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CONFIDENTIAL

Patient's Name:	**SANTILLAN, Maria Del Rosario**
Social Security No:	XXX-XX-3894
Date of Birth:	03/26/1967
Employer:	Premier Staffing
Insurance Carrier:	York Insurance
Claim #:	TWCS-3293; TWCS-1588
WCAB #:	ADJ9569723; ADJ9569722
Date of Injury:	CT 01/01/2012 TO 04/08/2014; 02/22/2013
Date of Initial Evaluation:	07/24/2014
Date of Final Evaluation:	02/02/2017
Date of Report:	02/02/2017

PRIMARY TREATING PHYSICIAN BASIC COMPREHENSIVE MEDICAL-LEGAL PERMANENT AND STATIONARY REPORT [ML 102] WITH REVIEW OF RECORDS

TO THE PARTY AUTHORIZED BY THE PATIENT:

Ms. Santillan is a 49-year-old, Spanish-speaking, right-handed, single Hispanic female.

JOB DESCRIPTION AS RELATED BY PATIENT

Job Title: Warehouse Supervisor. At the time of the injury, the patient was working 8-14+ hours per day, 6-7 days per week.

Specific Job Duties: The patient was responsible for walking, supervising, giving workers merchandise to pack, packing and lifting.

Activity, frequency and approximate number of hours a day (based on 8-14+ hours daily): continuous walking and standing, as well as intermittent bending, squatting, kneeling and twisting.

Hand manipulation was required. The patient is right-hand dominant. Simple grasping was required bilaterally. Power grasping was required bilaterally. Pushing and pulling were required bilaterally.

The job required the worker to reach or work above shoulder level. She was not required to use foot control for repetitive movements. Lifting and carrying items weighing 10 pounds or less to 50 pounds were required frequently. The heaviest items carried weighed approximately up to 40 pounds in various distances.

WORK STATUS FOLLOWING INDUSTRIAL INJURY

The patient has been temporarily totally disabled from 06/2014 to 02/2017.

EMPLOYMENT HISTORY

The patient worked for Premier Staffing, from 01/13/2012 to 04/08/2014. At the time of injury, she was working full-time. There was no concurrent employment. At present time, she is not working. She reported no prior employment.

WORK STATUS BEFORE INDUSTRIAL INJURY

Prior to injury, this patient was not symptomatic in relevant body parts; she was not actively disabled; she was not following any prior work restrictions; she was not self-limiting work activities; and she was not receiving ongoing medical attention for relevant body parts.

PAST MEDICAL HISTORY

Childhood illnesses – Unremarkable.
Other medical conditions – Unremarkable.

PAST SURGICAL HISTORY

The patient underwent herniorrhaphy.

PREVIOUS ACCIDENTS

The patient gives no indication or history of any previous unresolved injury.

PRIOR INJURIES/COMPLAINTS TO AFFECTED BODY PARTS

None.

SUBSEQUENT INJURIES

None.

MEDICATIONS

The patient reports taking Naprosyn.

ALLERGIES

No known allergies.

HABITS

The patient denies smoking, alcohol consumption or illicit drug use. She gets 5 hours of inconsistent sleep. She continues to walk as a form of exercise, despite the injury.

FAMILY HISTORY

The patient's mother is living at the age of 73. Her father is living at the age of 79 and has diabetes.

PERSONAL HISTORY

Last completed grade in school: High School in Mexico.
Other training: None.
Children: 1 child.
Type of personal transportation: Public Transportation.

MECHANISM OF INJURY #1

The patient states that from 01/01/2012 to 04/08/2014, while performing her usual and customary duties as a warehouse supervisor for Premier Staffing, she gradually developed pain in her neck, mid-back, lower back and left knee.

Ms. Santillan began her employment as a warehouse supervisor for Premier Staffing in 01/2013. As a warehouse supervisor, she was responsible for walking, supervising, giving workers merchandise to pack, packing, lifting, making sure the packing was correct and cleaning. Her job-related physical activities consisted of lifting, carrying, pushing, and pulling (weighing up to 30 to 50 pounds), bending at the neck, prolonged standing, constant walking,

occasional bending, kneeling, stooping, squatting, twisting, turning, hand manipulation, grasping, reaching and other physical activities required by her job duties. As a result of these activities, she gradually developed the symptoms mentioned above.

Ms. Santillan reported her symptoms to the employer who provided the patient with medical care at a clinic in the city of Compton. There she was evaluated, had x-rays taken of her lower back, was prescribed medications and was given sessions of therapy. Ms. Santillan was also given work restrictions that only permitted the patient to do light work, such as, no pulling, pushing or lifting. The patient continued performing her regular work activities, due to her financial necessity.

The patient stated that due to the constant walking and bending she began to feel increased pain in her knee. Ms. Santillan did not report the injury to her employer, but she did seek care on her own at the Los Angeles Community Hospital in the city of Los Angeles. There she was evaluated and had x-rays taken of her left knee. When Ms. Santillan returned to work, the pain in her left knee was unbearable and she was only able to work for 3 hours. The patient has not worked since 04/08/2014.

