Patient Demographics

DoseSpotClinic

Patient Information

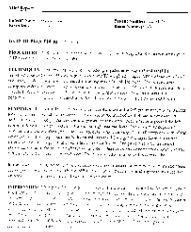
Patient Name:	Leighton Olaf
Date of Birth:	03/25/1992
MRN:	328785
Sex:	Female
SSN:	
Employer:	
Address:	Sw Willow Fork Dr Boardman, OR 97818
Phone Number:	+13036543456
Email:	Leightonolaf82@yopmail.com

Provider Information

Provider Name:	
Email Address:	

Insurance Information

Insurance Company:	Aetna
Policy Number:	W123456789
Policy Holder:	Leighton Olaf
Insurance Group Number:	0175056-011-00001
Relationship:	self



DRLOGY PATHOLOGY LAB

Accurate | Caring | Instant

0123456789 | 0912345678

drlogypathlab@drlogy.com

105 -108, SMART VISION COMPLEX, HEALTHCARE ROAD, OPPOSITE HEALTHCARE COMPLEX. MUMBAI - 689578

www.drlogy.com

Yash M. Patel
Age : 21 Years
Sex : Male
PID : 555

Sample Collected At:
125, Shivam Bungalow, S G Road,
Mumbai

Ref. By: **Dr. Hiren Shah**

Registered on: 02:31 PM 02 Dec, 2X
Collected on: 03:11 PM 02 Dec, 2X
Reported on: 04:35 PM 02 Dec, 2X

RANDOM BLOOD SUGAR (RBS)

Investigation	Result		Reference Value	Unit
GLUCOSE, RANDOM, PLASMA Hexokinase	245.00	Very High	70.00 - 140.00	mg/dL

Interpretation

The reference values for a "Normal" Random Glucose test in an average adult are 70–140 mg/dL (4.4–7.8 mmol/l), between 140-200 mg/dL (7.8–11.1 mmol/l) is considered pre-diabetes, and > 200 mg/dL is considered diabetes according to ADA guidelines (you should visit your doctor or a clinic for additional tests)

Thanks for Reference

****End of Report****

Medical Lab Technician
(DMLT, BMLT)

Dr. Payal Shah
(MD, Pathologist)

Dr. Vimal Shah
(MD, Pathologist)

International Journal of Research in Orthopaedics
Palaniappan G et al. Int J Res Orthop. 2021 Jan;7(1):162-164
http://www.ijoro.org

Case Report

DOI: https://dx.doi.org/10.18203/issn.2455-4510.IntJResOrthop20205582

A fracture of OS trigonum: a rare case report

Gnanaprakash Palaniappan*, Chetan John Rasquinha, Major K. Kamlanathan

Department of Orthopaedics, PSG Institute of Medical Sciences and Research, Coimbatore, Tamil Nadu, India

Received: 28 September 2020
Revised: 04 November 2020
Accepted: 04 November 2020

***Correspondence:**
Dr. Gnanaprakash Palaniappan,
E-mail: pagprakash@gmail.com

ABSTRACT

Fractures of os trigonum is an extremely rare event. It is one of the accessory ossicles of the foot found in about 7 % of the population. Very few cases have been reported in the literature about a fracture of the ostrigonum. We present a case of fracture of ostrigonum with associated fracture of the fibula and a large lacerated wound in the leg, in a young man sustained due to road traffic accident. The initial radiological examination with Xray ankle showed a doubtful fracture of posterior process of talus but was not clear. The diagnosis was clinched by CT scan of the ankle with 2mm cuts, which showed clearly a fracture of the os trigonum. It was treated by flap cover for the wound and plaster immobilisation for the fracture. So, any doubtful fracture near the posterior process of talus should be fully assessed radiologically with a CT scan to guide in the treatment.

Keywords: OS trigonum, Talus, Posterior process, Fracture

INTRODUCTION

OS trigonum is one of the accessory ossicles of the foot due to failure of fusion of a secondary center with the main bone of talus.[6] Fracture of this bone is extremely rare event. To the best of our knowledge very few cases-less than ten, have been reported in the literature.[1-3]

CASE REPORT

A 30-year-old man presented to our emergency department with history of road traffic accident-he was a two-wheeler driver hit by a speeding car and he was thrown out and landed on his right leg. His vitals were stable. He had a deep lacerated wound on the anteromedial aspect of his right leg (Figure 1) with swelling around his ankle.

