FRAUDSNIFFR

Medical Records Cover Page	
Client:	Sedgwick
Requester:	David Kinsella
Claim #:	Bell
Case #:	117254OT-01
Patient's Name:	Joan Bell
Date of Birth:	9/10/1948

Our office was contacted and requested to secure records for the above-referenced patient from the following facility:

Dr./Facility:	Brian Battersby, MD
Dr./Facility:	
Address:	
City/State/Zip:	
Telephone:	
Request Date:	February 14, 2025
Date Cleared:	February 19, 2025

Special Instructions:

Obtain medical records based on canvass result.

PATIENT
JOAN BELL
DOB 09/10/1948
AGE 76 yrs
SEX Female
PRN 1957E

FACILITY
Coastal Orthopaedics Spinal Surgery PA Practice
T (252) 635-1788
F (252) 635-3053
612 B Mccarthy Blvd
New Bern, NC 28562

Patient identifying details and demographics

FIRST NAME	JOAN	SEX	Female	RACE	-
MIDDLE NAME	-	DATE OF BIRTH	09/10/1948	ETHNICITY	-
LAST NAME	BELL	DATE OF DEATH	-	PREF. LANGUAGE	-
SSN	240-86-8158	PRN	1957E	STATUS	Active patient

CONTACT INFORMATION

ADDRESS LINE 1	2316 CRESTVIEW DRIVE	CONTACT BY	-
		EMAIL	-
ADDRESS LINE 2	-	HOME PHONE	-
CITY	New Bern	MOBILE PHONE	(252) 670-9948
STATE	NC	OFFICE PHONE	-
ZIP CODE	28562	OFFICE EXTENSION	-

FAMILY INFORMATION

NEXT OF KIN	-	PATIENT'S MOTHER'S MAIDEN NAME	-
RELATION TO PATIENT	-		
PHONE	-		
ADDRESS	-		

PATIENT
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ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Brian Battersby M.D
DATE 09/06/2023
AGE AT DOS 74 yrs
Electronically signed by Brian Battersby M.D at 09/10/2023 07:25 am

Chief complaint

6 WK FU (Appt time: 9/6/2023 1:40:00 PM) (Arrival time: 1:32 PM)

Vitals for this encounter

No vitals recorded

SUBJECTIVE

Patient is a 74 year old female who presents to clinic today with complaints of left shoulder pain. Date of injury: approx. April after a fall. The patient hasn't seen another provider for this problem. Pain level today is 4 out of 10. She complains of anterior shoulder pain. The pain radiates into her upper arm. The associated symptoms include: painful ROM. Aggravating Factors: motion, lifting arm. The patient has tried ibuprofen.

Problem 2: right foot: Date of onset is 6/10/23 with no specific injury. Pain level today is 2 out of 10. Aggravating factors: walking. She states that she uses her walking boot with prolonged walking.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems:. General: No fever, chills, or weight change.. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, in no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Patient is aware to Person, Place and Time..
Patient does understands directions.
Reviewed and discussed review of systems and medical history with the patient

Foot and Ankle Exam

Patient complains of pain in the right foot
Inspection: in sandals
Palpation: mild tender
Joint Stability: nl
Strength: decr
Range of Motion: decr
Reflexes: nl
Sensation: nl
Skin: nl
Special Tests: nl

Neuro/Vascular Exam:
Vascular exam is intact.
Pulses are equal and symmetric.
Sensation is intact except as stated above.
Gait: antalgic

Shoulder Exam

Patient complains of pain in the left shoulder
Inspection: nl
Palpation: tender rot cuf interval
Joint Stability: nl
Strength: decr
Range of Motion: nl
Sensation: nl
Reflexes: nl
Skin: nl
Special Tests: impingement

Neuro/Vascular Exam:
Vascular exam is intact.
Pulses are equal and symmetric.
Sensation is intact except as stated above.. ..

