

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Marcus D. Ellison

DOB

04/02/2009

AGE / SEX

17 yrs / Male

MRN / PATIENT ID

SM-441907

DATE OF SERVICE

08/13/2026

PROVIDER

Priya N. Raghavan, MD

CREDENTIALS

MD, CAQ Sports Medicine

REFERRAL SOURCE

Team athletic trainer, Northfield HS

VISIT TYPE

Sports Injury Pain Management Follow-Up — return-to-throw evaluation, week 6

CARE SETTING

Outpatient sports medicine clinic, PT-integrated

PRIMARY CARE PROVIDER

Alan Yu, DO — Northfield Family Health

ATHLETIC TRAINER / TEAM PHYSICIAN

B. Okafor, ATC / R. Devi, MD

CC CHIEF COMPLAINT

2 PRIMARY SPORTS INJURY PAIN CONCERN

"My elbow still grabs on the inside when I try to let a fastball go. It's way better than it was, but I don't trust it, and tryouts for the fall showcase are in five weeks."

S SUBJECTIVE

3 PATIENT-REPORTED INJURY HISTORY

3a INJURY CONTEXT & MECHANISM

Reason for evaluation

Week-6 interval follow-up of a grade II ulnar collateral ligament sprain of the right elbow managed non-operatively. Visit is for pain reassessment, review of repeat MRI obtained 08/06/2026, rehabilitation progression, and initiation of a structured interval throwing program.

Sport / activity context

Right-handed varsity pitcher, 11th grade, plus a travel-club schedule. Pre-injury workload was approximately 95–110 pitches per outing, twice weekly, with year-round throwing and no formal off-season. Added a slider in March 2026 at a private coach's direction. Goal is clearance for the regional showcase on 09/19/2026.

Mechanism of injury

Acute onset during a game on 07/02/2026 — felt a “pop and burn” on the medial elbow at ball release in the 5th inning, pitch count 88. Removed himself immediately; no fall, no direct blow. Overuse antecedents are prominent.

3b PAIN PROFILE

Location and distribution

Focal medial right elbow over the sublime tubercle, with intermittent radiation along the ulnar border of the forearm. No radiation proximal to the elbow. Unilateral; left elbow asymptomatic.

Onset and course

Acute onset 6 weeks ago superimposed on 4 months of low-grade medial soreness after long-toss. Steady improvement over weeks 1–4, then plateau. Currently pain-free with ADLs and light catch; pain returns only at higher-effort throwing.

Character and severity

Sharp with an accompanying pull at end-range lay-back; dull ache for 1–2 hours afterward. Current 1/10 at rest; best 0/10; worst 7/10 at injury; average 2/10 over the past week. Reaches 4/10 at approximately 75% effort throwing from 90 feet.

Aggravating and alleviating factors

Aggravated by valgus load at late cocking, long-toss beyond 90 feet, slider grip, and push-ups. Relieved by rest, ice after throwing, forearm-flexor strengthening, and scapular work. No relief needed from medication in the past 3 weeks.

3c IMPACT, TREATMENT & BACKGROUND

Associated symptoms

Denies locking, catching, or true instability. Reports transient ulnar-sided paresthesia in the small finger after prolonged throwing sessions in weeks 1–3, now resolved. No swelling since week 2. No grip weakness with daily tasks.

Functional and athletic impact

Full ADLs, full school participation, driving unrestricted. Not pitching or hitting; cleared for lower-body conditioning and running. Sleep undisturbed. Reports frustration and anxiety about missing showcase exposure in a recruiting year.

Prior conservative treatment

Relative rest and throwing cessation for 3 weeks; ice; hinged elbow brace for 2 weeks (discontinued week 3); formal physical therapy twice weekly since 07/14/2026 — 11 sessions completed, focused on forearm flexor-pronator strengthening, scapular stabilization, hip and trunk mobility, and throwing mechanics.

Prior interventional treatment

None. Platelet-rich plasma was discussed at the initial visit and deferred in favor of a rehabilitation trial. No corticosteroid injection — contraindicated at the ligament site.

