



Woodwinds Health Campus Emergency Department
1925 Woodwinds Drive
Woodbury MN 55125
Phone Number: 651-232-0348

Hellen A Ocheng
1281 Hazelwood St Apt 305
Saint Paul MN 55106

May 14, 2015

Dear Hellen:

**HealthEast Emergency Medicine
Activity Restriction Report**

Date of ED visit: 5/14/2015

Employer: Super Moms Bakery
Work Related Condition: Yes

Date of Injury: 5/14/2015

Work Status

Unable to return to work until after cleared to do so in follow appointments.

A handwritten signature in black ink, appearing to read "Eric Botz, MD".

Eric Botz, MD



Woodwinds Health Campus Emergency Department

1925 Woodwinds Drive
Woodbury MN 55125
Phone: 651-232-0348
Fax: 651-326-0307

Hellen A Ocheng

5/14/2015 Hospital Encounter

Location: Woodwinds Hospital

Your Plan

Thank you for choosing HealthEast for your health care.

You were examined and treated today on an urgent or emergency basis. Your condition has improved or we have ruled out an emergent cause of your symptoms so that you can be safely discharged from the Emergency Department. Please know that we may not be able to diagnose and treat all of your health problems in one Emergency Department visit, so follow-up with your regular care provider is very important.

After you leave, you should follow the instructions below. If you do not understand these instructions or have any questions about your care, treatment, or follow-up, we would be happy to help you. You may also contact your regular care provider for further information.

You may receive a phone call in the next 1-3 days to check to see how you are doing. You may also receive a survey in the mail in the next several weeks. We value your feedback and the time you would take to fill this survey out and return it.

Follow-up Information

Follow up with Tracy Dawn Rupke, MD On 5/15/2015. (at 10:00 am)

Specialty: Orthopedic Surgery

Contact information:

710 Commerce Dr, Ste 200

Woodbury MN 55125

651-968-5200

Discharge Instructions

Keep your foot elevated. Keep the hard soled shoe in place. We have scheduled an appointment for you to see Dr. Rupke, one of the orthopedic surgeon for specialists tomorrow at 10 AM in the Vadnais Heights Summit orthopedics clinic.

You should take Tylenol, 650 mg, up to 4 times per day for pain. If this regimen does not control your pain you can use the prescribed oxycodone, one to 2 tabs every 6 hours as needed. If you take this medication you should not drive or perform other activities that require full attention as it can make you drowsy. This medication also has the potential for addiction and increased tolerance.

Apply ice for 20 minutes at a time several times a day.

You should not eat or drink anything after midnight tonight in case the surgeon wants to do surgery tomorrow afternoon. This fracture most likely will require surgery at some point.

Return to the emergency room for uncontrolled pain, fever, vomiting or any change in mental status.

Medication List**START taking these medications****oxyCODONE 5 MG immediate release tablet**

Commonly known as: ROXICODONE

Take 2 tablets (10 mg total) by mouth every 6 (six) hours as needed for pain.

Where to Get Your Medications

These are the prescriptions that you need to pick up.

You may get the following medications from any pharmacy

- oxyCODONE 5 MG immediate release tablet

**This medicine list was created from information you provided and any recent medical records available to the emergency department physician. Your discharge instructions will indicate that you should continue these medicines based upon our evaluation of you today. This includes our review of this list as having no known harmful medication interactions. We are not responsible for medicines that were not prescribed in the emergency department today other than ruling out known harmful medicine interactions. You are instructed to review all of your medicines with your primary physician or other physicians who prescribe medicine to you.*

Your Visit Summary**Allergies**

No Known Allergies

Vital Signs - Last Recorded

Blood Pressure	Pulse	Temperature	Respirations	Oxygen Saturation
131/82	82	98.2 °F (36.8 °C) (Oral)	18	100%

ED Medication Administration from 05/14/2015 02:27 PM to 05/14/2015 05:15 PM

Date/Time	Order	Dose	Route	Action
05/14/2015 02:40 PM	ibuprofen tablet 600 mg (ADVIL, MOTRIN)	600 mg	Oral	Given
05/14/2015 02:40 PM	oxyCODONE-acetaminophen 5-325 mg 1 tablet (PERCOCET)	1 tablet	Oral	Given
05/14/2015 04:26 PM	HYDROMorphone injection 1 mg (DILAUDID)	1 mg	Intrav enous	Given

Diagnoses this visit

Your diagnoses were FRACTURE OF GREAT TOE, RIGHT, CLOSED, INITIAL ENCOUNTER , FRACTURE OF SECOND TOE, RIGHT, CLOSED, INITIAL ENCOUNTER , and FRACTURE OF THIRD TOE, RIGHT, CLOSED, INITIAL ENCOUNTER .

