT BLOCK/BIER BLOCK

You may experience some weakness and/or numbness in the arm or leg on the side of the injection. Limit strenuous activity until this is gone in four to eight hours.

STELLATE GANGLION INJECTION

It is normal for your eyelid to droop, blurry vision, hoarseness, or arm numbness and/or weakness on the side of the injection. These affects should pass in six to eight hours.

TRIGGER POINT OR OTHER LOCAL INJECTION

The area where you have been experiencing pain will most likely be numb. Limit strenuous activity to avoid straining muscles, which haven't been used for a while. It is good, however, to stretch that muscle which will help the pain stay away.

RADIOFREQUENCY/CRYO (Cryoanalysis)

You may experience discomfort in the area of the treatment for up to two weeks.

DISCOGRAM

You probably will have increased pain for about two days. If you notice a fever or significantly altered pain following the discogram, call Dr. McKenna or Dr. Ruggeroli.

BACLOFEN

You may feel weak for a short period of time. It is possible that you may develop a spinal headache. This usually clears on it's own. If not, call Dr. McKenna or Dr. Ruggeroli.

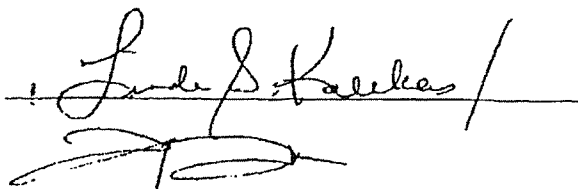
EPIDURAL NARCOTIC TRIAL

You may experience itching, trouble urinating or nausea. These side effects will resolve with time. You may also experience shortness of breath, if so, call Dr. McKenna or Dr. Ruggeroli.

ADDITIONAL INFORMATION

1. You may experience a temporary degree of increased pain or sensitivity as the local anesthetic wears off before the anti-inflammatory medication (steroid) takes effect.
2. To relieved discomfort at the injection site you may try an ice pack or heating pad.
3. After your procedure, avoid increasing your discomfort with strenuous activities and take Tylenol or other pain medication as prescribed.

Patient/Family Member Name



PAIN MANAGEMENT CHART AUDIT

EACH CHART SHALL BE AUDITED FOR COMPLETENESS AND SHALL BE COMPLETE PRIOR TO BEING FILED FOR STORAGE

EACH ITEM SHALL BE CHECKED AS COMPLETE OR INDICATED AS N/A

- | | |
|------------------------------------|---|
| A. PATIENT SUMMARY SHEET | <input checked="" type="checkbox"/> |
| B. PATIENT FACE SHEET | <input checked="" type="checkbox"/> |
| C. HIPAA RECEIPT ACKNOWLEDGMENT | <input checked="" type="checkbox"/> |
| D. RESUSCITATIVE MEASURES | <input checked="" type="checkbox"/> |
| E. CONSENT FOR PROCEDURE | <input checked="" type="checkbox"/> |
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| J. VALUABLES SHEET | <input checked="" type="checkbox"/> |
| K. PHYSICIAN'S ORDERS | <input checked="" type="checkbox"/> |
| L. LABORATORY REPORTS | <input checked="" type="checkbox"/> N/A |
| M. DISCHARGE INSTRUCTIONS | <input checked="" type="checkbox"/> |
| N. INITIAL PRE-ANESTHETIC RECORD | <input checked="" type="checkbox"/> |

SIGNATURE

J. Gustafson RN

DATE 3-1-10

Beau Orth
Dr. Anthony Ruggieri
DOS-2-24-10

7.54

SURGICAL ARTS CENTER

9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NV 89117 • 702 933-3600

Patient Name:

Bean Dith

DISCLOSURE AND CONSENT TO OPERATION OR OTHER SPECIAL PROCEDURES

To the patient: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, age or handicapping condition. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

GENERAL CONSENT & CONDITIONS: I (we) hereby authorize and understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize Dr. Anthony C. Ruggenti surgeon, and/or such assistant(s)

as may be selected by him/her to perform: lumbar sacral Transforaminal epidural with Steroid injection under fluoroscopy.

My physician has explained the procedure(s) necessary to treat my condition, possible risks and consequences associated with this/these procedure(s). I understand this explanation is not exhaustive and other risks and consequences may arise. No guarantee(s) or assurances have been made to me as to the result or cure. I feel comfortable with the information I have received and therefore give my informed consent.

If any presently unforeseen condition arises or is discovered during the course of this/these operation(s) or procedure(s), I authorize and request the performance of such operation(s) or procedure(s) in addition to or different from those now contemplated which my physician or associate(s) or designer(s) consider necessary or advisable in the exercise of his/her professional judgement.

In the event that a transfer is required to a local hospital, I understand and authorize Surgical Arts Center to release photocopies of Medical Records to that hospital. Photocopies will include but is not limited to, patient history, physical exam reports, physicians' and nurses' notes, lab and X-ray reports. I also give consent for the hospital to give Medical Records to Surgical Arts Center.

If it is necessary to remove any body material, I hereby authorize Surgical Arts Center to use their discretion in its disposal.

INDEPENDENT STATUS OF PHYSICIANS: I understand that physicians on the staff of this Center may be employees or independent contractors who have been granted the privilege of using this Facility for the care and treatment of their patients.

Surgical Arts Center is owned by Dr. Steven Thomas and Dr. Michael McKenna who also perform procedures at this facility.

ANESTHETICS: I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the anesthesia.

CONSENT TO DRAW BLOOD: I, the undersigned, do hereby consent to the withdrawal of a blood sample from my body in the event of a Medical Emergency or in the event that an employee or physician of Surgical Arts Center has had an accidental needle puncture or mucus membrane (eye, mouth, etc.) exposure to my blood or of a body fluid.

OBSERVERS: I consent for a health care representative to be present during the procedure as deemed necessary.

I understand that from time to time the Surgical Arts Center and its medical staff participate in medical training programs, under the supervision of a physician. For the purpose of advancing medical education. I consent to the admittance of medical observers to the operating room.

PHOTOGRAPHY: I understand that Surgical Arts Center and my physician may photograph certain parts of the procedure and use the negatives or prints for the purposes as may be deemed necessary. I consent to the photographing of the operation or procedure to be performed.

PERSONAL VALUABLES: I release the Surgical Arts Center from all responsibility relative to the loss and/or damage to property, money or valuables which are not deposited with the surgical center for safe keeping.

ADVANCE DIRECTIVES: I understand that it is my responsibility to share information with Surgical Arts Center concerning my Advance Directives if one exists.

DISCHARGE AGREEMENT: I have been informed and understand that it is absolutely necessary for someone to accompany me home after surgery. I understand that I cannot drive myself home and must be discharged into the care of and driven from the outpatient surgery center by another responsible adult.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

[Signature]
Patient or other legally responsible person

self
Relationship

[Signature]
Witness to Signature

2-24-10
Date

0815
Time

SAC-100 (5-2009)
1457

P00433
R.App. 000174

Pain Management

Surgical Arts Center
9499 W. Charleston, Ste 250
Las Vegas, NV 89117

25633 M 02/24/2010
Anthony Mjm C Ruggeroli MD
Orth Beau R

Medications: None

Allergies: (Penicillin)

Medical Problems: High blood pressure Yes ☒ No Heart condition Yes ☒ No
Asthma/Lung problems Yes ☒ No Hepatitis Yes ☒ No
Diabetes: Yes ☒ No Aids/HIV positive Yes ☒ No
Smoking: Yes ☒ No Kidney disease Yes ☒ No
Coumadin: Yes ☒ No Shortness of Breath Yes ☒ No
Aspirin: Yes ☒ No Street drugs Yes ☒ No

If yes to any of above or any other medical problems, please describe:

Physical Examination:

Pain Description: Back Problems.

Blood Pressure: 138/91 Pulse: 62

	Normal	Other
HEENT:	<input type="checkbox"/>	_____
Cardiac:	<input type="checkbox"/>	_____
Pulmonary:	<input type="checkbox"/>	_____
Neuro:	<input type="checkbox"/>	_____

DIAGNOSIS: Lumbar Radic (722.10) Cerv Radic (722.0) Lumb Disc (722.10) Cerv Disc (722.4)
Lumb Spond (721.3) Cerv Spond (721.0) Sacroiliac Arthropathy (720.2)
CRPS I UE (337.21) CRPS ILE (337.22) Cervical Strain (847.2) Lumbar Strain (847.0)
Other: _____

PLAN: Lumbar: TFED ILED/Caudal Z-jt Z-jt RF Disco Sympathetic
Cervical: TFED ILED Z-jt Z-jt RF Disco Sympathetic
SI joint Hip/Intra-articular Occipital Nerve Piriformis
ED Trial ITB Trial SCS Trial(total contacts) IDDS Implant
Other: _____

Physician Signature: [Signature] Date: 2-24-10

UNIVERSITY OF NEVADA, LAS VEGAS
ATHLETIC TRAINING DEPARTMENT
MEDICAL REFERRAL

PATIENT: Victor (X) SPORT: Volleyball
APPOINTMENT DATE: 5/21/10 DAY: Wednesday TIME: 5:00 (AM/PM)
TO BE SEEN BY: Dr. King AT: Shirley H. Center
REASON FOR REFERRAL: injury

REFERRED BY: Krista Sawyer, D.C. (Dr. Michael Mulligan)

MEDICAL ADVISOR'S REPORT

DIAGNOSIS: _____

X-RAY REPORT: _____

MEDICATION: _____

FURTHER RECOMMENDATIONS: _____

Rest / Ice / Pain relief / Heat
5-7 days / 10-15 min / 3-4 times a day

____ COMPLETE REST ☒ MODIFIED ACTIVITY ____ FULL ACTIVITY

ATHLETE MAY RETURN TO PRACTICE IN APPROXIMATELY _____ DAYS.

RETURN FOR NEXT EXAM IN 22 AT (DR. OFFICE) SHC ____ LAC 105

16 M.D. ____ SEND F/U REPORT TO SHC

ALL BILLS AND

FORMS SHOULD BE SENT TO:

UNLV ATHLETIC TRAINING DEPARTMENT
ATTN: _____ OFFICE
4505 MARYLAND PARKWAY • BOX 450007
LAS VEGAS, NV 89154-0007
PHONE: (702) 895-3677
FAX: (702) 895-4474

PLEASE BE ADVISED THAT THE _____ MAINTAINED BY UNLV IS A SECONDARY _____ THIS
COVERS THOSE AMOUNTS NOT COVERED BY THE PRIMARY COLLECTABLE _____ CARRIED BY THE
STUDENT OR PARENTS.