ASSESSMENT

Xray type: ap/lat right foot healed 2nd met fracture no change in alignment. abundant callus may be adherant to 3rd mt.
ap/lat left shoulder no glenohumeral djd acromial spur no narrowing

Diagnoses attached to this encounter:

Displaced fracture of 2nd metatarsal bone of foot, sequela [ICD-10: S92.3235], [ICD-9: 905.4], [SNOMED: 263251009]

Impingement syndrome of left shoulder [ICD-10: M75.42], [ICD-9: 726.2], [SNOMED: 310411000119104]

PLAN

Injection Site #1: The left shoulder was prepped with alcohol/Betadine. Injection performed using 2% Lidocaine followed by Betamethasone 2cc. A 22 gauge needle was used. The site was dressed with a sterile bandage.. Injection Site #2: The left shoulder bursa was prepped with alcohol/Betadine. Injection performed using 2% Lidocaine followed by Betamethasone 2cc. A 22 gauge needle was used. The site was dressed with a sterile bandage.. fu 6w

Care plan

needs hoka shoes and slippers. pool aerobics for general conditioning

PATIENT
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SEX Female
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ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Brian Battersby M.D
DATE 07/26/2023
AGE AT DOS 74 yrs
Electronically signed by Brian Battersby M.D at 07/26/2023 07:47 pm

Chief complaint

2 WK FU (Appt time: 7/26/2023 1:50:00 PM) (Arrival time: 1:39 PM)

Vitals for this encounter

No vitals recorded

SUBJECTIVE

Patient is a 74 year old female who presents to clinic today with complaints of right foot pain. Date of onset is 6/10/23 with no specific injury. Patients pain level today is minimal. She states that she has had improvement. Aggravating factors: walking. Pt presents with cast boot.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems:. General: No fever, chills, or weight change.. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, in no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Patient is aware to Person, Place and Time..
Patient does understands directions.
Reviewed and discussed review of systems and medical history with the patient

Foot and Ankle Exam

Patient complains of pain in the right foot
Inspection: nl
Palpation: nontender 2nd toe
Joint Stability: nl
Strength: Improved
Range of Motion: Improved
Refelxes: nl:
Sensation: nl
Skin: nl
Special Tests: nl

Neuro/Vascular Exam:
Vascular exam is intact.
Pulses are equal and symetric.
Sensation is intact except as stated above.
Gait: bnl..

ASSESSMENT

Xray type: AP/LAT RIGHT FOOT.DF. abundant callus no change in alignment

Diagnoses attached to this encounter:

Closed fracture metatarsal [ICD-10: S92.301A], [ICD-9: 825.25], [SNOMED: 36924003]

PLAN

wean from boot flu 6w

PATIENT
JOAN BELL

DOB	09/10/1948
AGE	76 yrs
SEX	Female
PRN	1957E

FACILITY
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ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	Brian Battersby M.D
DATE	07/12/2023
AGE AT DOS	74 yrs

Electronically signed by Brian Battersby M.D at 07/17/2023 02:45 pm

Chief complaint

2 WK FU (Appt time: 7/12/2023 11:10:00 AM) (Arrival time: 11:17 AM)

Vitals for this encounter

	07/12/23 11:29 AM
Height	63 in
Weight	168 lb
BMI	29.76

SUBJECTIVE

Patient is a 74 year old female who presents to clinic today with complaints of right foot pain. Date of onset is 6/10/23 with no specific injury. Patients pain level today is minimal. She states that she has had improvement. Aggravating factors: walking. Pt presents with cast boot.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems:. General: No fever, chills, or weight change.. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, in no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Patient is aware to Person, Place and Time..
Patient does understands directions.
Reviewed and discussed review of systems and medical history with the patient

Foot and Ankle Exam

Patient complains of pain in the right 2nd toe
Inspection: in loosefitting boot
Palpation: mild tender
Joint Stability: abn
Strength: I
Range of Motion: decr
Refelxes: n;:
Sensation: n;
Skin: n;
Special Tests: n'

Neuro/Vascular Exam:

Vascular exam is intact.
Pulses are equal and symetric.
Sensation is intact except as stated above.
Gait: in boot nl..

ASSESSMENT

Xray type: ap/lat right foot bkm batonetted 2nd met fract excellent allgnmnet

Diagnoses attached to this encounter:

Closed fracture metatarsal [ICD-10: S92.301A], [ICD-9: 825.25], [SNOMED: 36924003]

PLAN

continue boot wear. but inflate boot so it fits snug

Care plan

flu 4w

PATIENT
JOAN BELL
DOB 09/10/1948
AGE 76 yrs
SEX Female
PRN 1957E

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ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Brian Battersby M.D
DATE 06/20/2023
AGE AT DOS 74 yrs
Electronically signed by Brian Battersby M.D at 06/22/2023 05:01 pm

Chief complaint

FU (Appt time: 6/20/2023 2:30:00 PM) (Arrival time: 2:16 PM)