All movements of ankle, particularly plantar flexion was extremely painful. X-rays revealed comminuted fracture of shaft of fibula at mid third distal third junction with a fracture fragment at the posterior aspect of talus. (Figure 2-4).

Figure 1: Clinical pictures.

To clarify the nature of the fragment a CT scan was taken and axial, and sagittal cuts revealed a fracture of the ostrigonum-which is extremely rare (Figure 5-10). He was

Order Form

12/06/2023

DoseSpotClinic
N Washington Ave
Green Brook, NJ 08812

NPI:

Phone: (860) 944-9421 Fax: (860) 995-9416

Stewart Slater Male 01/02/2000
(860) 955-9531

Scott Dr
Hillsborough, NJ 08844

Primary Insurance

Insurance Address

Subscriber Name

Insured Name

Address

Priority:

ICD10 Code

MR MUSCULOSKELETAL

- ☐ Shoulder
- ☐ Elbow ☐L ☐R
- ☐ Wrist ☐L ☐R
- ☐ Hand ☐L ☐R
- ☐ Hip ☐L ☐R
- ☐ Knee ☐L ☐R
- ☐ Lower Leg ☐L ☐R
- ☐ Ankle ☐L ☐R
- ☐ Foot ☐L ☐R
- ☐ MR Arthrography Specify joint:

MR BODY

- ☐ Abdomen ☐ Pelvis
- ☐ MRCP ☐ Liver
- ☐ Kidney

MR NEURO

- ☐ Brain
- ☐ IAC's/Orbits
- ☐ Pituitary
- ☐ Soft Tissue Neck
- ☐ Brachial Plexus ☐L ☐R
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
  - ☐ w/3D Myelogram
- ☐ Sacrum/Coccyx
- ☐ WEIGHT BEARING MRI

MR SPECIAL

- ☐ Breast
- ☐ Cardiac
- ☐ Enterography (MRE)
- ☐ Prostate
- ☐ TMJ
- ☐ Urogram
  (Abd/Pel w/wo with 3D recon)

MRA

- ☐ Brain ☐ Carotid
- ☐ Abdomen ☐ Kidney
- ☐ Runoff (Abd, Pel, Bilat legs)
- ☐ MRV Specify area of interest:

☐ MR OTHER Specify area of interest:

CT NEURO

- ☐ Brain ☐ Sinus
- ☐ Facial Bones
- ☐ IAC's/Temporal Bone
- ☐ Orbits ☐ Soft Tissue Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine

CT MUSCULOSKELETAL ☐

Extremity (Specify area of interest)

- ☐ w/3D Recon.

☐ CT Arthography (Specifc Joint)

CT BODY

- ☐ Chest ☐ Abdomen ☐ Pelvis
- ☐ Urogram (Abd/Pel w/wo with 3D recon)
- ☐ Cardiac Calcium Score
- ☐ Low Dose Lung Screen

VASCULAR CT ANGIOGRAPHY

(All with IV contrast–no oral contrast)

- ☐ CTA Brain ☐ CTA Carotids
- ☐ CTA Chest (Pulmonary Embolus Protocol)
- ☐ CTA Aorta (Chest, Abd, Pel)
- ☐ CTA Coronary Arteries
- ☐ CTA Venous Structure
- ☐ CT OTHER (Specify area of interest)

X-RAY/FLUOROSCOPY

- ☐ Chest ☐ Abdomen
- ☐ Pelvis ☐ Cervical Spine
- ☐ Thoracic Spine ☐ Flex
- ☐ Lumbar Spine ☐ Ext.
- ☐ Scoliosis/AP & LAT (T+L Spine)
- ☐ Pelvis Hip ☐RT &/or ☐LT
- ☐ Upper Extremity Indicate Site: _____ ☐RT ☐LT
- ☐ Lower Extremity Indicate Site: _____ ☐RT ☐LT
- ☐ Upper GI-W/Air per Rad*
- ☐ Ba Enema-W/Air per Rad*
- ☐ Esophagram*
- ☐ Small Bowl Study*
- ☐ Other

NUCLEAR MEDICINE Provide comparison films

- ☐ DaTscan
- ☐ Bone Scan Whole Body
- ☐ Bone Scan 3 Phase of:

☐ Bone Scan Limited of:

- ☐ Hepatobiliary Scan (HIDA)
  ☐ With EF ☐ W/O EF
- ☐ Thyroid Scan & Uptake*
- ☐ Liver/Spleen Scan
- ☐ Parathyroid Scan with SPECT
- ☐ Muga Resting
- ☐ Gastric Emptying Scan* Single Phase Only
- ☐ Renogram* ☐Lasix ☐No Lasix
- ☐ Renogram* With Captopril
- ☐ Lung Scan ☐Vent/LPerf ☐Quantilation
- ☐ Other _____

