Appendix Figure 1. Medical record abstraction form for presumptive cases of subdeltoid bursitis

Subdeltoid Bursitis

VSD Study ID

_____

1. BACKGROUND INFORMATION

Abstractor initials

_____

Abstraction date

_____

2. VACCINATION

We are interested in the inactivated influenza vaccine (IIV) for the 2016-2017 flu season. The vaccination date is prepopulated.

Vaccination date

_____

Are there clinic notes available for the vaccination visit?

◯ Yes
◯ No
(If there is registry information but no clinic note, select "No")

Was there an influenza vaccine given on this day?

◯ Yes
◯ No
◯ Unknown

Was the route of the administration for the influenza vaccine intramuscular (IM)?

◯ Yes
◯ No
◯ Unknown

Was the influenza vaccine administered in the deltoid muscle (ie, the upper arm)?

◯ Yes
◯ No
◯ Unknown

Vaccination side from VSD data (this is a pre-populated value)

_____

Does the pre-populated side match the side mentioned in the chart/registry?

◯ Yes
◯ No

Shoulder of interest

If the side from the chart/registry (right or left) does not agree with the prepopulated value above, then use the chart value. If no chart value is available, then use the prepopulated value. Hereafter, this will be referred to as the "shoulder of interest" and will be populated in questions about the side of symptoms/injury.

◯ Right
◯ Left

Setting of vaccination Select the location that best describes where the patient was vaccinated. If the patient is a healthcare worker who received his/her vaccination at the place of employment, select "work."	◯ Clinic/Doctor's Office ◯ Urgent Care ◯ Emergency Room ◯ Hospital Inpatient ◯ Pharmacy ◯ Work ◯ Flu vaccine clinic/booth ◯ Other (specify) ◯ Unknown
Specify "other location of vaccination"	_____
Credentials of the vaccinator	◯ LPN (Licensed Practical Nurse) ◯ MA (Medical Assistant) ◯ MD/DO (Physician) ◯ NP (Nurse Practitioner) ◯ PA (Physician's Assistant) ◯ Pharmacist ◯ Pharmacy Assistant ◯ RN (Registered Nurse) ◯ Unknown ◯ Other (specify)
Specify other credentials of vaccinator	_____
Were any problems with the vaccine injection noted (eg, administration error)?	◯ Yes ◯ No
If yes, specify errors noted:	_____
Were any other vaccinations given on this day?	◯ Yes ◯ No ◯ Unknown
Was any vaccine given in the same arm as the influenza vaccine?	◯ Yes ◯ No ◯ Unknown
Did the patient have any post-vaccination shoulder or arm complaints noted at this visit?	◯ Yes ◯ No
Does the note/problem list mention any previous shoulder symptoms?	◯ Yes ◯ No
Side of previous shoulder symptoms:	◯ Right ◯ Left ◯ Both ◯ Unknown
Are height/weight units given in metric (cm/kg) or imperial (feet/inches/pounds)?	◯ Metric ◯ Imperial

Date of closest visit with height recorded, within 6 months	_____ (If height is not available from the date of vaccination, enter the next closest date notes are available, either before or after.)
Height (inches) Convert to inches if value is given in feet. 1 foot=12 inches	_____ (If value is not available from the day of vaccination, enter values from the closest date.)
Height (centimeters)	_____
Calculated height in inches	_____
Date of closest visit with weight recorded, within 6 months	_____ (If weight is not available from the day of vaccination, enter the next closest date that the weight is recorded, either before or after.)
Weight (pounds)	_____ (If value is not available from the day of vaccination, enter values from the closest date.)
Weight (kilograms)	_____
Calculated weight in pounds	_____
BMI If height and weight are not available but BMI is listed, enter that value. If height and weight are entered above, leave this blank.	_____ ( )

3. MEDICAL ENCOUNTERS ON THE SAME DAYS AS VACCINATION

Were there any other visits on the same calendar day as the vaccination?	◯ Yes ◯ No ◯ Unknown
Type of encounter	◯ Outpatient (primary care and specialty care office visit) ◯ Urgent care ◯ Emergency room ◯ Hospital inpatient ◯ Phone call ◯ Email ◯ Other (specify)
Specify other	_____