ATTENTION PROVIDED: THIS REFERRAL IS FOR SERVICES OBTAINED BY THE AFOREMENTIONED PHYSICIAN.
REFERRAL TO ANOTHER PROVIDER MUST BE APPROVED BY THE HEAD ATHLETIC TRAINER.

PR/0007-2/08-09

Surgical Arts Center

9490 W Charleston Blvd Suite 250 Las Vegas, NV 89117
702-933-3600 Fax: 702-933-3601

February 24, 2010

Page 1

Chart Document

Beau R Orth

Male DOB:

02/24/2010 - Operative Report**Provider: Anthony C. Ruggeroli, MD****Location of Care: Surgical Arts Center****Date of Procedure: 02/24/2010****Procedure Performed At: Surgical Arts Center****Patient: Orth, Beau****Preoperative Diagnosis: 1) LUMBAR DISC HERNIATION/PROTRUSION/BULGE (ICD-722.10)****Postoperative Diagnosis: 1) LUMBAR DISC HERNIATION/PROTRUSION/BULGE (ICD-722.10)**

Procedure(s): 1) left L5-S1 transforaminal epidural steroid injection
2) left S1 transforaminal epidural steroid injection
3) fluoroscopic needle localization / guidance and spinal exam
4) Intravenous conscious sedation, moderate

Medications: lidocaine 1%, bupivacaine 0.75%, depomedrol 40mg/ml, Omnipaque 180,
midazolam

Performing Physician: Anthony C. Ruggeroli, M.D.**Complications: NONE**

Description of the procedure: After informed consent was verified, the patient was brought to the fluoroscopy suite, and was placed in the prone position. Triple alcohol skin prep was accomplished over the lumbosacral area, and sterile drapes were applied. Non invasive monitoring was placed, including BP, pulse oximetry, and EKG, and was continued throughout the remainder of the case. Positioning comfort was verified with the patient and adjusted/modified as necessary.

Incremental doses of midazolam was administered intravenously for anxiolysis; the patient remained cooperative and responsive to voice throughout the remainder of the procedure. Refer to nursing record for total dose utilized.

C-arm fluoroscopy was used to identify lumbar segment L5-S1 and the left S1 dorsal foramen, and angulated obliquely, and as necessary, to optimize image detail of the left L5-S1 intervertebral foramen and the left S1 dorsal foramen. Skin wheals were then raised over the windows using approximately 0.5 ml of 1% lidocaine per wheal. Next, styletted 22ga needles were used to penetrate the skin, and were advanced; one towards the caudad aspect of the L5-S1 foramen, with the other needle directed towards the lateral aspect of the left S1 dorsal foramen. Multiple views were used, as necessary, including A/P and lateral views, to optimize final position of the needles during adjustments. No paresthesias were reported during this process. Next, approximately 0.75ml of omnipaque 180 was injected through each needle, where an outline of the roots and mesial aspects of the pedicles, L5 and S1, was observed, indicating epidural distribution, without vascular uptake. Next, a solution was prepared comprising of a mixture of depomedrol 40mg/ml and 0.75% bupivacaine, two to one. 1.5ml of that solution was injected through each

FEB-25-2010(THU) 08:53

Melasma Pain Mgmt

(FAX) 702 307 7942

P. 031/031

Surgical Arts Center

8499 W Charleston Blvd Suite 250 Las Vegas, NV 89117
702-933-3600 Fax: 702-933-3601

February 24, 2010

Page 2
Chart Document

Beau R Orth

Male DOB:

needle, two injections total, without patient complaint and the needle was removed intact.

The patient will see me back in follow up as scheduled and will track pain scores and function in the interim.

Anthony C. Ruggeroli, M.D.

CC to:

Signed by Anthony C. Ruggeroli, MD on 02/24/2010 at 12:26 PM

Pain Management Procedure Record

PRE-OP:
 Ride/Name: Rob Waiting Y or N
 Phone: 348-8115
 Allergies: PCN

HISTORY:
 HCG: N/A
 Accucheck: N/A
 Anticoagulants: N/A
 P.T. INR
 History: _____

IV:
 Site: LEA #22 #24
 Attempts: 1
☒ Hep Lock w/ NS Flush

Pain Level: 5 / 10

Time	B.P.	Pulse	SaO2
0810	130/71	62	98%

☐ IV _____
☐ Antibiotic _____

RN: Shel Stang Jr

INTRA-OP: Time Start: 900
 Time End: 917

Position ☐ R Lateral ☒ Prone ☐ Sitting
☐ L Lateral ☐ Supine
 Prep ☒ Alcohol ☐ Duraprep ☐ Hibiclens ☐ Betadine

Time	B.P.	Pulse	SAO2	LOC
In: 900	140/85	81	99	2
905	141/83	71	98	2
910	135/70	75	98	2
915	131/66	77	97	4
out: 917	128/74	70	96	3

Time	Medications	Site	RN	Nurse's Notes
901/909	Versed 212 mg	IV	JC	<input type="checkbox"/> O2: _____ /min/N/C
	Fentanyl mcg	IV		<input type="checkbox"/> Celestone 6mg/cc
	Diprivan mg	IV		<input checked="" type="checkbox"/> Depomedrol 80mg/cc
	Alfentanil mcg	IV		<input checked="" type="checkbox"/> Lidocaine 1% 2% 4%
	Romazicon mg	IV		<input checked="" type="checkbox"/> Isovue 300 / Isovue 180
				<input checked="" type="checkbox"/> Marcaine 0.25% 0.5% .75%
				<input type="checkbox"/> Dexamethasone 10mg/ml
				<input type="checkbox"/> PFNS

Procedure: TPED Left S. + L.S. Tol Procedure: _____ RN: Ull
 RN: 10/24/2010

ADMISSION ASSESSMENT:

CARDIOVASCULAR

Heart Sounds: audible distant
 Peripheral Pulses: equal, unequal, weak
 strong bounding, absent
 Neck Veins: distended, flat

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent
 Respirations: no distress, sob, labored, accessory muscles
 used
 Cough: absent, non-productive, productive

NEUROLOGICAL

LOC: alert, lethargic, unresponsive
 Orientation: oriented, disoriented,
 Pupils: equal, unequal, reactive, unreactive

INTEGUMENTARY

Skin Color: pink, pale, cyanotic, jaundice
 Skin Temperature: warm, dry, cool, clammy, diaphoretic
 Skin Turgor: loose, tight
 Mucous Membrane: moist, dry, cracked

GASTROINTESTINAL

Abdomen: soft, firm, hard, flat, distended
 Bowel Sounds: absent, present

BEHAVIOR

Cooperative: restless, withdrawn, crying, talkative, resistive,
 combative, calm & relaxed, anxious, fearful

Level of Consciousness:

1: Agitated _____ 2: Alert _____ 3: Sedated _____
 4: Drowsy _____ 5: Sleeping: _____

25633

M 02/24/2010

Anthony Mjm C Ruggero II MD
 Orth Beau R

Surgical Arts Center 9499 W Charleston, Suite 250 Las Vegas, NV 89117 (702) 933-3600

Pain Management Procedure Record

POST-OP:

Time	B.P.	Pulse	SaO2	Time	Nurse's Notes
0917	128/74	76	97	0917	Received from OR via scanner
0922	126/75	75	96		Steady but possibly anxious
0927	128/76	77	96		Aspirin 325mg
				0935	Wound - 200cc left leg
					seal - OK
Time	Meds	Site	RN		
				0945	Eval by Dr. Kropf
					meds - 2 Aspirin 325mg
					stable condition

DISCHARGE:

☒ Tol P.O. fluids well

☒ D/C criteria met

☒ Cleared for D/C by MD

☒ IV D/c'd

☒ Ambulatory

☐ Wheelchair

Injection Site Condition:

Banip Pain Level: 0/10

☒ w/responsible adult

Time Discharged: 0945

RN:

AW [Signature]

POST-PROCEDURE CONTACT REPORT:

Date: 2-24-10 ☒ Letter Sent ☐ Phone

Complications:

☒ Yes

☐ No

RN:

AW [Signature]

POST-OP ASSESSMENT:

CARDIOVASCULAR

Heart Sounds: audible, distant

Peripheral Pulses: equal, unequal, weak

strong bounding, absent

Neck Veins: distended, flat

NEUROLOGICAL

LOC: alert, lethargic, unresponsive

Orientation: oriented, disoriented,

Pupils: equal, unequal, reactive, unreactive

GASTROINTESTINAL

Abdomen: soft, firm, hard, flat, distended

Bowel Sounds: absent, present

RESPIRATORY

Breath Sounds: clear, rales, rhonci, diminished, loud, absent

Respirations: no distress, sob, labored, accessory muscles used

Cough: absent, non-productive, productive

INTEGUMENTARY

Skin Color: pink, pale, cyanotic, jaundice

Skin Temperature: warm, dry, cool, clammy, diaphoretic

Skin Turgor: loose, tight

Mucous Membrane: moist, dry, cracked

BEHAVIOR

Cooperative: restless, withdrawn, crying, talkative, resistive, combative, calm & relaxed, anxious, fearful

Identity/Procedure/Site Verification

Pre-operative:

- ☒ Patient states first identifier (list) name
- ☒ Patient states second identifier (list) D.O.B.
- ☒ Patient's responses match ID band
- ☒ Patient states procedure, site, side, and physically identifies same.
- ☒ Consent matches patient stated responses.
- ☒ Medical record relevant data, i.e. H&P, matches patient stated responses.
- ☒ OR schedule is consistent with patient responses and H&P.
- ☒ Site is marked yes (N/A for Pain Management and Cosmetic Procedures)
- ☒ Site initiated by Physician (N/A for Pain Management and Cosmetic Procedures)
- Discrepancy Noted: Yes ☐ No ☒

Explain: _____

Discrepancy Resolution _____

Resolution Communicated to Team. _____

R.N.: Paul Stung

Intra-operative:

- ☒ Confirmation of: patient identity, procedure, consent, site and positioning.
- ☒ Radiographs / Implants / Special Equipment available
- ☒ "Time Out" @ 9:00 to Verify:
 - ☒ Correct patient
 - ☒ Correct site
 - ☒ Correct procedure
 - ☒ Appropriately displayed x-rays on correct patient
 - ☒ Staff Participating in "Time Out" are same Surgeon, Anesthesiologist, Circulating Nurse, and Scrub Tech documented on OR record
- Otherwise List: _____