Medication history and response

Naproxen 500 mg BID with food for 10 days after injury, good early response, discontinued 07/16/2026. Acetaminophen 650 mg PRN, used twice in the past month. Topical diclofenac 1% used after PT sessions. No opioids. Family counseled on NSAID and supplement rules under state athletic-association and NCAA banned-substance guidance; patient uses no supplements.

Surgical / injury history

Right ulnar shaft greenstick fracture age 9, healed uneventfully. Left ankle inversion sprain 2024. No prior elbow injury, no dislocation, no concussion. No prior surgery, no hardware.

Training / load management history

No pitch-count logging outside school games; overlapping school and club seasons since February with an estimated 8 competitive months per year. Sleeps 6–6.5 hours on school nights. Reports inconsistent post-outing recovery routine and no scheduled shutdown period. Adherent to HEP 5–6 days per week.

Relevant medical history

Healthy. No diabetes, inflammatory or connective tissue disease. Beighton score 2/9 — no generalized hypermobility. No anticoagulants, no immunosuppression. No stress fracture history. Vitamin D level 26 ng/mL in July, supplementation started.

Recent imaging / testing

MRI right elbow 07/08/2026: partial-thickness tear of the anterior bundle of the UCL involving the distal insertion, approximately 40% of fiber thickness, with periligamentous edema; flexor-pronator strain, no retraction; no loose body, no OCD lesion. Repeat MRI 08/06/2026: interval decrease in edema, partial healing at the distal insertion, no progression. Elbow radiographs 07/02/2026 negative for avulsion or physeal widening.

Pertinent negatives

Denies inability to use the arm, deformity, rapidly worsening swelling, fever, chills, night pain, weight loss, progressive numbness, or vascular symptoms. No red flags identified.

ROS SPORTS INJURY PAIN REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Joint, muscle, tendon or ligament pain; stiffness or swelling	Positive — medial elbow pain with high-effort throwing. No swelling.
Instability, locking, catching, popping, weakness or reduced ROM	Negative for locking or catching. Perceived instability at lay-back only.
Numbness, tingling, radiating pain, gait difficulty, balance issues, falls	Prior transient small-finger paresthesia, resolved. No current symptoms.
Bruising, deformity, redness, warmth, fever, chills, infection concern	Negative throughout.
Sleep disturbance, mood symptoms, pain-related distress, performance anxiety	Positive — recruiting-related anxiety. Sleep 6–6.5 hrs, not pain-limited.
Medication side effects, GI symptoms from NSAIDs, sedation, dizziness, bleeding	Negative. NSAIDs tolerated and now discontinued.
Training, competition, ADL limitations, return-to-play concerns	Positive — no throwing or hitting; conditioning permitted.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
98.2 °F	114/68 mmHg
HEART RATE	RESPIRATORY RATE

HEART RATE

58 bpm

RESPIRATORY RATE

14 /min

OXYGEN SATURATION

99% RA

HEIGHT

6 ft 1 in

WEIGHT

182 lb

BMI

24.0

PAIN SCORE

1/10 at rest, 4/10 at 75% effort throwing

5a GENERAL APPEARANCE & INSPECTION

General appearance

Well-appearing adolescent male, athletic build, no distress, moves the right arm freely, no guarding or assistive device.

Inspection

No effusion, ecchymosis or deformity. Symmetric carrying angle. No medial epicondyle prominence or forearm atrophy. Mild right scapular dyskinesis with overhead elevation.

5b PALPATION, RANGE OF MOTION & STRENGTH

Palpation

Mild tenderness over the distal UCL at the sublime tubercle (2/10, down from 6/10 at week 1). Flexor-pronator mass non-tender. Medial epicondyle physis non-tender. No crepitus, no palpable defect, no ulnar nerve subluxation with flexion.

Range of motion

Right elbow 0–142°, left 0–145°. Pronation and supination full and symmetric. Shoulder: right ER 108° / IR 42°, left ER 96° / IR 58° — 16° GIRD on the right with preserved total arc.

Strength

Wrist flexion and pronation 5/5 bilaterally, symmetric grip 52 kg right / 50 kg left. Painless resisted testing. Shoulder ER 5/5 with mild fatigue on endurance testing. Hip abduction 4+/5 bilaterally.