Definitions of provider types [Attachment: "Provider groups.docx"]	
Provider type (See definitions in the above document)	◯ Primary Care ◯ ER/Urgent Care/Inpatient ◯ Shoulder specialist ◯ Non-shoulder specialist ◯ Other
Specify other:	_____
Was there any mention of the [v_shoulder] shoulder at this visit?	◯ Yes ◯ No
List any shoulder or arm diagnoses on the [v_shoulder] side made at this visit	_____
When did the shoulder or arm symptoms start? Please be as specific as possible. If a date is given, give the date. If a duration is given (eg, "two weeks ago,") count backwards that amount of time from the visit date and use that as the start date, even if the duration given was inexact (eg, "about two weeks ago.") If a range is given (eg, "one to two weeks ago,") give the earliest possible start date (in that case, two weeks prior to the appointment). Use the calendar box to select a date, and write the exact statement regarding the start date or symptom duration in the text box.	_____ (If duration of symptoms is not discussed, leave this blank.)
Is this date exact or an estimation?	◯ Exact ◯ Estimate (Select "estimate" if symptom duration/onset date was not discussed.)
Give the statement regarding the start date or symptom duration as it is in the chart. If duration is not discussed, enter that here as well.	_____
Was the shoulder or arm diagnosis attributed to the influenza vaccination by the provider?	◯ Yes ◯ No ◯ Not stated
If yes, copy and paste the visit note. Ensure that you don't include any identifiable information beyond date of visit. If note cannot be copied and pasted, please upload a redacted copy of the note at the bottom of this form.	_____

4. PRE-EXISTING SHOULDER CONDITIONS DOCUMENTED PRIOR TO VACCINATION DATE

Working backward from the date of vaccination to six months prior to vaccination, look for any visits for shoulder or upper arm problems, symptoms, or injuries. Do not worry about any injuries or symptoms to the elbow, forearm, wrist, or hand.

Any prior shoulder/upper arm symptoms found?

(If there is a shoulder problem listed in the problem list but not addressed, this is "no.")

- ◯ Yes
- ◯ No

Visit date of most recent visit for shoulder/upper arm symptoms prior to vaccination

_____

Definitions of provider types

[Attachment: "Provider groups.docx"]

Provider type

Use the above document to determine provider types.

- ◯ Primary Care
- ◯ ER/Urgent Care/Inpatient
- ◯ Shoulder specialist
- ◯ Non-shoulder specialist
- ◯ Other

Specify other provider:

_____

Was this prior problem in the side of interest ([v_shoulder])?

- ◯ Yes
- ◯ No
- ◯ Unknown

Was there a previous diagnosis of bursitis or other bursal disorders in [v_shoulder] shoulder?

If yes, STOP and mark form complete.

- ◯ Yes
- ◯ No

Was there a previous shoulder/upper arm diagnosis other than bursitis in [v_shoulder] shoulder?

- ◯ Yes
- ◯ No

Specify other shoulder/upper arm diagnoses (list all shoulder/upper arm diagnoses given at this visit)

_____

5. NEXT MEDICAL ENCOUNTER AFTER VACCINATION

We are interested in the first medical encounter that happened on a date other than the vaccination date, within six months of vaccination, even if it is not related to the shoulder/arm or vaccination.

Date of next medical encounter

_____

Type of encounter	◯ Outpatient (primary care and specialty care office visit) ◯ Urgent care ◯ Emergency room ◯ Hospital inpatient ◯ Phone call ◯ Email ◯ Other (specify)
Specify other	_____
Definitions of provider types [Attachment: "Provider groups.docx"]	
Provider type	◯ Primary Care ◯ ER/Urgent Care/Inpatient ◯ Shoulder specialist ◯ Non-shoulder specialist ◯ Other
If other, specify	_____
What was the chief complaint of this visit?	_____
Did the patient complain of shoulder/upper arm symptoms in the [v_shoulder] side as part of this encounter?	◯ Yes ◯ No

6. FIRST SHOULDER/UPPER ARM VISIT POST-VACCINATION

Look for the first visit for shoulder/upper arm symptoms, within 6 months. If the visit is clearly NOT for the shoulder of interest, go to the first visit that is for the shoulder of interest/both shoulders/laterality is unclear.