WOMEN'S IMAGING

- ☐ 3D Mammogram - Screening
- ☐ 3D Mammogram - Diagnostic
  w/ CAD and Breast US if questionable mammo ☐L ☐R ☐B
- ☐ Breast US - Screening ☐L ☐R ☐B
- ☐ Breast US - Diagnostic ☐L ☐R ☐B
- ☐ DEXAscan ☐L ☐R ☐B
- ☐ Stereotactic Biopsy ☐L ☐R ☐B
- ☐ Needle Localization ☐L ☐R ☐B
- ☐ US biopsy ☐L ☐R ☐B
- ☐ Cyst Aspiration ☐L ☐R ☐B
- ☐ MR Biopsy ☐L ☐R ☐B

PET

- ☐ PET/Skull Base to Thigh*
- ☐ PET / Whole Body*
- ☐ PET/Brain Amyvid Alzheimers
- ☐ PET/Brain* ☐ PET/Bone Scan

ULTRASOUND

- ☐ Abdomen
- ☐ Pelvis w/ Transvaginal
- ☐ Aorta
- ☐ Retroperitoneum
- ☐ Scrotum
- ☐ Thyroid

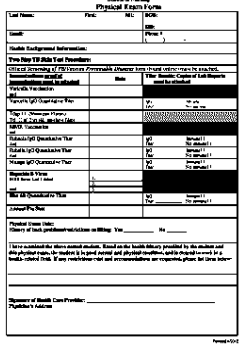
VASCULAR ULTRASOUND

- ☐ Arterial ☐ Venous
  - ☐ Upper Ext.
  - ☐ Lower Ext.
    ☐L ☐R ☐BILAT
- ☐ ABI
- ☐ Insufficiency
- ☐ Carotid
- ☐ Renal Doppler

☐ US OTHER (Specify area of interest)

_____

Electronically signed by



California State University, Long Beach
School of Nursing
Physical Exam Form

Last Name: First: MI: DOB:

SSN:

Email: Phone: ( ) -

Health Background Information:

Two Step TB Skin Test Procedure:

Official Screening of TB Vaccine Commercially Available Tests (Tuberculin Skin Test)

Immunizations and/or Laboratories must be attached	Date	Titer Results: Copies of Lab Reports must be attached
Varicella Vaccination or		
Varicella IgG Quantitative Titer		IgG: Immune / Not immune
Step 1: Measles, Mumps, Rubella (MMR) Vaccination or		
MMR Vaccination or		
Rubeola IgG Quantitative Titer		IgG: Immune / Not immune
Rubella IgG Quantitative Titer		IgG: Immune / Not immune
Mumps IgG Quantitative Titer		IgG: Immune / Not immune
Hepatitis B Virus HBS Ag and Anti-HBsAg	1. 2. 3.	
Hep B Quantitative Titer		IgG: Immune / Titer _____ Not immune /
Annual Flu Shot		

Physical Exam Date:
History of back problems/restrictions on lifting: Yes _____ No _____

I have examined the above named student. Based on the health history provided by the student and this physical exam, the student is in good mental and physical condition, and is cleared to work in a health-related field. If any restrictions exist and accommodations are requested, please list them below:

Signature of Health Care Provider: _____
Physician's Address

Revised 4/2012

Application Form for Registration of Clinical Establishments

I.ESTABLISHMENT DETAILS

1.**Name of the establishment**: _____

2.**Address**: _____
Village/Town:_____ Block:_____
District: _____State: _____ Pin code_____
Tel No (with STD code):_____Mobile: _____Fax : _____
Email ID : _____Website (if any): _____

3.**Month and Year of starting**: _____

(From 4 to 11 mark all whichever are applicable)

4. **Location:**
Rural Urban Metro
Notified / inaccessible areas (including Hilly / tribal areas)

5. **Ownership of Services**

Government/Public Sector
Central government State government Local government (Municipality, Zilla parishad, etc)
Public Sector Undertaking Other ministries and departments (Railways, Police, etc.)
Employee State Insurance Corporation Autonomous organization under Government

Non-Government / Private Sector
Individual Proprietorship Partnership Registered companies (registered under central/provincial/state Act) Society/trust (Registered under central/provincial/state Act)