Discrepancy Noted: Yes ☐ No ☒

Explain: _____

Discrepancy Resolution _____

Resolution Communicated to Team. _____

R.N.: J. Gustafson

PACU:

- ☒ Confirm patient identity via arm band/chart.
- ☒ No Consent and procedure documented on OR record match within scope of related procedures.
- If "No", Explain: _____
- Surgeon Notified of Discrepancy _____

R.N.: Wade Jones

Surgical Arts Center
9499 West Charleston, Suite 250
Las Vegas, NV 89117

25633 M 02/24/2010
Anthony Mjm C Ruggeroli MD
Orth Beau R

Nurse's Notes Continued:

Pain Management Patient Care Plan

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential to lack knowledge concerning proposed Pain Management procedure	Patient will acknowledge understanding of proposed procedure prior to the performance of the procedure	Provide explanation regarding proposed procedure	Communicate with patient and family regarding specific procedure and answer any questions	(Satisfactory) Unsatisfactory
Potential to lack pre-procedure preparation	Prepare patient for the procedure in the safest manner possible	Assess patient for drug allergies, NPO status, current medications (including blood thinners), smoking habits and alcohol consumption; check blood sugar on all diabetics and breath sounds on all thoracic patients, and any other pertinent information that could affect the outcome of the procedure	Patient interviewed and history taken; H&P reviewed; results of pre-operative testing reviewed when ordered	(Satisfactory) Unsatisfactory
Anxiety	Reduce anxiety	Answer questions and provide comfort	Establish rapport with patient and family; answer questions and provide comfort measures	(Satisfactory) Unsatisfactory
Desire for correct procedure site	Prevention of incorrect procedure site	Verify procedure site, check schedule and chart; obtain consent	Visually and verbally verify procedure site with patient; obtain written consent	(Satisfactory) Unsatisfactory
Lack of discharge knowledge	Patient will possess sufficient discharge knowledge to ensure a smooth transition from Surgical Arts Center to home	Complete discharge instructions specific to procedure gone over with patient	Discharge instructions specific to procedure will be gone over allowing the patient to ask questions and restate the instructions	(Satisfactory) Unsatisfactory

PRE-OP NURSE SIGNATURE:

Carol Strunk, RN

PERIPROCEDURE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential Injury to patient	PT. will not acquire injury perioperatively	Maintain patient safety and comfort	Greet pt; verify arm band, consent, op site, allergies and any other pertinent information; encourage questions; position patient appropriately; monitor pt.	(Satisfactory) Unsatisfactory

PROCEDURE NURSE SIGNATURE:

J. G. [Signature]

PACU STANDARDS OF CARE

Nursing Diagnosis	Goal	Plan	Implementation	Comments
Potential for Injury	PT. will not acquire injury in PACU	Maintain patient safety and comfort	PT. assessment; vs q 5 min x 3 or until stable using appropriate intervention if necessary; offer & encourage nourishment; maintain preop musculoskeletal system level of function; discharge after instructions given and criteria met.	(Satisfactory) Unsatisfactory

PACU NURSE SIGNATURE:

[Signature]

Surgical Arts Center
702-933-3600
fax 702-933-3601
9499 W. Charleston Blvd, Las Vegas, NV 89117

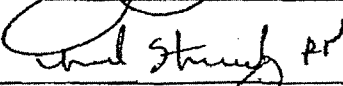
VALUABLES

These items have been taken from me and placed into the security envelope:

These items have been left in my possession:

☒ I have no valuables/jewelry/money with me today

Patient Signature: 

Witness: 

Date: 2-24-10 Time: 0815

I ACKNOWLEDGE RECEIPT OF THE ITEMS PLACED IN THE SECURITY ENVELOPE:

SIGNATURE: _____

RELATIONSHIP: _____

WITNESS: _____

Date: _____ Time: _____

25633 M 02/24/2010
Anthony Mjm C Ruggeroli MD
Orth Beau R

1466

P00442
R.App. 000183

Surgical Arts Center
9499 W. Charleston #250
Las Vegas, NV 89117
(702) 933-3600

25633 M 02/24/2010
Anthony Mjm C Ruggeroli MD
Orth Beau R

Dr Ruggeroli Pain Management Orders

Pre-Procedure Orders:

- 7-24-10
Instr*
1. Obtain appropriate consent
 2. Start heplock unless patient requests no IV access
 3. Vital signs BP/P/SAO2
 4. O2 2-8L/min. nasal cannula or mask PRN
 5. Urine HCG if indicated
 6. Accucheck on all diabetic patients.
 7. Additional Orders:

Procedure Orders:

- Noted
2-24-10
9:00
J. Gunka*
1. O2 2-8L/min nasal cannula or mask prn
 2. Versed 4 mg IV
 3. Fentanyl _____ mcg IV
 4. Propofol _____ mg IV
 5. Alfenta _____ mcg IV
 6. Romazicon _____ mg IV
 7. Additional Orders:

Post Procedure Orders:

- noted:
available
2/24/10*
1. Vital Signs q 5 minutes until stable
 2. Diet as tolerated
 3. DC IV or heplock before discharge
 4. Provide and review written copy of post procedure instructions including medications and restrictions
 5. Discharge patient when all criteria met .
 6. Additional orders:

Physician Signature *[Signature]*

Date 2-24-10

Surgical Arts Center
9499 W. Charleston, Ste 250
Las Vegas, NV 89117

25633 M 02/24/2010
Anthony Mjm C Ruggeroli MD
Orth Beau R

DISCHARGE INSTRUCTIONS

The Injection you received contained the local anesthetic and possibly some steroid medication (to reduce inflammation and pain, not the muscle-building kind of steroid). You should have decreased or no pain from four to eight hours due to the local anesthetic. Some pain at the Injection site may be present tonight, but should be gone within 24 hours.

If you have an emergency question or problems concerning the injection, call Dr. McKenna / Dr. Ruggeroli at 307-7700. If you cannot contact Dr. McKenna or Dr. Ruggeroli and feel it is an emergency, go to the nearest emergency room for treatment.

EPIDURAL INJECTION

Do not drive an automobile, use stairs or engage in strenuous activities until the numbness has completely worn off and full strength has returned to your arms and legs. Your arms and/or legs may be weaker than they feel for up to eight hours after the injection.

FACET INJECTION/LUMBAR SYMPATHETIC BLOCK/SELECTIVE NERVE ROOT BLOCK/BIER BLOCK

You may experience some weakness and/or numbness in the arm or leg on the side of the injection. Limit strenuous activity until this is gone in four to eight hours.

STELLATE GANGLION INJECTION

It is normal for your eyelid to droop, blurry vision, hoarseness, or arm numbness and/or weakness on the side of the injection. These affects should pass in six to eight hours.

TRIGGER POINT OR OTHER LOCAL INJECTION

The area where you have been experiencing pain will most likely be numb. Limit strenuous activity to avoid straining muscles, which haven't been used for a while. It is good, however, to stretch that muscle which will help the pain stay away.

RADIOFREQUENCY/CRYO (Cryoanalysis)

You may experience discomfort in the area of the treatment for up to two weeks.

DISCOGRAM

You probably will have increased pain for about two days. If you notice a fever or significantly altered pain following the discogram, call Dr. McKenna or Dr. Ruggeroli.

BACLOFEN

You may feel weak for a short period of time. It is possible that you may develop a spinal headache. This usually clears on it's own. If not, call Dr. McKenna or Dr. Ruggeroli.

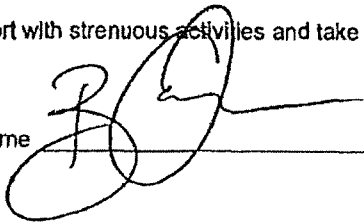
EPIDURAL NARCOTIC TRIAL

You may experience itching, trouble urinating or nausea. These side effects will resolve with time. You may also experience shortness of breath, if so, call Dr. McKenna or Dr. Ruggeroli.

ADDITIONAL INFORMATION

1. You may experience a temporary degree of increased pain or sensitivity as the local anesthetic wears off before the anti-inflammatory medication (steroid) takes effect.
2. To relieved discomfort at the injection site you may try an ice pack or heating pad.
3. After your procedure, avoid increasing your discomfort with strenuous activities and take Tylenol or other pain medication as prescribed.

Patient/Family Member Name _____



INSTRUCTION TO PATIENT: Please print or indicate by a check mark (✓) your answer to each question. These answers will greatly help your anesthesiologist to give you the best possible care during your operation. If you do not understand any question (or your answer is uncertain) simply place a question mark (?) next to the answer column.

Name Beau Orth Age 30 Sex M

Height 6'1 Weight 220 lbs. Right Handed ☒ Left Handed ☐

1. List all medications (prescription, non-prescription, herbal products, and vitamins) taken over the past 6 months.

2. List all allergies to medications / Include foods.

Penicillin

3. List all previous surgeries (and when).

Shoulder Surgery Dec '07

HAVE YOU OR HAVE YOU HAD . . . YES NO

- | | | |
|------------------------------------|-------------------------------------|-------------------------------------|
| 12. Glaucoma | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. Stiff Jaw or Neck | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. A Cold in the past month | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15. Shortness of Breath | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 16. Chronic Cough | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 17. Asthma | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 18. Heart Attack | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 19. Chest Pain; Angina | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 20. Palpitations | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 21. High Blood Pressure | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 22. Hepatitis | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 23. Hiatal Hernia | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 24. Rheumatic Fever | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 25. Ulcers | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 26. Stroke | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 27. Seizures | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 28. Blackouts | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 29. Back Problems | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 30. Muscle Disease | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 31. Arthritis | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 32. Diabetes | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 33. Thyroid Problems | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 34. Bleeding Tendencies | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 35. Sickle Cell Anemia | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 36. Blood Transfusions | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 37. Kidney Disease | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 38. Aids/HIV Positive | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 39. Any Others | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

- | | | |
|--|------------------------------|--|
| 4. Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery? | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> |
| 5. Have you or your family had any unusual reaction to anesthesia? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have or are you taking "street drugs"? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you had recent weight change? (Significant amount).... | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Are you pregnant? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Do you smoke? If yes, _____ cigarettes per day | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Do you have caps, false teeth, or contact lenses? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Do you drink alcoholic beverages | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| How much? _____ | | |

Remarks:

Patient Label

25633 M 02/24/2010
Anthony Mjm C Ruggeroli MD
th Beau R

2/23/10
Date

[Signature]
Signature (Patient/For Person filling Out Form)

SURGICAL ARTS CENTER
9499 W. CHARLESTON, SUITE 250 • LAS VEGAS, NEVADA 89117
702 933-3600 fax 702 933-3601

Pre-Anesthesia Record

SAC-203 (Rev 02/2004)

1469

P00445
R.App. 000186

STATE OF NEVADA)
)ss:
COUNTY OF CLARK)

MARY HONEYFIELD, being first duly sworn states:
(Name of Custodian of Records)

1. I am the Custodian of Record for McKenna Ruggeroli Helmi Pain Spec.

and, as such, I act as a Custodian of Records for my employer.