If the answer to the previous question (Did the patient complain of shoulder/upper arm symptoms?) is yes, answer these questions based on that visit. If the answer was no, look for the next visit that involves shoulder/upper arm symptoms and answer the questions based on that visit.

If no shoulder/upper arm visits are found within 6 months, stop abstraction.

Date of first shoulder/upper arm visit	_____
Type of encounter	◯ Outpatient (primary care and specialty care office visit) ◯ Urgent care ◯ Emergency room ◯ Hospital inpatient ◯ Other (specify)

Specify other	_____
Type of provider	◯ Orthopedics ◯ Rheumatologist ◯ Physical Medicine & Rehabilitation ◯ Sports Medicine ◯ Primary Care Physician (eg, internal medicine, family medicine, pediatrics) ◯ Physical Therapy ◯ Occupational Therapy ◯ Other (specify)
Specify other provider type	_____
Which side has the symptoms?	◯ Right ◯ Left ◯ Both ◯ Unknown
When did the shoulder or arm symptoms start? Please be as specific as possible. If a date is given, give the date. If a duration is given (eg, "two weeks ago,") count backwards that amount of time from the visit date and use that as the start date, even if the duration given was inexact (eg, "about two weeks ago.") If a range is given (eg, "one to two weeks ago,") give the earliest possible start date (in that case, two weeks prior to the appointment). Use the calendar box to select a date, and write the exact statement regarding the start date or symptom duration in the text box.	_____ (Leave blank if symptom duration or onset date was not discussed at this visit.)
Is this date exact or an estimation?	◯ Exact ◯ Estimate (Select "estimate" if duration of symptoms was not discussed.)
Give the statement regarding the start date or symptom duration as it is in the chart. If duration is not discussed, enter that here as well.	_____
Check all the symptoms that were reported	☐ Pain/Soreness ☐ Reduced range of motion/Stiffness ☐ Weakness ☐ Numbness ☐ Tingling ☐ Radiating pain ☐ Swelling ☐ Fever
Was a specific injury or action, other than vaccination, mentioned as the cause of the shoulder/upper arm symptoms?	◯ Yes ◯ No
Were the shoulder/upper arm symptoms attributed to the vaccine by the patient or provider?	◯ Yes ◯ No

If yes, copy and paste the visit note. Ensure that you do not include any identifiable information beyond date of visit.

If note cannot be copied and pasted, please upload a redacted copy of the note at the bottom of this form.

_____

Was vaccination mentioned at all in the visit note?

◯ Yes
◯ No

Were any symptoms documented described as being related to a vaccine injection?

Select as many as apply.

☐ Induration/Hard mass
☐ Erythema/Swelling/Redness
☐ Pain/Soreness
☐ Rash
☐ Other

Specify other

_____

Were any of the following physical exam findings noted to be positive for the [v_shoulder] shoulder?

Note: only indicated those that were noted as positive or present. Do not select tests which were noted as being negative.

☐ Neer (Impingement Test 1)
☐ Hawkin's (Impingement Test 2)
☐ No physical exam recorded
☐ Other (specify)

Specify other physical exam findings pertaining to the [v_shoulder] shoulder/upper arm

_____

Was a diagnostic ultrasound performed during this visit?

Note: This does not include therapeutic ultrasound, which does not result in images or diagnoses.

◯ Yes
◯ No

What were the findings of the ultrasound?

☐ Normal/negative
☐ Bursitis/thickened bursal sac
☐ Any rotator cuff tear
☐ Any tendinitis/tendinosis/tedinopathy
☐ Calcific tendinosis
☐ Impingement
☐ Synovitis
☐ Adhesive capsulitis/capsular thickening
☐ Edema/fluid around tendon
☐ Other (specify)

Specify other ultrasound findings

_____

Was bursitis or a bursal disorder of the [v_shoulder] shoulder diagnosed at this visit?

◯ Yes
◯ No

List all other diagnoses given at this appointment, even if they don't pertain to the [v_shoulder] shoulder

_____

Examples of medications

[Attachment: "Treatments.docx"]

Which of the following treatments were performed or newly prescribed?

Do not document any procedures that are recommended but not performed (eg, provider recommends shoulder injection, but patient declines).