6. **Name of the owner of Clinical Establishment:** _____
Address: _____
Village/Town:_____Block:_____District: _____State: _____ Pin code_____
Tel No (with STD code):_____Mobile: _____Fax : _____
Email ID: _____

7. **Name, Designation and Qualification of person in-charge of the clinical establishment**: _____
Qualification(s): _____
Registration Number: _____
Name of Central/State Council (with which registered): _____
Tel No (with STD code):_____Fax: _____Mobile: _____E-mail ID: _____ __

8. Systems of Medicine offered: (please tick whichever is applicable)
Allopathy Ayurveda Unani Siddha Homoeopathy Yoga Naturopathy Sowa-Rigpa

9. Type of establishment :(please tick whichever is applicable)

(I).**Clinic (Outpatient)**

- Single practitioner
  (Consultation services only/with diagnostic services/with short stay facility)

- Poly clinic
  (Consultation services only/with diagnostic services/with short stay facility)
- Dispensary
- Health Checkup Centre

(II). Day Care facility

Medical Surgical Medical SPA Wellness centers (where qualified medical professionals are available to supervise the services).

(III). Hospitals including Nursing Home (outpatient and inpatient):

- Hospital Level 1 a
- Hospital Level 1 b
- Hospital Level 2
- Hospital Level 3 (Non teaching)
- Hospital Level 4 (Teaching)

(IV). Dental Clinics and Dental Hospital:

a. Dental clinics

i. Single practitioner
ii. Poly Clinics (dental)

b. Dental Hospitals (specialties as listed in the IDC Act.)

i. Oral and maxillofacial surgery
ii. Oral medicine and radiology
iii. Orthodontics
iv. Conservative dentistry and Endodontics
v. Periodontics
vi. Pedodontics and preventive dentistry
vii. Oral pathology and Microbiology
viii. Prosthodontics and crown bridge
ix. Public health dentistry

(V).Diagnostic Centre

A. Medical Diagnostic Laboratories:

Pathology Biochemistry Microbiology
Molecular Biology and Genetic Labs Virology

B. Diagnostic Imaging centers

i. Radiology

- General radiology
- Interventional radiology

ii. Electromagnetic imaging

- Magnetic Resonance Imaging (MRI),
- Positron Emission Tomography (PET) Scan

iii. **Ultrasound**

C. Miscellaneous

- Electro Cardio Graphy(ECG)
- Tread Mill Test
- Electro Encephalo Graphy(EEG)
- Mammography
- Echocardiography
- Electro MyoGraphy (EMG)
- Electrophysiological studies

D. **Collection centers**

For the clinical labs and diagnostic centres shall function under registered clinical establishment

Yes/No

if Yes, then No of Collection Centre: ☐

(VI). Allied Health professions:

- Audiology
- Behavioral health (counseling, marriage and family therapy etc)
- Exercise physiology
- Nuclear medicine technology
- Medical Laboratory Scientist
- Dietetics
- Occupational therapy
- Optometry
- Orthoptics
- Orthotics and prosthetics
- Osteopathy
- Paramedic
- Podiatry
- Health Psychology/ Clinical Psychology
- Physiotherapy
- Radiation therapy
- Radiography / Medical imaging
- Respiratory Therapy
- Sonography
- Speech pathology

(VII) AYUSH

Ayurveda

Ausadh Chikitsa Shalya Chikitsa Shodhan Chikitsa Rasayana
Pathya Vyavastha

Yoga

Ashtang Yoga

Unani

Matab Jarahat Ilaj-bit-Tadbeer Hifzan-e-Sehat

Siddha

Maruthuvam Sirappu Maruthuvam Varmam Thokknam & Yoga

Homoeopathy

General Homoeopathy

Naturopathy
External Therapies with natural modalities Internal Therapies

II.TYPES OF SERVICE

- **TYPE**

General Practice Services
Single Specialty Services
Multi Specialty Services (including Palliative care Centre, Trauma Centre, Maternity Home - applicable for hospitals only)
Super Specialty Services

- **SPECIALITY SPECIFIC**

Medical Specialties – for which candidates must possess recognized PG degree (MD/Diploma/DNB or its equivalent degree)

i. Anesthesiology
ii. Aviation Medicine
iii. Community Medicine
iv. Dermatology, Venerology and Leprosy
v. Family Medicine
vi. General Medicine
vii. Geriatrics
viii. ImmunoHaematology and Blood Transfusion
ix. Nuclear Medicine
x. Paediatrics
xi. Physical Medicine Rehabilitation
xii. Psychiatry
xiii. Radio-diagnosis
xiv. Radio-therapy
xv. Rheumatology
xvi. Sports Medicine
xvii. Tropical Medicine
xviii. Tuberculosis & Respiratory Medicine or Pulmonary Medicine