2. On the 30 day of July, 2015, my employer received a request calling for production of all records, billing and radiology films in our facility's possession or under their control pertaining to Beau Orth.

3. I and/or persons acting under my supervision and control made a complete search of all available records.

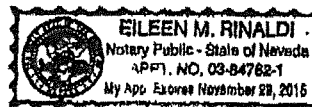
4. Our facility's Records Department maintains records for _____ years.

5. Our facility's Record Department, located the records and things, copies of which have been produced with this certificate. I have examined the original of these records and things and have made or caused to be made a true and exact copy of them. The reproduction of them provided with this certificate is true and complete.

6. The original of those records was made at or near the time of the act, event, condition, opinion or diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of McKenna Ruggeroli and Helmi Pain Specialists.

Mary Honeyfield
(Signature)
MARY HONEYFIELD
(Printed Name)

SIGNED AND SWORN to before me,
a Notary Public, on this 30 day of
July, 2015.
Eileen M. Rinaldi
NOTARY PUBLIC



07/27/2015 3:39PM (GMT-04:00)

P00236
R.App. 000187

AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

Affiant being first duly sworn, deposes and says:

1. I, LAURA TASCIONE as agent for DR Anthony Ruggieri
(Print Name of Affiant) (Name of Company or Business)

am the Custodian of Records of the medical records and/or billing records of the above entitled office or institution.

2. That I have examined the original of the attached medical records and/or billing records of BEAU ORTH and that the attached copy is a true and complete copy of the originals thereof.

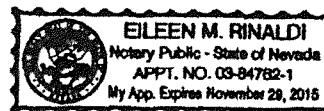
3. That the original of the medical records and/or billing records were made and recorded at or near the time that the services or statements recorded therein were rendered and that the same records, notes, data and information were made from information transmitted by a person with knowledge of the information contained in each record and that these records were kept in the regular course of the healthcare provider's regularly conducted business activities.

4. Affiant is the duly authorized representative and custodian of records of this healthcare provider and attests that the records supplied pursuant to this Affidavit are and were maintained and duly relied upon in the normal course and scope of the business of this healthcare provider's office.

LAURA TASCIONE
AFFIANT

SUBSCRIBED AND SWORN to before
me this 21 day of July, 2014.

Eileen M. Rinaldi
NOTARY PUBLIC in and for said
County and State



McKenna, Ruggeroli and Helmi Pain Specialists
6070 S Fort Apache Road Suite 100 Las Vegas, NV 89148-5615
7023077700 Fax: 7023077942

July 30, 2015
Page 1
Office Visit

Beau R Orth
Male DOB:

07/28/2015 - Office Visit: Follow up visit
Provider: Anthony C Ruggeroli
Location of Care: McKenna, Ruggeroli and Helmi Pain Specialists

History of Present Illness

Reason for visit: Re Evaluation
Chief Complaint: lumbar and left leg pain
Attorney Involved? no
Claiming as work related? no

Past Medical History

Back Problems
The patient denies any contributory past medical history.

Surgeries

Shoulders/Arms
low back surgery X2

Family History

The patient denies any contributory family medical history.
The patient denies any contributory family medical history.
Current Allergies (reviewed today):
PENICILLIN V POTASSIUM (PENICILLIN V POTASSIUM) (Critical)

Social History/Risk Factors

Work status: working
Daily activities: bending/squatting, lifting/pushing/pulling, repetitive movements, moderate to heavy physical labor/activity
Regular Exercise? yes
Alcohol use: 1-3 drinks per week
Tobacco use: Never smoker
Drug use: no
Last bone density test: never
Prior treatment for bone density? no
Handedness: right
Height: 74
Weight: 238

Risk Factors

Tobacco Use: Never smoker
Passive smoke exposure: no

Smokeless Tobacco Usage: Never

Fall Risk Assessment

History of broken bones as an adult? Yes

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July 30, 2015
Page 2
Office Visit

Beau R Orth
Male DOB:

Fallen more than twice in the last year? No
Have you sustained injuries from any of those falls? No
Take Calcium and/or Vitamin D Supplements? No
Currently taking Osteoporosis medications? No
Patient is not considered a risk for falls

Pain Follow-Up

Average pain since last visit: 6
Side effects from pain medications: yes
New medication since last visit: no

Tobacco Use: Never smoker

ADL

Present work status: regular, full time
Number of work days missed since last visit: 0
ER visit for pain since last visit: no

Review of Systems

General: Complains of fatigue.

Ears/Nose/Throat: Denies decreased hearing, difficulty swallowing.

Cardiovascular: Denies chest discomfort, swelling of hands/feet, racing heart beat, weight gain, palpitations, blackouts/fainting, shortness of breath with exertion/activity, difficulty breathing while lying down.

Respiratory: Denies wheezing, coughing-up blood, cough.

Musculoskeletal: Complains of joint swelling, joint pain, stiffness, back pain.

Skin: Denies night sweats, dryness, suspicious lesions, changes in nail beds, changes in skin color, poor wound healing.

Neurologic: Complains of headaches, numbness, tingling.

Psychiatric: Denies anxiety, depression, claustrophobia.

Endocrine: Denies cold intolerance, heat intolerance, excessive thirst, excessive urination.

Heme/Lymphatic: Denies persistent infections, seasonal allergies.

Patient scheduled for procedure: No

Patient provided the above responses and/or history obtained.

Physical Exam

Vital Signs

Height: 74 inches

Weight: 238 pounds

Blood Pressure: 124/77 mm Hg

Calculations

Body Mass Index: 30.67

BMI out of Range, Nutritional Counseling given: yes

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July 30, 2015
Page 3
Office Visit

Beau R Orth
Male DOB:

Lower Extremity Exam

Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsi flexion, knee extension, and hip flexion against resistance is without deficit bilaterally.

Deep Tendon Reflexes:

Knees: Right: normal Left: absent

Ankles: Right: normal Left: decreased

Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:

Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: negative bilaterally.

Sensation to Sharp:

Right: normal; S1 / L5 / L4 / L3 dermatomes intact

Left: S1 diminished

Comments to light touch

Lumbosacral Exam

Gross Exam Lumbosacral: surgical scar or other scar present

Palpation of Lumbosacral Soft Tissues:

Left: Mid tender, Lumbosacral tender

Lumbar Range of Motion:

extension limited with pain, rotation limited with pain

Assessment:

Assessed LUMBAR SPONDYLOSIS/FACET BASED PAIN as deteriorated - Anthony C Ruggeroli

Assessment of established problem(s):

The patient notes escalating left lumbar pain, despite doing a diligent home program. He was near pain free for two weeks following the radio frequency thermal coagulation procedure, and over the course of the next several months, the pain returned to baseline. He also notes ongoing left lower extremity pain, to a lesser degree relative to the lumbar pain, as well as off and on "numbness and tingling". At this point, for treatment of the mechanical left lumbar pain, repeating the radio frequency thermal coagulation is reasonable and medically necessary. This treatment option was discussed with him in detail, and due to work commitments, he will need to notify the office as to when he would be able to proceed.

Plan:

The patient is to contact the office to schedule the radio frequency thermal coagulation procedure as his work schedule allows

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Office Visit

Beau R Orth

Male DOB:

10870

Electronically signed by Anthony C Ruggeroli on 07/29/2015 at 4:29 PM

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July 17, 2014
Page 1
External Correspondence

Beau R Orth
Male DOB:

10870

06/03/2014 - External Correspondence: Appointment Reminder
Provider: Anthony C Ruggeroli
Location of Care: McKenna, Ruggeroli and Helmi Pain Specialists

Appointment reminder sent via Patient Portal

P00242
R.App. 000193

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July 17, 2014
Page 1
External Correspondence

Beau R Orth
Male DOB:

10870

05/27/2014 - External Correspondence: Appointment Reminder
Provider: Anthony C Ruggeroli
Location of Care: McKenna, Ruggeroli and Helmi Pain Specialists

Appointment reminder sent via Patient Portal

P00243
R.App. 000194

Beau R Orth
Male DOB:

10870

05/14/2014 - Operative Report
Provider: Anthony C Ruggeroli
Location of Care: Surgical Arts Center

Date of Procedure: 05/14/2014

Procedure Performed At: Surgical Arts Center

Patient: Orth, Beau

Preoperative Diagnosis: 1) LUMBAR SPONDYLOSIS/FACET BASED PAIN (ICD-721.3)
2) positive medial branch local anesthetic blocks and or facet injections
3) short term relief following therapeutic facet injection:

Postoperative Diagnosis: 1) same as above

Procedure(s): 1) radiofrequency thermal coagulation, left medial branch L3
2) radiofrequency thermal coagulation, left medial branch L4
3) radiofrequency thermal coagulation, left L5 dorsal ramus
4) fluoroscopic needle localization/guidance
5) Intravenous conscious sedation, moderate

Medications: lidocaine 1%, midazolam

Performing Physician: Anthony C. Ruggeroli, M.D.

Complications: NONE

Description of the procedure: After informed consent was verified, the patient was brought to the fluoroscopy suite, and placed in the prone position. DuraPrep skin prep was accomplished over the lower thoracic and lumbosacral skin regions, and sterile drapes were placed. A sterile down drape was placed over the gluteal and lower extremities to create a sterile field. Non invasive monitoring was placed, including BP, pulse oximetry, and EKG, and was continued throughout the remainder of the case. Positioning comfort was verified with the patient and adjusted/modified as necessary.

Incremental doses of midazolam was administered intravenously for anxiolysis; the patient remained cooperative and responsive to voice throughout the remainder of the procedure. Refer to nursing record for total dose utilized.

A large surface area return electrode was placed on the dorsal aspect of the right calf and connected to the generator unit. The RF needles that were intended to be used were grossly inspected; insulated surfaces were found to be intact. The cables were also visually inspected and found to be intact.