(Please use the above document if you are unsure of the class of medication)

- ☐ Shoulder injection
- ☐ Oral steroids
- ☐ NSAIDs
- ☐ Opiates/Narcotic pain medication
- ☐ Topical analgesics
- ☐ Other analgesics
- ☐ Osteopathic/chiropractic manipulation
- ☐ Physical therapy/Occupational therapy
- ☐ Surgery
- ☐ Other (specify)
- ☐ None

(If shoulder injection was performed, make sure to fill out the "Shoulder Injection" section below.)

Specify other: _____

7. FIRST BURSITIS VISIT

Find the first visit in which bursitis is in the list of diagnoses, within 6 months of vaccination. If the first shoulder visit after vaccination resulted in a diagnosis of bursitis, this section does not need to be completed.

If no visits for bursitis are found within 6 months of vaccination, stop abstraction.

Visit date: _____

Type of encounter

- ◯ Outpatient (primary care and specialty care office visit)
- ◯ Urgent care
- ◯ Emergency room
- ◯ Hospital inpatient
- ◯ Other (specify)

Specify other: _____

Type of provider

- ◯ Orthopedics
- ◯ Rheumatologist
- ◯ Physical Medicine & Rehabilitation
- ◯ Sports Medicine
- ◯ Primary Care Physician (eg, internal medicine, family medicine, pediatrics)
- ◯ Physical Therapy
- ◯ Occupational Therapy
- ◯ Other (specify)

Specify other: _____

Which shoulder was diagnosed with bursitis?

- ◯ Right
- ◯ Left
- ◯ Both
- ◯ Unknown

When did the shoulder or arm symptoms start?

Please be as specific as possible. If a date is given, give the date. If a duration is given (eg, "two weeks ago,") count backwards that amount of time from the visit date and use that as the start date, even if the duration given was inexact (eg, "about two weeks ago.") If a range is given (eg, "one to two weeks ago,") give the earliest possible start date (in that case, two weeks prior to the appointment). Use the calendar box to select a date, and write the exact statement regarding the start date or symptom duration in the text box.

_____
(Leave blank if symptom duration or onset date was not discussed at this visit.)

Is this date exact or an estimation?

◯ Exact
◯ Estimate
(Select "estimate" if duration was not discussed.)

Give the statement regarding the start date or symptom duration as it is in the chart. If duration is not discussed, enter that here as well.

_____

Was a specific injury or action, other than vaccination, mentioned as the cause of the shoulder symptoms?

◯ Yes
◯ No

Were the shoulder symptoms attributed to the vaccine by the patient or provider?

◯ Yes
◯ No

If yes, copy and paste the visit note. Ensure that you don't include any identifiable information beyond date of visit.

If note cannot be copied and pasted, please upload a redacted copy of the note at the bottom of this form.

_____

Check all the symptoms that were reported

☐ Pain/Soreness
☐ Reduced range of motion/Stiffness
☐ Weakness
☐ Numbness
☐ Tingling
☐ Radiating pain
☐ Swelling
☐ Fever

Were any of the following physical exam findings noted to be positive for the [v_shoulder] shoulder?

Note: only indicated those that were noted as positive or present. Do not select tests which were noted as being negative.

☐ Neer (Impingement Test 1)
☐ Hawkin's (Impingement Test 2)
☐ No physical exam recorded
☐ Other (specify)

Specify other physical exam findings pertaining to the [v_shoulder] shoulder

_____

Was a diagnostic ultrasound performed during this visit?

Note: This does not include therapeutic ultrasound, which does not result in images or diagnoses.

◯ Yes
◯ No

What were the findings of the ultrasound?

☐ Normal/negative
☐ Bursitis/thickened bursal sac
☐ Any rotator cuff tear
☐ Any tendinitis/tendinosis/tedinopathy
☐ Calcific tendinosis
☐ Impingement
☐ Synovitis
☐ Adhesive capsulitis/capsular thickening
☐ Edema/fluid around tendon
☐ Other (specify)

Specify other ultrasound findings

_____

List all diagnoses given at this appointment, even if they don't pertain to the [v_shoulder] shoulder

_____

Examples of medications

[Attachment: "Treatments.docx"]

Which of the following treatments were performed or newly prescribed?