Vitals for this encounter

No vitals recorded

SUBJECTIVE

Patient is a 75 year old female who presents to clinic today with complaints of right foot pain. Patient here for CT scan results. Date of onset is 6/10/23 with no specific injury. Patients pain level today is 3 (1-10). She complains of swelling and redness across the top of her foot. Aggravating factors. walking. Pt presents with a walker and a cast boot, patient states her toes have hurt more in the cast boot but she cannot walk without the boot.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems: General: No fever, chills, or weight change.. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, In no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Patient is aware to Person, Place and Time..
Patient does understands directions.
Reviewed and discussed review of systems and medical history with the patient

Foot and Ankle Exam

Patient complains of pain in the right 2nd ray
Inspection: aligned
Palpation: tender
Joint Stability: abl
Strength: decr
Range of Motion: decr
Refelxes: nlnlnln;:
Sensation: nl
Skin: nl
Special Tests: nl

Neuro/Vascular Exam:
Vascular exam is intact.
Pulses are equal and symetric.
Sensation is intact except as stated above.
Gait: In boot..

ASSESSMENT

ct scan with excellent overlap of fracture ends. xray right foot ap lat. today excellent alignment. angulation corrected with boot wear

Diagnoses attached to this encounter:

Closed fracture metatarsal [ICD-10: S92.301A], [ICD-9: 825.25], [SNOMED: 36924003]

PLAN

full time boot wear.

Care plan

flu 2w repeat films

PATIENT
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DOB 09/10/1948
AGE 76 yrs
SEX Female
PRN 1957E

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F (252) 635-3053
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New Bern, NC 28562

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Brian Battersby M.D
DATE 06/14/2023
AGE AT DOS 74 yrs
Electronically signed by Brian Battersby M.D at 06/17/2023 06:43 am

Chief complaint

POSSIBLE GOUT (Appt time: 6/14/2023 10:10:00 AM) (Arrival time: 9:57 AM)

Vitals for this encounter

	06/14/23 10:04 AM
Height	63 in
Weight	168 lb
BMI	29.76

SUBJECTIVE

Patient is a 75 year old female who presents to clinic today with complaints of right foot pain. Date of onset is 6/10/23 with no specific injury. The patient hasn't seen another provider for this problem. Patients pain level today is 4 (1-10). She complains of swelling and redness across the top of her foot. Aggravating factors: walking. Pt presents with a walker.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems:. General: No fever, chills, or weight change.. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, in no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Patient is aware to Person, Place and Time..
Patient does understands directions.
Reviewed and discussed review of systems and medical history with the patient

Foot and Ankle Exam

Patient complains of pain in the right foot
Inspection: metatarsal swelling
Palpation: tender 2nd ray
Joint Stability: abnl
Strength: decr
Range of Motion: decr
Refelxes: nl:
Sensation: nl
Skin: nl
Special Tests: n

Neuro/Vascular Exam:
Vascular exam is intact.

Pulses are equal and symetric.
Sensation is intact except as stated above.
Gait: antalgic..

ASSESSMENT

Xray type: ap/lat right foot bkm distal short oblique frature with angulation and displacement.

Diagnoses attached to this encounter:

Closed fracture metatarsal [ICD-10: S92.301A], [ICD-9: 825.25], [SNOMED: 36924003]

PLAN

boot applied. need ct scan to eval displacement of wtg bearing axis 2nd ray

Care plan

ct scan scheduled 24 june flu post study

PATIENT
JOAN BELL
DOB 09/10/1948
AGE 76 yrs
SEX Female
PRN 1957E

FACILITY
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New Bern, NC 28562

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Brian Battersby M.D
DATE 03/14/2023
AGE AT DOS 74 yrs
Electronically signed by Brian Battersby M.D at 03/16/2023 02:35 pm

Chief complaint

4 WEEK RT KNEE (Appt time: 3/14/2023 1:30:00 PM) (Arrival time: 1:25 PM)

Vitals for this encounter

	03/14/23 1:34 PM
Height	63 in
Weight	168 lb
BMI	29.76

SUBJECTIVE

Patient is a 75 year old female who presents to clinic today for follow up on her right knee. Pt is here following injection. She states that she has had improvement in her symptoms. Pain level today is 2 out of 10. Aggravating Factors: walking, bending, climbing steps. The patient has tried pain meds, celebrex. She is in pain management.. She would like to discuss inserts for her shoes.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems:. General: No fever, chills, or weight change.. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, In no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Patient is aware to Person, Place and Time..
Patient does understands directions.
Reviewed and discussed review of systems and medical history with the patient