Surgical specialties - for which candidates must possess, recognized PG degree (MS/Diploma/DNB or its equivalent degree)

i. Otorhinolaryngology
ii. General Surgery
iii. Ophthalmology
iv. Orthopedics
v. Obstetrics & Gynecology

Medical Super specialties –
i. Cardiology
ii. Clinical Hematology including Stem Cell Therapy
iii. Clinical Pharmacology

iv. Endocrinology
v. Immunology
vi. Medical Gastroenterology
vii. Medical Genetics
viii. Medical Oncology
ix. Neonatology
x. Nephrology
xi. Neurology
xii. Neuro-radiology

Surgical Super-specialities-

i. Cardiovascular thoracic Surgery)
ii. Urology
iii. Neuro-Surgery
iv. Paediatrics Surgery.
v. Plastic & Reconstructive Surgery
vi. Surgical Gastroenterology
vii. Surgical Oncology
viii. Endocrine Surgery
ix. Gynecological Oncology
x. Vascular Surgery

III INFRASTRUCTURE DETAILS

10. **Area of the establishment** (in sqft):
a) Total Area: _____b) Constructed area: _____

11. **Out Patient Department:**
11.1 Total no. of OPD Clinics: _____

11.2 Specialty-wise distribution of OPD Clinic

S.No.	Specialty

12. **In Patient Department:**
12.1. Total number of beds: _____
12.2. Specialty-wise distribution of beds, please specify:

S.No.	Specialty	Beds

13. **Biomedical waste Management**
13.1 **Method of treatment and /or disposal of Bio-medical waste**
☐ Through Common Facility ☐ Onsite Facility
☐ Any other (please specify): _____

13.2.**Whether authorization from Pollution Control Board/Pollution Control Committee obtained**?

☐ Yes ☐ No ☐ Applied For ☐Not Applicable

IV HUMAN RESOURCES

14. **Total number of Staff (as on date of application):**
No. of permanent staff:_____ No. of temporary staff: _____

Please furnish the following details:-

Category of staff	**Name**	**Qualification**	**Registration No**	**Nature of service Temporary/ Permanent**
Doctors				
Nursing staff				
Para-medical staff				
Pharmacists				
Administrative staff				
Others, please specify				

Separate annexure may be attached.

Support Staff

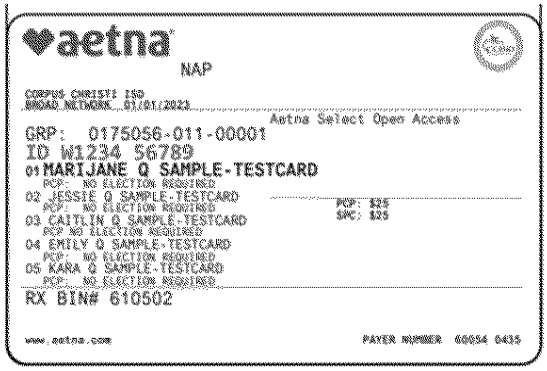
Category	Total no.	Remark

15. **Payment options for Registration Fees:**
☐ Online payment☐ Demand Draft Bank Challan

Amount (in Rs):_____
Details: _____
Receipt No._____

I,. .....on behalf of myself and the company/ society/association/body hereby declare that the statements above are correct and true to the best of my knowledge and I shall abide by all the provisions made under the Clinical Establishment (Registration and Regulation) Act 2010.
I undertake that I shall inform the DistrictRegistering Authority of any changes in the particulars given above.
I shall comply with the minimum standards prescribed under Clinical Establishment Act for the services provided by us and also all other conditions of registration as stipulated under the aforesaid Act and Rule there-under.

Place: Signature of the Authorized Signatory
Date: Office Seal


aetna
NAP
CORPUS CHRISTI ISD
BROAD NETWORK 01/01/2023
Aetna Select Open Access
GRP: 0175056-011-00001
ID W1234 56789
01 MARIJANE Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
02 JESSIE Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
03 CAITLIN Q SAMPLE-TESTCARD
PCP NO ELECTION REQUIRED
04 EMILY Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
05 KARA Q SAMPLE-TESTCARD
PCP: NO ELECTION REQUIRED
PCP: $25
SPC: $25
RX BIN# 610502
www.aetna.com
PAYER NUMBER 60054 0435