You were seen by

Eric Brandon Roth, MD

MyChart Signup

HealthEast has a new electronic health record to help you manage your health information using your computer or the MyChart App.

With MyChart you can review instructions from your health care provider, send a secure message to your provider, view test results, manage your appointments and more.

To sign up or learn more, go to healtheast.org/mychart and click on **Sign Up Now**. Enter your MyChart Activation Code exactly as it appears below to complete the sign-up process. If you do not sign up before

MyChart Signup (continued)

the expiration date, you must request a new code. Your activation code will expire in 14 days.

MyChart Activation Code: ARYZQ-8S3ZA-Z5BBF

Expires: 5/28/2015 5:15 PM

If you have questions, visit healtheast.org/mychart-faq, e-mail mychart@healtheast.org or call 651-232-1660 to talk to our MyChart staff. Remember, MyChart is NOT to be used for urgent needs. For medical emergencies, dial **911**.



APPLICATION FOR DISABILITY PARKING CERTIFICATE PS2005-30

DISABLED INDIVIDUAL SECTION

To be completed by or for the person with a physical disability

Full Name (Please Print) Last, First and Middle _____ Date of Birth _____/_____/_____
 Address _____
 City _____ State _____ Zip Code _____
 Are you a licensed driver? Yes No
 Do you have a Minnesota ID Card? Yes No
 License/ID Number _____
 Have you ever had a Minnesota Disability Parking Certificate? Yes No MN disability license plates? Yes No
 List certificate and/or plate # _____
 If applying for replacement, check reason: Lost Stolen Damaged Other; Please Explain _____
 Check here if this application is for two parking certificates Check here if this application is for a second parking certificate
 (Not available if you have disability license plates) (Limit of 2 certificates per person)

I hereby certify the above information is complete and accurate to the best of my knowledge.
 I also give permission to the Health Professional to supply the information requested.

Date _____ Signature _____

HEALTH PROFESSIONAL MEDICAL STATEMENT SECTION

Certificate Type:
 FEE \$5.00 ea. Temporary 1 to 6 Months Must Specify → Certificate Expiration Date
 FEE \$5.00 ea. Short Term 7 to 12 Months Must Specify → 1 / 2010
 No Fee Long-Term 13 to 71 months Must Specify → Month Year
 No Fee 6-year Certificate For permanent disabilities

IMPORTANT!
 If no date is indicated the certificate will be issued for the minimum duration of certificate type

The applicant must meet one or more of the definition(s) of a "physically disabled person" described below.
 • Check which definition(s) the applicant meets.
 • Symptoms described generically such as "Back Pain", "Leg Pain" are not acceptable.
 • Incomplete information will cause significant delays in processing

Deputy Stamp

 NO FEE FEE PAID

- The Applicant:**
- 1. Has a cardiac condition to the extent that the applicant's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association.
 - 2. Uses portable oxygen.
 - 3. Has an arterial oxygen tension (PAO₂) of less than 60 mm/Hg on room air at rest.
 - 4. Is restricted by a respiratory disease to such an extent that the applicant's forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter.
 - 5. Has lost an arm or leg and does not have or cannot use an artificial limb.
 - 6. Due to disability, uses a wheelchair or cannot walk without the aid of:
 Another Person; A Walker; A Cane; ~~Crutches~~ Braces; A Prosthetic Device; or other Assistive Device.
 (Specify diagnosis of condition causing Disability) right great toe fracture
 - 7. Has a disability that would be aggravated by walking 200 feet under normal environmental conditions to an extent that would be life-threatening.
 This condition is: _____
 - 8. Due to disability cannot walk 200 feet without stopping to rest
 This condition is: _____
 - 9. Cannot walk without a significant risk of falling
 This condition is: _____

Disability Definitions 6-9 below must state the specific diagnosis of the condition causing disability.

Is the applicant qualified, in all medical respects to exercise reasonable and ordinary control over a motor vehicle?
 Yes Yes, with adaptive equipment No, please specify _____
 Failure to answer this question will result in a request for a medical report.

I certify, by my signature as a licensed physician, physician's assistant, advanced practice registered nurse, or chiropractor that, in my professional opinion Hellen Achena (Patient's name) meets the definition of physically disabled person and is entitled to a disability parking certificate. I would be guilty of a misdemeanor and subject to a fine of \$500.00 for fraudulently certifying the applicant.

Signature & Title _____ Date 5/15/15 Print Name Tracy Rupke, MD
 Telephone Number (651) 968-5375 Address, City, State, Zip Code 3580 Arcade Street, Vadnais Heights, MN 55127