Do not document any procedures that are recommended but not performed (eg, provider recommends shoulder injection, but patient declines).

(Please use the above document if you are unsure about the class of medication)

☐ Shoulder injection
☐ Oral steroids
☐ NSAIDs
☐ Opiates/Narcotic pain medication
☐ Topical analgesics
☐ Other analgesics
☐ Osteopathic/chiropractic manipulation
☐ Physical therapy/Occupational therapy
☐ Surgery
☐ Other (specify)
☐ None
(If the patient received a shoulder injection, ensure the section "Shoulder Injection" is completed below.)

Specify other:

_____

8. FIRST VISIT WITH A SPECIALTY PROVIDER

Specialty providers include orthopedic surgeons, rheumatologists, physical medicine and rehabilitation, sports medicine, physical therapy, and occupational therapy. We are not interested in visits with specialty providers for problems unrelated to the shoulder. If the first shoulder visit or first bursitis visit was with a specialty provider, please check yes to the first question, which will skip this section.

Look as far forward into the EMR as you have available.

Was the first shoulder visit or first bursitis visit with a specialty provider?	◯ Yes ◯ No
Did the patient meet with a specialty provider for the shoulder?	◯ Yes ◯ No
Date of first specialty visit:	_____
Type of encounter	◯ Outpatient (primary care and specialty care office visit) ◯ Urgent care ◯ Emergency room ◯ Hospital inpatient ◯ Other (specify)
Specify other	_____
Type of provider:	◯ Orthopedics ◯ Rheumatologist ◯ Physical Medicine & Rehabilitation ◯ Sports Medicine ◯ Physical Therapy ◯ Occupational Therapy ◯ Other (specify)
Specify other	_____
Which shoulder was this visit about?	◯ Right ◯ Left ◯ Both ◯ Unknown
When did the shoulder or arm symptoms start? Please be as specific as possible. If a date is given, give the date. If a duration is given (eg, "two weeks ago,") count backwards that amount of time from the visit date and use that as the start date, even if the duration given was inexact (eg, "about two weeks ago.") If a range is given (eg, "one to two weeks ago,") give the earliest possible start date (in that case, two weeks prior to the appointment). Use the calendar box to select a date, and write the exact statement regarding the start date or symptom duration in the text box	_____ (Leave blank if onset date or symptom duration was not discussed.)
Is this date exact or an estimation?	◯ Exact ◯ Estimate (Select "estimate" if duration was not discussed.)
Give the statement regarding the start date or symptom duration as it is in the chart. If duration is not discussed, enter that here as well.	_____

Was a specific injury or action, other than vaccination, mentioned as the cause of the shoulder symptoms?	◯ Yes ◯ No
Were the shoulder symptoms attributed to the vaccine by the patient or provider?	◯ Yes ◯ No
If yes, copy and paste the visit note. Ensure that you don't include any identifiable information beyond date of visit. If note cannot be copied and pasted, please upload a redacted copy of the note at the bottom of this form.	_____
Check all the symptoms that were reported	☐ Pain/Soreness ☐ Reduced range of motion/Stiffness ☐ Weakness ☐ Numbness ☐ Tingling ☐ Radiating pain ☐ Swelling ☐ Fever
Were any of the following physical exam findings noted to be positive for the [v_shoulder] shoulder? Note: only indicated those that were noted as positive or present. Do not select tests which were noted as being negative.	☐ Neer (Impingement Test 1) ☐ Hawkin's (Impingement Test 2) ☐ No physical exam recorded ☐ Other (specify)
Specify other physical exam findings pertaining to the [v_shoulder] shoulder	_____
Was a diagnostic ultrasound performed during this visit? Note: This does not include therapeutic ultrasound, which does not result in images or diagnoses.	◯ Yes ◯ No
What were the findings of the ultrasound?	☐ Normal/negative ☐ Bursitis/thickened bursal sac ☐ Any rotator cuff tear ☐ Any tendinitis/tendinosis/tedinopathy ☐ Calcific tendinosis ☐ Impingement ☐ Synovitis ☐ Adhesive capsulitis/capsular thickening ☐ Edema/fluid around tendon ☐ Other (specify) ☐ None
Specify other ultrasound findings	_____
Was bursitis or a bursal disorder diagnosed by the provider at this visit?	◯ Yes ◯ No

List all other diagnoses given at this appointment, even if they don't pertain to the [v_shoulder] shoulder

_____

Examples of medications

[Attachment: "Treatments.docx"]

Which of the following treatments were performed or newly prescribed?