C-arm fluoroscopy was used, and medial branch target sites involving lumbar left L4 and L3 were identified, including the target site for the left L5 dorsal ramus, following fluoroscopic angulation that best approximated parallel alignment of the RF needle with respect to the expected course of medial branches and the L5 dorsal ramus. The target sites identified the junction of the SAP/TP at L5 and L4, as well as the S1 SAP/sacral ala junction. Skin wheals were placed over each target site using 1% lidocaine, approximately 0.5ml per wheal, using a 30ga. Needle. 110mm insulated curved needles, with 10mm

Beau R Orth
Male DOB:

10870

active ends were used to penetrate the skin and were directed towards each target/medial branch, without patient complaint. Osseous contact was made with each target without patient complaint. Multiple fluoroscopic angulations were utilized to guide and verify optimal placement, including lateral views which demonstrated the distal ends of the needles to be dorsal relative to their respective intervertebral foramina. The patient had no complaints during placement and subsequent adjustments, paresthesias or otherwise.

Stimulation test patterns were performed at each described target site, including 50HZ to 1 volt and 2HZ to less than 3volts, which did not produce any lower extremity paresthesias or motor activity, reported or visualized. With the needles in place, the stylettes were removed and 0.5ml of 1% lidocaine was injected through each needle to minimize patient discomfort during the lesioning process.

The electrode was then placed into the needle addressing the left L5 dorsal ramus, and was firmly seated within the hub. Impedance and temperature values were consistent with an intact system. A lesion was then created @ 80C for 90 seconds without patient complaint after a brief ramp up period. The needle was then removed intact.

The next medial branch was addressed, the left L4 medial branch, where, again, the electrode was placed into the needle, and was firmly seated within the hub. Impedance and temperature values were again checked and were found to be consistent with an intact system. A lesion was then created @ 80C for 90 seconds without patient complaint after a brief ramp up period. The needle was then removed intact.

Attention was then placed to the left L3 medial branch, where, again, the electrode was placed into the needle, and was firmly seated within the hub. Impedance and temperature values were again checked and were found to be consistent with an intact system. A lesion was then created @ 80C for 90 seconds without patient complaint after a brief ramp up period. The needle was then removed intact.

Band aids were place over the puncture sites. The patient was told to expect post procedure discomfort and instructed to use ice packs and NSAIDS/ PO analgesics and see me in the office as scheduled in two weeks. The patient was also instructed to contact me sooner if any problems or questions arose.

Anthony C. Ruggeroli, M.D.

CC to: Andrew Cash, MD

McKenna, Ruggeroli and Helmi Pain Specialists
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July 17, 2014
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Operative Report

Beau R Orth
Male DOB:

10870

Electronically signed by Anthony C Ruggeroli on 05/16/2014 at 12:46 PM

P00246
R.App. 000197

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Page 1
Procedure Images

Beau R Orth

Male DOB: 10870

05/14/2014 - Procedure Images: Procedure Images
Provider: Anthony C Ruggeroli
Location of Care: Surgical Arts Center
This document contains image attachments
Doc ID:

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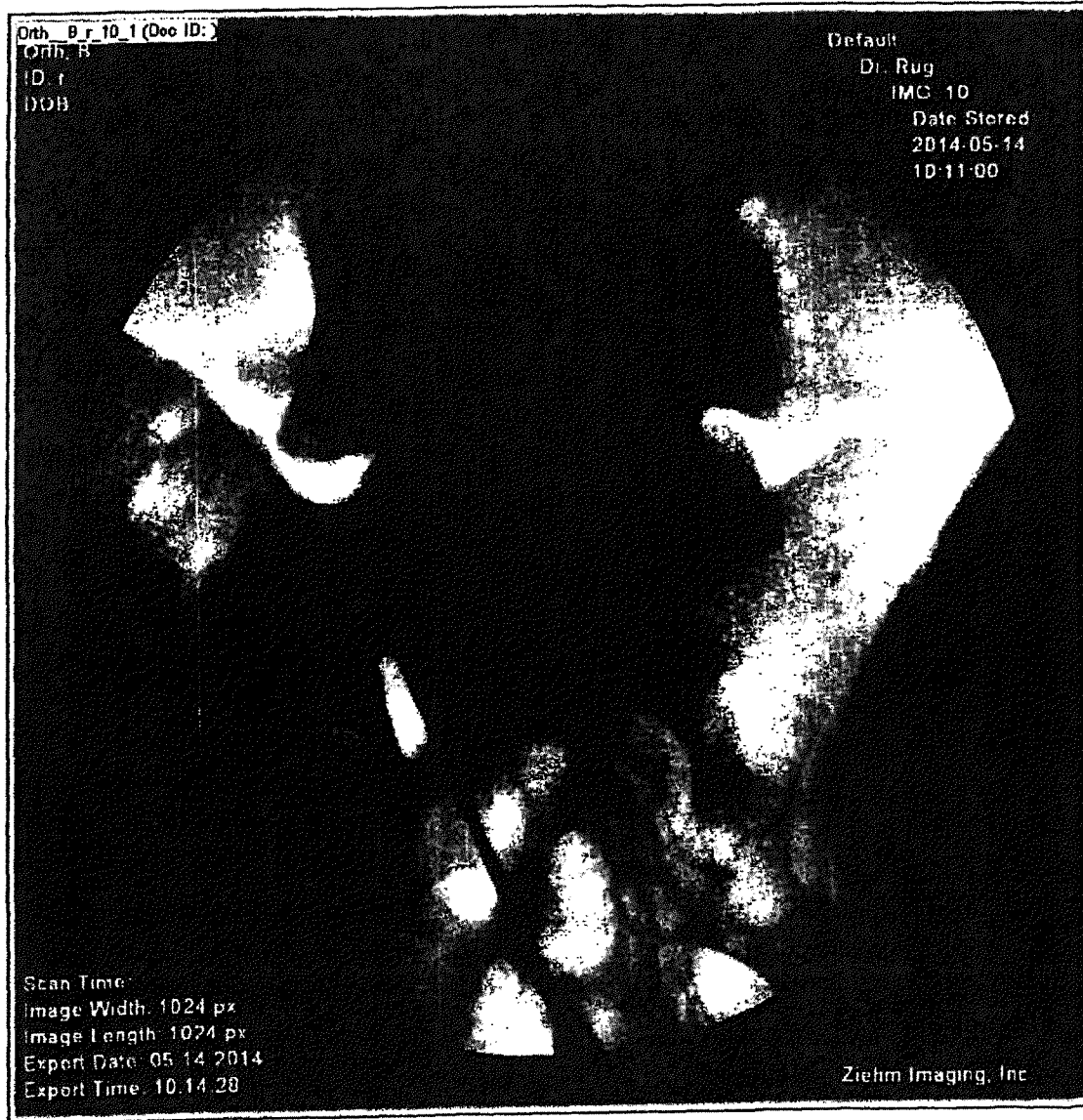
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Procedure Images

Beau R Orth
Male DOB:

10870



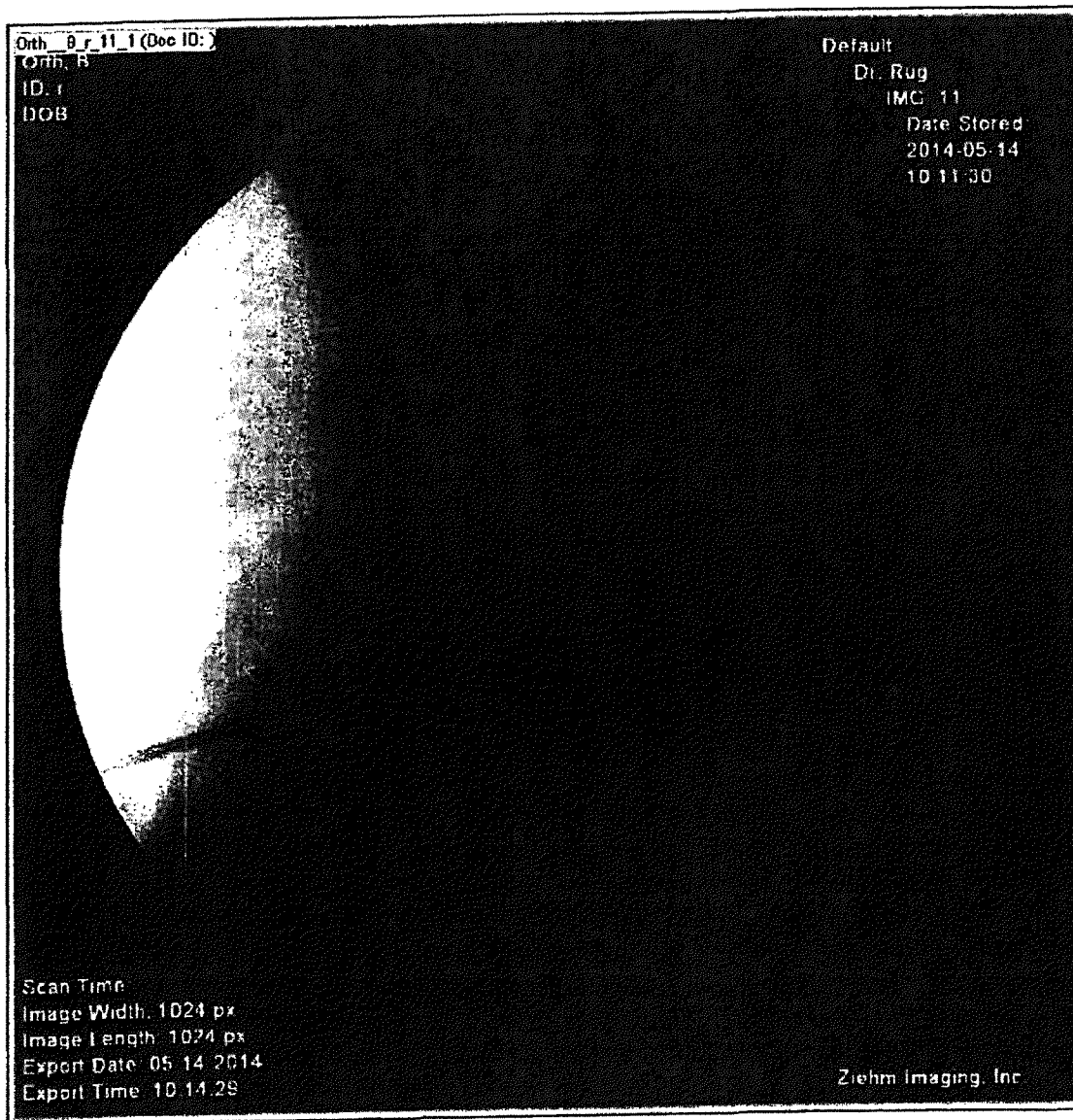
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Male DOB:

10870



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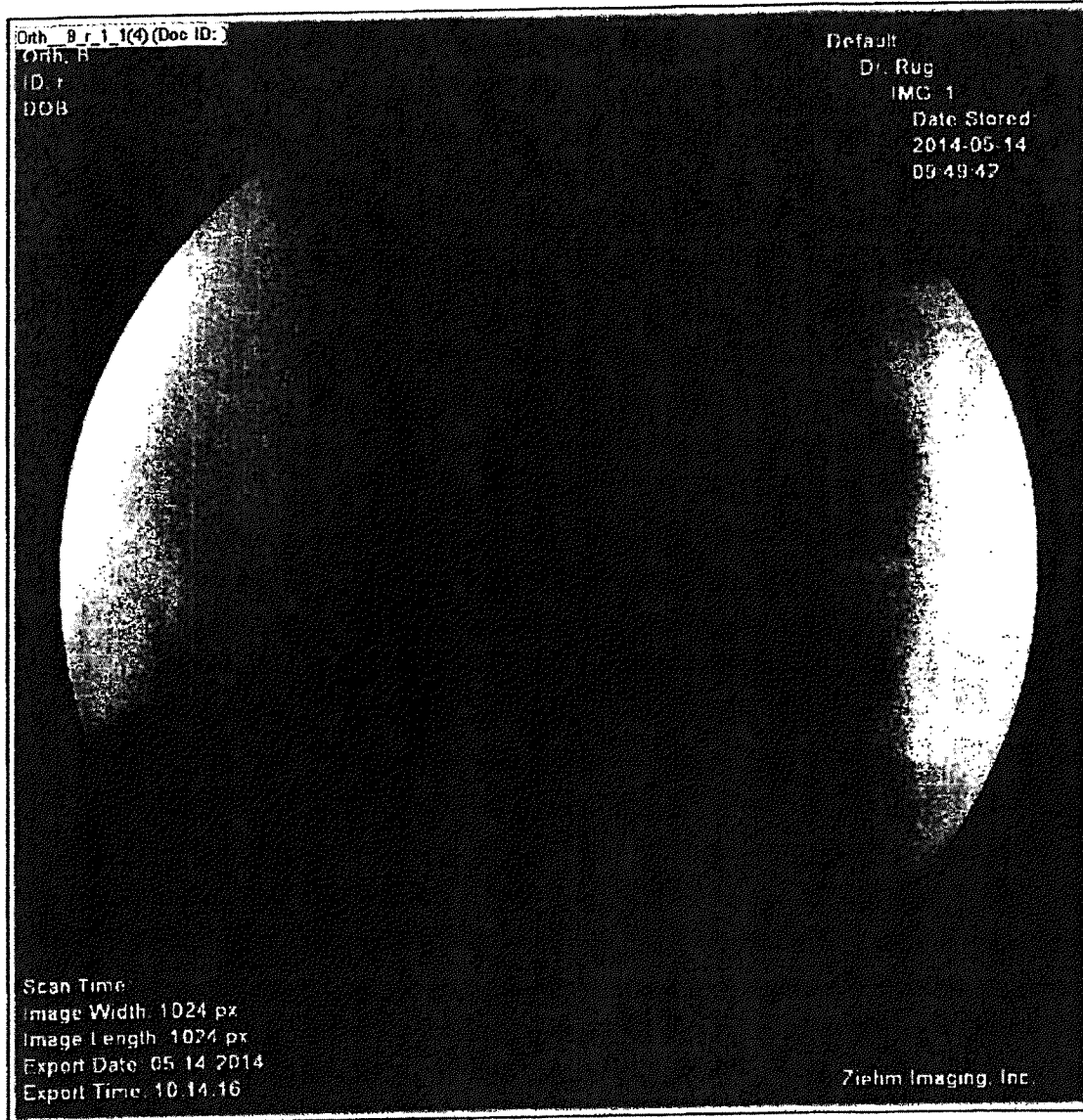
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Procedure Images

Beau R Orth

Male DOB:

10870



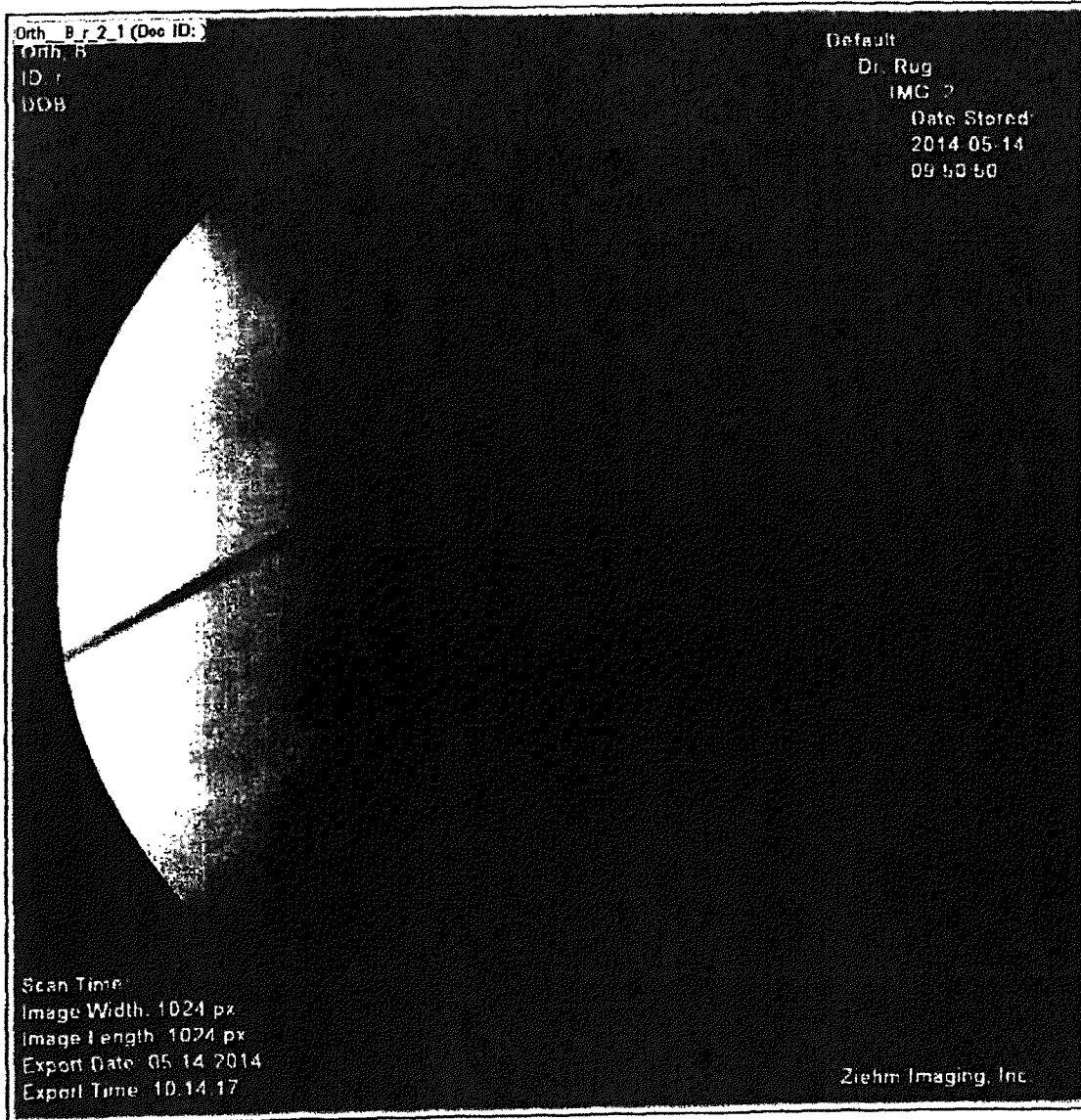
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Procedure Images

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Male DOB:

10870



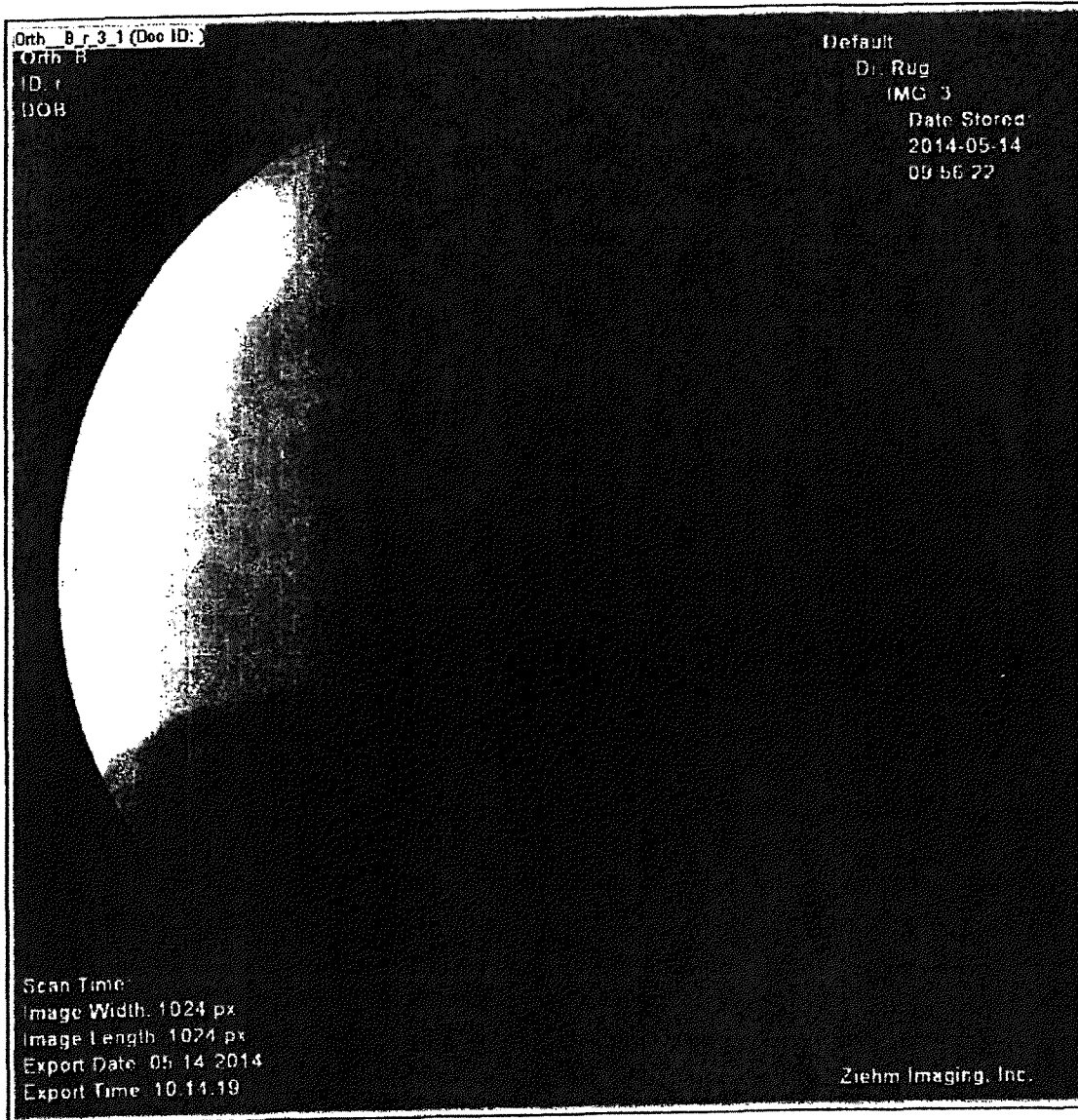
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Male DOB:

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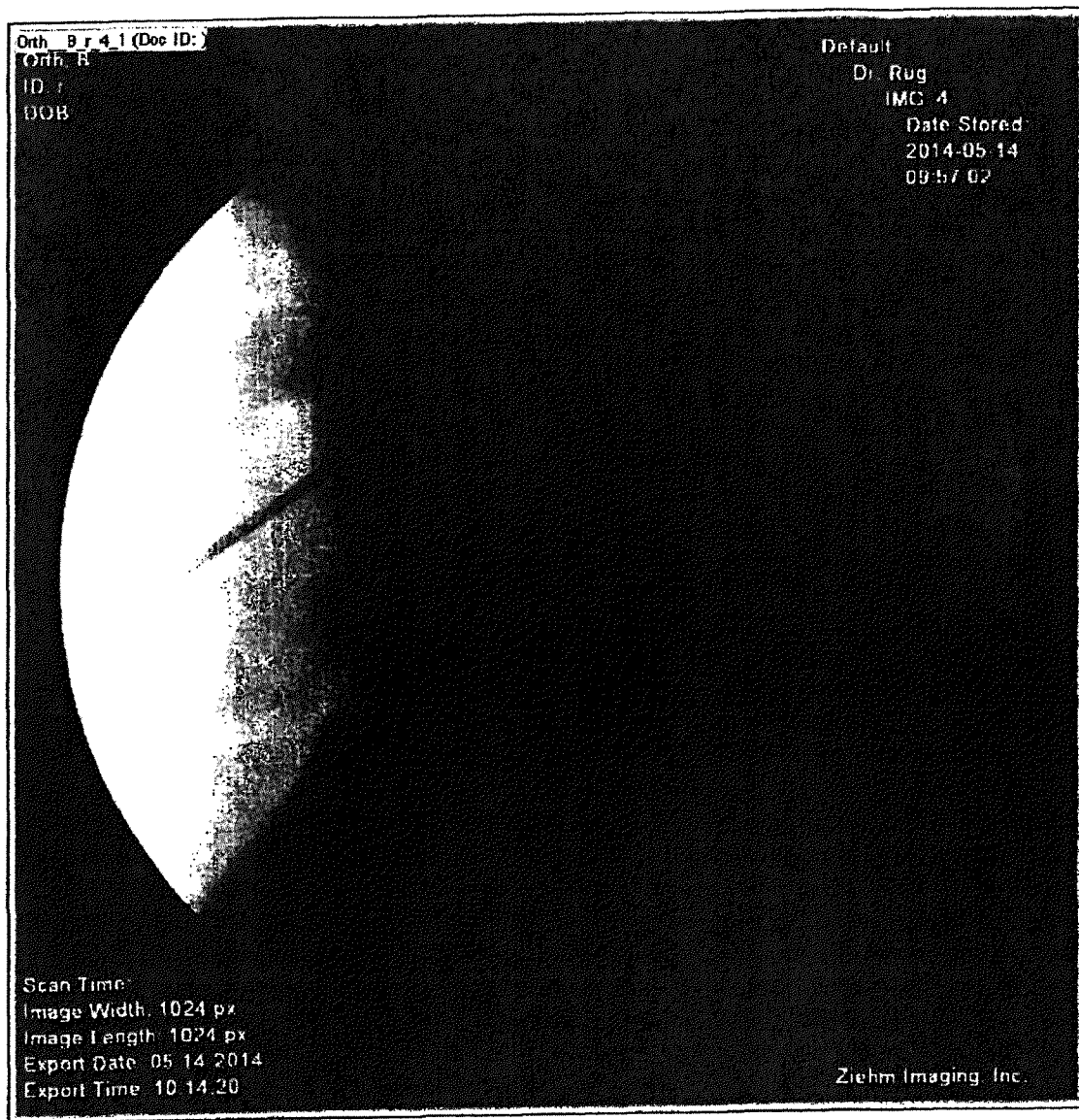
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Procedure Images

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Male DOB:

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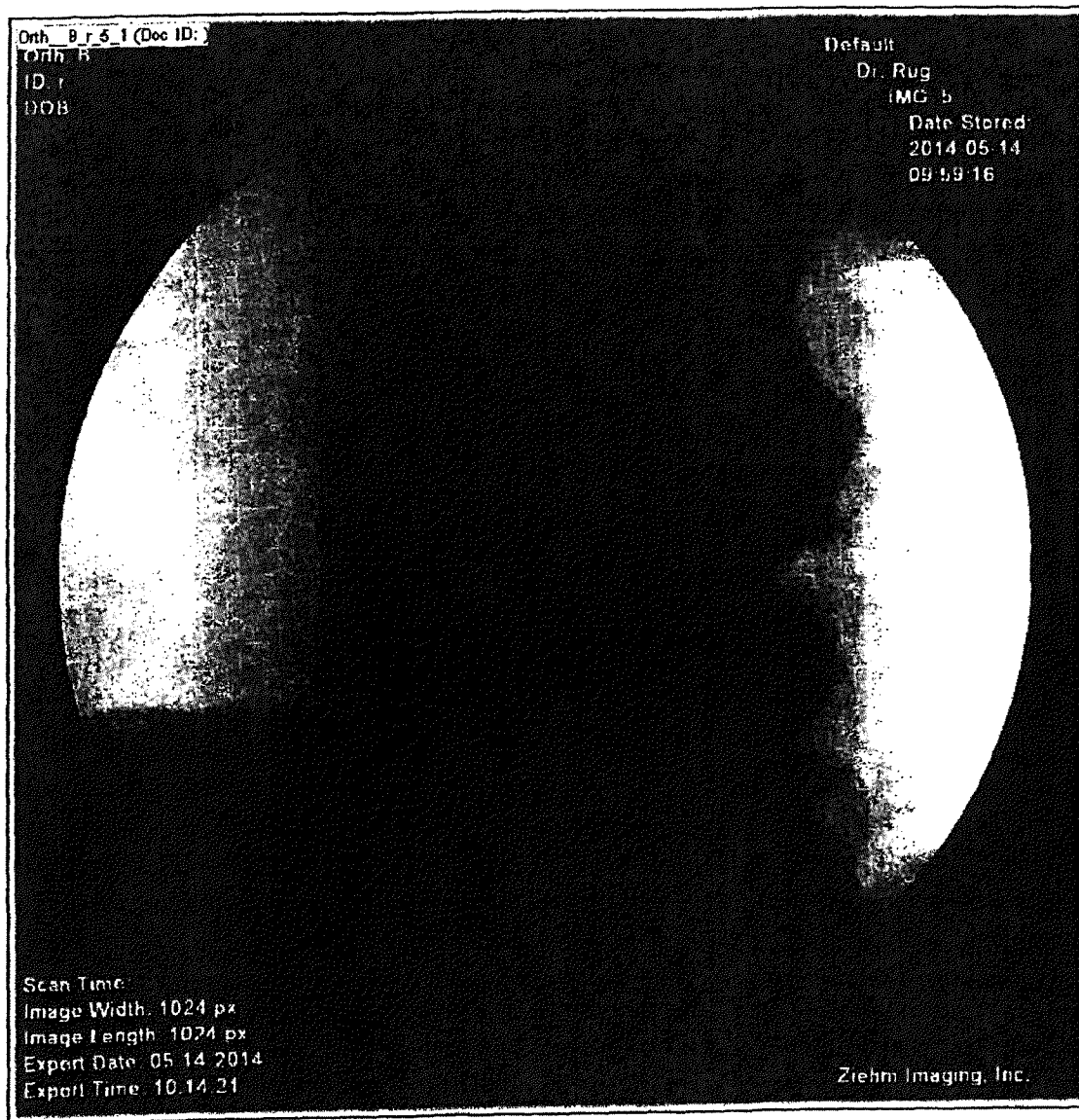
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Procedure Images

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Male DOB:

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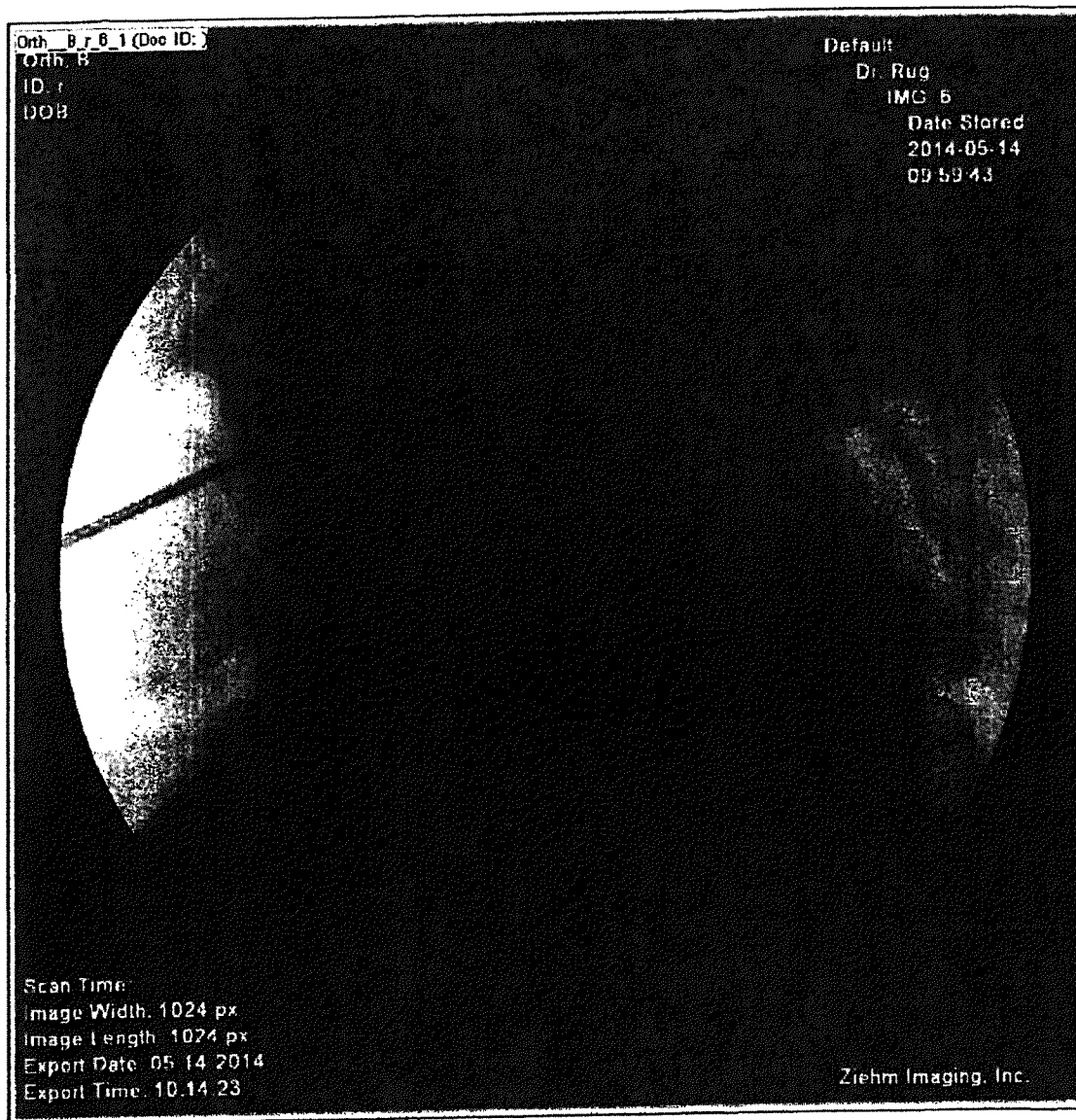
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Male DOB:

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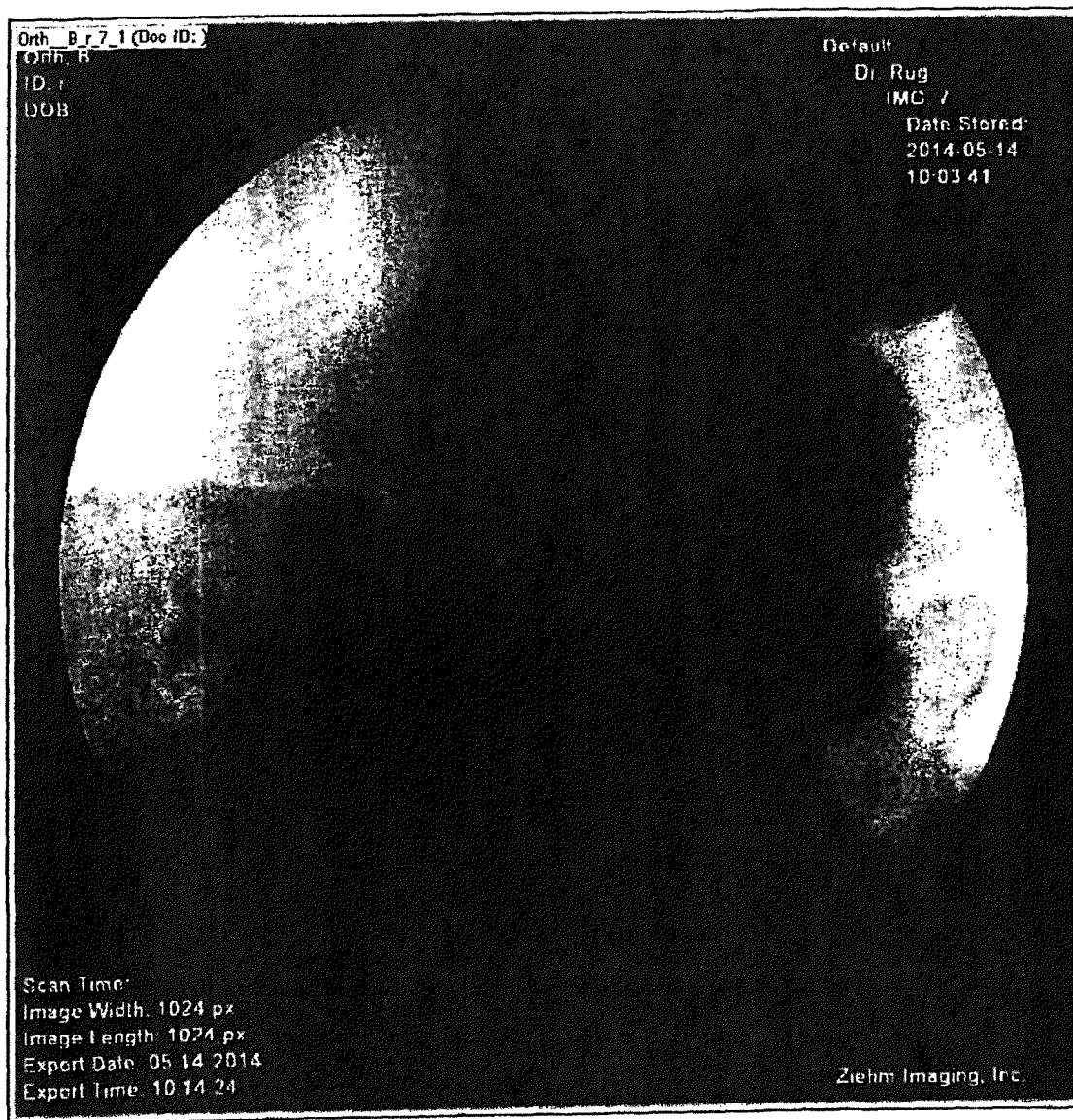
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Male DOB:

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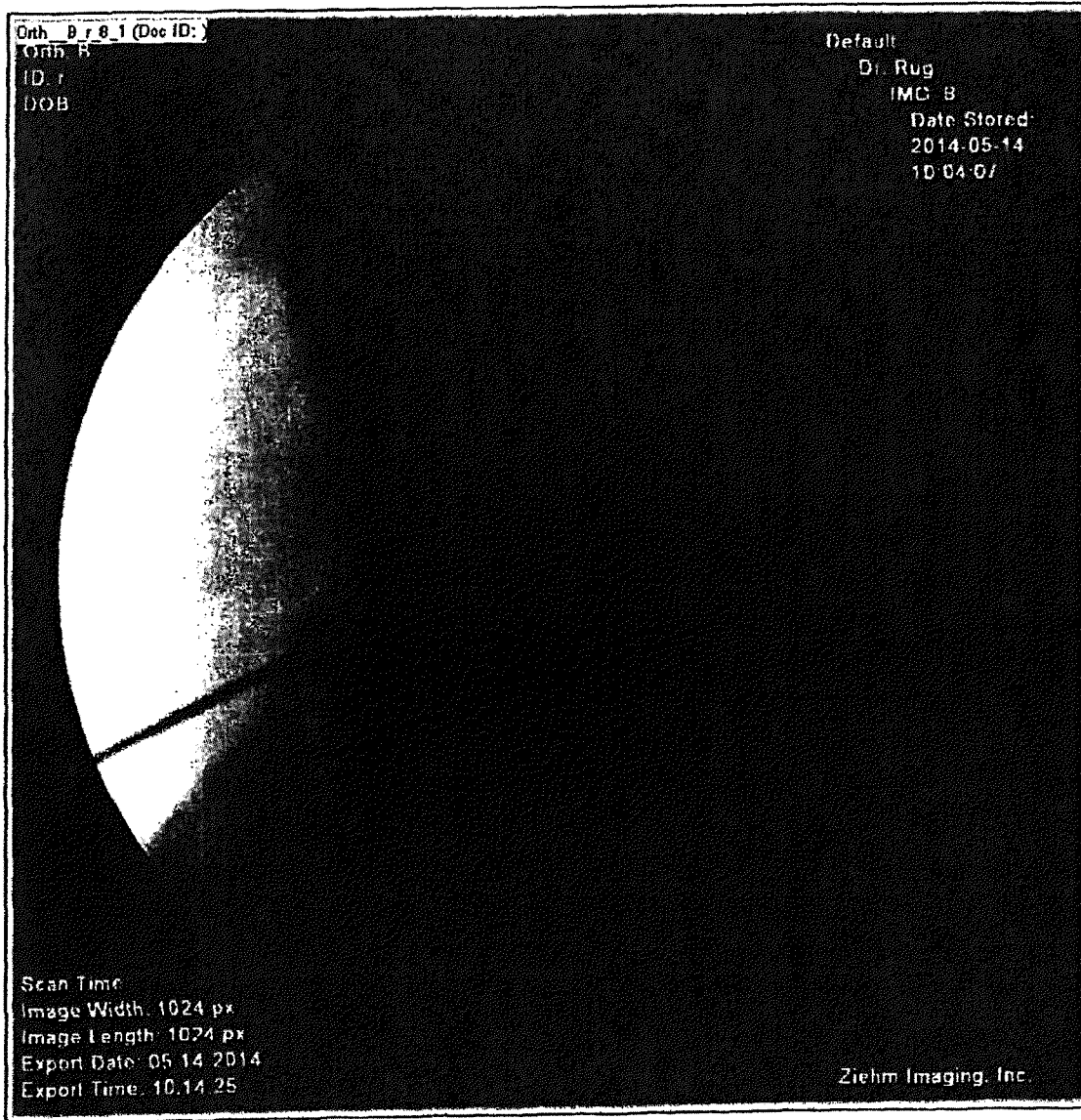
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Male DOB:

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