5c NEUROLOGIC, VASCULAR & FUNCTIONAL TESTING

Neurologic

Sensation intact in median, radial and ulnar distributions. Negative Tinel at the cubital tunnel. Negative elbow flexion compression test at 60 seconds. Coordination and balance intact.

Vascular

Radial and ulnar pulses 2+, capillary refill <2 s, no edema, limb warm and well perfused.

Functional / sport-specific testing

Single-leg squat with mild right trunk lean. Plank and side-plank endurance below age norms. Throwing mechanics on video: early trunk rotation with delayed arm cocking, producing increased valgus load. Long-toss to 90 feet at 70% effort reproduced 3/10 medial pain at release.

Special tests

Moving valgus stress test positive at 70–100° with reproduction of medial pain, no endpoint laxity. Milking maneuver mildly positive. Valgus stress at 30°: firm endpoint, no gapping. Negative flexion-pronation test for posteromedial impingement.

6 FOCUSED REGIONAL FINDINGS**Elbow / wrist / hand**

As documented above — focal distal UCL tenderness, positive moving valgus stress without laxity, full painless grip and resisted wrist flexion.

Shoulder / upper extremity

16° GIRD on the dominant side, mild scapular dyskinesis, ER endurance deficit. No impingement, labral or instability signs.

Spine and lower kinetic chain

Thoracic extension limited. Bilateral hip abduction weakness and reduced trunk endurance identified as contributing kinetic-chain deficits. Lumbar exam unremarkable, no radicular signs.

7 SCORES, INTERPRETATION & COMPARISON

NUMERIC PAIN RATING SCALE

1/10 rest · 4/10 throwing (was 7/10)

PEG SCALE

2 / 1 / 2 — mean 1.7 (was 4.3)

QUICKDASH

9.1 (was 34.1 at week 1)

QUICKDASH SPORTS/PERFORMING MODULE

43.8 (was 87.5)

KERLAN-JOBE ORTHOPAEDIC CLINIC SCORE

61 / 100

TIMELINE IN REHABILITATION

Week 6 of 12–16 expected

RETURN-TO-PLAY READINESS

Not yet met — pain-free 90-ft throw at 75% effort and symmetric ER endurance required before phase 2

FUNCTIONAL GOALS

Pain-free interval throwing phase 1 by week 8; mound progression by week 11; showcase participation contingent on criteria, not on date

8 REVIEWED OR ORDERED**Imaging**

MRI right elbow 08/06/2026 (reviewed with radiology): interval decrease in periligamentous edema, partial healing at the distal UCL insertion, no progression of the partial tear, flexor-pronator strain resolved. Prior MRI 07/08/2026 and radiographs 07/02/2026 as above.

Electrodiagnostic testing

Not indicated. Ulnar symptoms resolved with no objective deficit.

Laboratory studies

25-OH vitamin D 26 ng/mL (07/2026, insufficient) — cholecalciferol 2000 IU daily started. CBC and CMP within normal

limits.

Functional / biomechanical testing

Video throwing analysis 08/13/2026 as documented. Formal motion-capture assessment scheduled with the performance lab for 08/27/2026.

Procedure reports and prior records reviewed

Athletic trainer sideline note 07/02/2026, urgent care note and radiographs, 11 physical therapy progress notes, and the initial sports medicine consultation of 07/08/2026.

A

ASSESSMENT

9 SPORTS INJURY PAIN CLINICAL INTERPRETATION

- **Grade II partial-thickness tear, anterior bundle of the right ulnar collateral ligament, distal insertion** — dominant arm, week 6 of non-operative management. Imaging and examination both show interval improvement with partial healing and no laxity on static valgus testing.
- **Pain generator:** the healing distal UCL under valgus load. Positive moving valgus stress with a firm endpoint supports a symptomatic but competent ligament rather than functional insufficiency.
- **Differential considered:** flexor-pronator strain (resolved on repeat imaging), ulnar neuritis (transient, now resolved), medial epicondyle apophysitis (excluded — physis closed on radiographs, non-tender), posteromedial impingement (negative testing).
- **Contributing risk factors:** year-round throwing without a shutdown period, absent pitch-count monitoring outside school games, a slider introduced at 17, 16° GIRD, scapular dyskinesis, hip and trunk endurance deficits, short sleep, and vitamin D insufficiency. These are the recurrence drivers and are as important as the ligament itself.
- No red flags. Neurovascular status intact. No indication for surgical referral at this time.
- **Return-to-play status:** not cleared. Criteria for advancing to interval throwing phase 1 are met with the exception of pain-free 75%-effort throwing at 90 feet. Recruiting timeline is understood but will not drive progression.