Do not document any procedures that are recommended but not performed (eg, provider recommends shoulder injection, but patient declines).

(Please use the above document if you are unsure of the class of medication)

- ☐ Shoulder injection
- ☐ Oral steroids
- ☐ NSAIDs
- ☐ Opiates/Narcotic pain medication
- ☐ Topical analgesics
- ☐ Other analgesics
- ☐ Osteopathic/chiropractic manipulation
- ☐ Physical therapy/Occupational therapy
- ☐ Surgery
- ☐ Other (specify)

(If the patient received a shoulder injection, ensure the section "Shoulder Injection" is completed below.)

Specify other:

_____

9. FIRST SHOULDER INJECTION

Look for the first notation of a shoulder injection in the visit notes for the first six months following the 2016-2017 influenza vaccination. Shoulder injections are most likely to be performed by primary care or shoulder specialists; they will not be performed by physical or occupational therapy nor non-shoulder specialists (eg, ophthalmology, nephrology, endocrinology) and these visits do not need to be checked for shoulder injections.

Did the patient receive a shoulder injection?

- ◯ Yes
- ◯ No

Date of shoulder injection

_____

If shoulder injection was done, what medication was injected?

- ☐ Steroid (eg, betamethasone, Celestone Soluspan, methylprednisolone, Depo-Medrol)
- ☐ Anesthetic (eg, lidocaine, Xylocaine, bupivacaine, Marcaine)
- ☐ Other

Specify other

_____

What was the response to the injection noted at this visit?

- ☐ Pain relieved
- ☐ Range of motion improved
- ☐ No change
- ☐ Unknown / not documented
- ☐ Other (specify)

Specify other

_____

Did the patient have another visit or encounter (including phone calls/email) with this provider/team/clinic, for any reason, within the following 3 months?	◯ Yes ◯ No
Visit/encounter date:	_____
Was the shoulder steroid injection mentioned?	◯ Yes ◯ No
How long did the patient note relief of pain from previous injection?	◯ No pain relief ◯ < 1 day ◯ 1 day-1 week ◯ >1 week-1 month ◯ >1 month ◯ Pain still relieved ◯ Duration not specified

10. FIRST SHOULDER SURGERY POST-VACCINATION

Look for surgical reports (as opposed to surgery clinic notes) after the day of the index influenza vaccination. There is no upper time frame for your search.

Does the patient have a record of any shoulder surgery?	◯ Yes ◯ No
Date of surgery:	_____
Are notes available for this surgery?	◯ Yes ◯ No
Was the surgery in the [v_shoulder] shoulder?	◯ Yes ◯ No
Pre-operative diagnosis:	_____ (Write "unknown" if pre-op diagnosis was not given.)
Post-operative diagnosis	_____ (Write "unknown" if post-op diagnosis was not given.)

Procedures performed during surgery:	☐ Arthroscopy ☐ Manipulation under anesthesia ☐ Lysis of adhesions ☐ Rotator cuff repair ☐ Subacromial decompression ☐ Joint debridement ☐ Distal clavicle excision ☐ Labrum/superior labrum anterior and posterior (SLAP) repair ☐ Bursectomy ☐ Synovectomy ☐ Tenodesis ☐ Acromioplasty ☐ Other
Specify other	_____
Was there any mention of the bursa?	◯ Yes ◯ No
Copy and paste the statement(s) regarding the bursa	_____
Did the patient have another surgery on any later date on the [v_shoulder] shoulder post-vaccination?	◯ Yes ◯ No

11. RADIOLOGY

Check the radiology section of the EMR for reports on radiology studies performed. There is no upper time frame for your search.