Foot and Ankle Exam

Patient complains of pain in the left foot
Inspection: nl
Palpation: nl
Joint Stability: nl
Strength: foot drop
Range of Motion: nl
Refelxes: nl:
Sensation: nl
Skin: nl
Special Tests: n

Neuro/Vascular Exam:
Vascular exam is intact.
Pulses are equal and symetric.General: Normotensive, In no acute distress. Appears stated age. Appropriately dressed.

Mood and Affect is normal for age and condition
Pulses are equal and symetric.
Patient is aware to Person, Place and Time..
Reviewed and discussed review of systems and medical history with the patient

Knee Exam

Patient complains of pain in the right knee
Inspection: improved
Palpation: nl
Joint Stability: nl
Strength: nl
Range of Motion: nl
Refelxes: nl
Sensation: nl
Skin: nl
Special Tests: nl

Neuro/Vascular Exam:
Vascular exam is intact.
Patient does understands directions.
Gait: nl.
Sensation is intact except as stated above.
Gait: fslap gate..

ASSESSMENT

Diagnoses attached to this encounter:

Left foot drop [ICD-10: M21.372], [SNOMED: 308291000119105]

PLAN

AFO left foot. flu8w

Care plan

flu 8w

PATIENT
JOAN BELL
DOB 09/10/1948
AGE 76 yrs
SEX Female
PRN 1957E

FACILITY
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ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Brian Battersby M.D
DATE 02/14/2023
AGE AT DOS 74 yrs
Electronically signed by Brian Battersby M.D at 02/15/2023 04:53 pm

Chief complaint

OLD PT/ RT KNEE (Appt time: 2/14/2023 11:20:00 AM) (Arrival time: 11:34 AM)

Vitals for this encounter

	02/14/23 11:47 AM
Height	63 in
Weight	168.2 lb
BMI	29.79

SUBJECTIVE

Patient is a 75 year old female who presents to clinic today with complaints of right knee pain. Date of injury: 1/23/23 after a fall. . The patient has seen another provider for this problem. Pt was seen at CEMC ER.Patients pain level today is 5 (1-10). The pain radiates into her shin. She states that her swelling has improved. Aggravating Factors: walking, bending. Patient presents today with use of walker. The patient has tried pain meds, celebrex. She is in pain management.

Major events: BREAST CA, MASTECTOMY, BACK SURGERY X4, COLON RESECTION X 2. Ongoing medical problems: DM, HTN, CA, ARTHRITIS, HX. OF STROKE. Family health history: DM. Preventive care: Not recorded. Social history: NONSMOKER, ALCOHOL-NONE, MARRIED, RETIRED. Nutrition history: REGULAR DIET. Developmental history: NA.

Review of systems:. Eyes: - blurred or/and - double vision.. Head: - Headaches or/and - migraines.. Chest: - cough or/and - shortness of breath..

OBJECTIVE

General: Normotensive, in no acute distress. Appears stated age. Appropriately dressed.
Mood and Affect is normal for age and condition
Pulses are equal and symetric.
Patient is aware to Person, Place and Time..
Reviewed and discussed review of systems and medical history with the patient

Knee Exam

Patient complains of pain in the right knee
Inspection: nl
Palpation: tender medial space
Joint Stability: nk
Strength: decr
Range of Motion: decr
Refelxes: nl
Sensation: nl;
Skin: n;
Special Tests: n;

Neuro/Vascular Exam:

Vascular exam is intact.

Patient does understands directions.

Gait: with walker.

ASSESSMENT

Xray type: ap/lat right knee bkm djd right knee no evid boney injury

Diagnoses attached to this encounter:

Pain in right knee [ICD-10: M25.561], [ICD-9: 719.46], [SNOMED: 468231000124100]

Unilateral primary osteoarthritis, right knee [ICD-10: M17.11], [ICD-9: 715.16], [SNOMED: 239862000]

PLAN

Injection Site #1: The right knee was prepped with alcohol/Betadine. Intra-articular injection performed, using 2% Lidocaine followed by Betamethasone 2cc. A 22 gauge needle was used. The site was dressed with a sterile bandage..

Care plan

flu 4w