P

PLAN

10 SPORTS INJURY PAIN MANAGEMENT BY PROBLEM

- **Activity modification:** no competitive pitching, no hitting, no slider grip. Continue lower-body conditioning, running and non-provocative upper-body work. Cross-train with bike and pool.
- **Rehabilitation:** continue PT twice weekly for 4 more weeks. Priorities — posterior shoulder mobility to close the GIRD gap, ER endurance, scapular control, hip abductor and trunk endurance, thoracic extension. Daily HEP maintained.
- **Interval throwing:** begin phase 1 (45–60 ft, flat ground, every other day) once the 90-ft 75%-effort throw is pain-free — reassess in 2 weeks. Advance only on the criteria listed, one level per two sessions, with a mandatory 48-hour symptom check after each progression.
- **Medication:** no scheduled NSAID — avoided during ligament healing. Acetaminophen 650 mg PRN. Continue topical diclofenac after sessions. Cholecalciferol 2000 IU daily; repeat vitamin D in 12 weeks.

- **Interventional:** deferred. If the week-10 reassessment shows a symptom plateau without further healing, discuss leukocyte-poor PRP to the distal UCL versus orthopedic surgical consultation with the family.
- **Bracing:** no brace required. Hinged brace remains available for the first two weeks of mound work if requested.
- **Diagnostics:** no further imaging unless symptoms worsen or a plateau persists at week 10. Motion-capture throwing analysis 08/27/2026.
- **Injury prevention / load management:** written pitch-count and rest-day schedule shared with the school and club coaches, an annual 3-month throwing shutdown, no overlapping school and club outings, slider deferred to age 18, sleep target 8–9 hours, and a standardized post-outing recovery routine.
- **Referrals and coordination:** continued athletic trainer co-management, letter to the school and club coaching staff, sports nutrition consult for energy availability and vitamin D, sport psychology referral offered for recruiting-related anxiety.
- **Education:** family counseled on the natural history of partial UCL tears, the recurrence risk of returning before criteria are met, the specific red flags requiring urgent evaluation (new instability, progressive numbness, an acute pop with sudden pain loss of control), and the reality that the showcase date may not be achievable.

F

FOLLOW-UP

11 REASSESSMENT PLAN

Follow-up

Return in 2 weeks (08/27/2026) for pain reassessment, repeat moving valgus stress testing, ER endurance and GIRD re-measurement, review of the motion-capture analysis, and a decision on starting interval throwing phase 1. Week-10 visit (09/10/2026) will determine mound progression versus escalation to PRP or surgical consultation. Athletic trainer to report any symptom recurrence within 24 hours. Urgent return for an acute pop, new instability, or progressive ulnar neurologic symptoms.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

42 minutes

COUNSELING / COORDINATION OF CARE

18 minutes

RECORDS REVIEW TIME

7 minutes

IMAGING REVIEW TIME

9 minutes

PROCEDURE PLANNING TIME

Not applicable

RETURN-TO-PLAY COUNSELING TIME

12 minutes

E/M LEVEL

99214 — established patient, moderate MDM

PROCEDURE CODE(S)

None this visit

IMAGING GUIDANCE CODE(S)

Not applicable

BASIS FOR BILLING

Medical decision making, with time documented (42 min) supporting the level

PRIMARY ICD-10

S53.441A — Sprain of ulnar collateral ligament of right elbow, initial encounter for closed injury

SECONDARY ICD-10

M25.521 — Pain in right elbow; Z87.828 — Personal history of other (healed) physical injury; E55.9 — Vitamin D deficiency, unspecified

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Priya N. Raghavan

CREDENTIALS

MD, CAQ Sports
Medicine

SPECIALTY

Sports Injury Pain
Management

DATE

08/13/2026

TIME

4:48 PM