Did the patient have a shoulder MRI?	◯ Yes ◯ No
Date:	_____
Was this MRI of the [v_shoulder] shoulder?	◯ Yes ◯ No
Is a report available for this MRI? If no, check the clinic notes after this date for any reference to this MRI.	◯ Yes ◯ No
Copy and paste a copy of the report. Ensure that no PHI beyond the visit date is included. If the report cannot be copied and pasted, please upload a redacted copy of the report at the bottom of this form.	_____
Was the MRI read as normal or negative?	◯ Yes ◯ No

MRI tendon findings/assessments/impressions

Please check all tendon findings that are listed. If a given tendon is not mentioned, please check "none" for that tendon.

	Tendinitis	Tendinosis	Tendinopathy	Complete tear	Partial tear	None
Infraspinatus tendon	☐	☐	☐	☐	☐	☐
Subscapularis tendon	☐	☐	☐	☐	☐	☐
Supraspinatus tendon	☐	☐	☐	☐	☐	☐
Teres minor tendon	☐	☐	☐	☐	☐	☐
Biceps tendon	☐	☐	☐	☐	☐	☐

Select if any of the other MRI findings/assessments/impressions were found:

- ☐ Acromioclavicular joint degeneration/arthritis
- ☐ Bursitis/fluid in bursa
- ☐ Capsular edema/thickening/adhesive capsulitis
- ☐ Coracohumeral ligament thickening
- ☐ Cortical lesion
- ☐ Glenohumeral joint degeneration/arthritis
- ☐ Glenohumeral ligament [Inferior] thickening
- ☐ Glenohumeral ligament [superior] thickening
- ☐ Hill-Sachs deformity
- ☐ Humeral head cyst
- ☐ Humeral head deformity
- ☐ Humeral head edema
- ☐ Humeral head impaction fracture
- ☐ Impingement
- ☐ Joint effusion
- ☐ Labrum degeneration
- ☐ Labrum tear
- ☐ Muscle atrophy (any muscle)
- ☐ Osteophytes/bone spurs
- ☐ Synovitis
- ☐ Other

Specify other

_____

Did the patient have a diagnostic shoulder ultrasound performed by radiology? The report would be with the radiology reports.

- ◯ Yes
- ◯ No

Date of ultrasound:

_____

Was the ultrasound in the [v_shoulder] shoulder?

- ◯ Yes
- ◯ No

Is a report available for this ultrasound?

- ◯ Yes
- ◯ No

Copy and paste a copy of the report. Ensure that no PHI beyond the visit date is included.

If the report cannot be copied and pasted, please upload a redacted copy of the report at the bottom of this form.

_____

Select all findings/assessments/impressions of the ultrasound:	☐ Normal/negative ☐ Bursitis/thickened bursal sac ☐ Any rotator cuff tear ☐ Any tendinitis/tendinosis/tedinopathy ☐ Calcific tendinosis ☐ Impingement ☐ Synovitis ☐ Adhesive capsulitis/capsular thickening ☐ Edema/fluid around tendon ☐ Other
Specify other	_____

12. LAST VISIT RELATED TO THE SHOULDER

Review all records beyond the 2016-2017 vaccination date for the last visit available that mentions the [v_shoulder] shoulder.

Date of visit:	_____
Type of encounter:	◯ Outpatient (primary care and specialty care office visit) ◯ Urgent care ◯ Emergency room ◯ Hospital inpatient ◯ Other (specify)
Specify other	_____
Type of provider:	◯ Orthopedics ◯ Rheumatologist ◯ Physical Medicine & Rehabilitation ◯ Sports Medicine ◯ Primary Care Physician (eg, internal medicine, family medicine, pediatrics) ◯ Physical Therapy ◯ Occupational Therapy ◯ Other (specify)
Specify other provider type	_____
Did the patient note that his/her symptoms had resolved?	◯ Yes ◯ No ◯ Unknown
Symptoms that the patient is still experiencing:	☐ Pain/Soreness ☐ Decreased range of motion/Stiffness ☐ Weakness ☐ Numbness ☐ Impingement ☐ Atrophy ☐ Other

Specify other	_____
Was bursitis diagnosed at this visit?	◯ Yes ◯ No
List all other diagnoses given at this appointment, even if they don't pertain to the [v_shoulder] shoulder	_____

13. GENERAL COMMENTS

Do you have any questions or comments not addressed in the form? Please enter them here.	_____
Use this box to upload any redacted visit notes/surgical notes/radiology reports that could not be copied and pasted in an above field.	