She then sought care with a chiropractor at Cuevas Chiropractor. Ms. Santillan has been receiving treatment to relieve her left knee pain.

Ms. Santillan then began attending a clinic in the city of Paramount, there she was evaluated and was given sessions of therapy.

MECHANISM OF INJURY #2

The patient states that on 02/22/2013, while performing her usual and customary duties as a warehouse supervisor for Premier Staffing, she injured her lower back.

Ms. Santillan began her employment as a warehouse supervisor for Premier Staffing in 01/2013. As a warehouse supervisor, she was responsible for walking, supervising, giving workers merchandise to pack, packing, lifting, making sure the packing was correct and cleaning.

The patient stated that she lifted a box that weighed approximately 40 to 50 pounds and immediately felt pain in her lower back. She stated that she felt not only a sharp shooting pain but also a pull in her lower back. Ms. Santillan reported her symptoms to the employer who provided the patient with medical

care at a clinic in the city of Compton. There she was evaluated, had x-rays taken of her lower back, was prescribed medications, and was given sessions of therapy. Ms. Santillan was also given work restrictions that only permitted the patient to do light work, such as, no pulling, pushing or lifting. The patient continued performing her regular work activities, due to her financial necessity, until 04/08/2014.

Ms. Santillan then began attending treatment at a clinic in the city of Paramount, where she was evaluated and was given sessions of therapy.

Presently, Mr. Santillan remains off work and states that her symptoms persist and have not improved. She now presents herself to this facility for a medical evaluation.

This patient indicated that she did not proficiently speak or understand the English language to assure accurate and meaningful communication with health care professionals regarding her medical condition and requested the assistance of an interpreter. Therefore, to secure precise reciprocal communication, I utilized an interpreter from "Accurate Interpreting LLC" to conduct this follow-up evaluation.

COURSE OF MEDICAL TREATMENT

After Ms. Santillan was initially seen in our office, the diagnostic impression was as follows:

CT 01/01/2012 TO 04/08/2014

1. CERVICAL MUSCULOLIGAMENTOUS STRAIN/SPRAIN.
2. THORACIC MUSCULOLIGAMENTOUS STRAIN/SPRAIN.
3. LUMBOSACRAL MUSCULOLIGAMENTOUS STRAIN/SPRAIN WITH RADICULITIS.
4. RULE OUT LUMBOSACRAL SPINE DISCOGENIC DISEASE.
5. LEFT KNEE STRAIN/SPRAIN.
6. RULE OUT LEFT KNEE INTERNAL DERANGEMENT.

DOI 02/22/2013

1. LUMBOSACRAL MUSCULOLIGAMENTOUS STRAIN/SPRAIN WITH RADICULITIS.
2. RULE OUT LUMBOSACRAL SPINE DISCOGENIC DISEASE.

The patient was started on passive and active chiropractic and physical therapy. A course of acupuncture was added to the patient's treatment regimen for an additional palliative effect. All therapy was performed by or under the supervision of a Board Certified Chiropractor, Registered Physical Therapist and Licensed Acupuncturist. She was provided with prescriptions for Tramadol, Mobic, Flurbi (NAP) cream, Gabacyclotram, Terocin patch and Norco. During the initial evaluation by the chiropractor, physical therapist and acupuncturist, she was educated about her orthopedic problems and their prevention; activity and environmental modifications; exercises, including office and home exercises. The importance of home exercises was stressed to her, and she was handed written instructions. During the course of her therapy, she was evaluated and re-evaluated periodically by the chiropractor, physical therapist and acupuncturist.

The patient was initially evaluated on 07/24/2014 and had subsequent follow-up evaluations on 11/13/2014, 12/18/2014, 01/29/2015, 03/12/2015, 04/23/2015, 05/28/2015,. 07/09/2015, 08/07/2015, 08/20/2015, 09/24/2015, 10/08/2015, 10/22/2015, 12/10/2015, 02/04/2016, 03/10/2016, 04/07/2016, 05/12/2016, 06/23/2016, 07/28/2016, 09/01/2016, 11/17/2016 and 01/05/2017.

The patient was referred for magnetic resonance imaging (MRI) of the left knee, which was performed on 12/15/14. As interpreted by Amjad Safvi, M.D., the following impressions were given:

Multiposition MRI of the Left Knee with and without Contrast:

1.) Myxoid degeneration involving body and posterior horn of medial meniscus.
2.) Small knee joint effusion.
3.) A well-defined lobulated mass noted in the posterior aspect of distal femur. It appears hypointense on T1W and intermediate on T2W/STIR images and is not showing post contrast enhancement. This is suggestive of ganglion cyst, hemangioma or enlarged lymph node. Correlate with ultrasonography.
4.) No other obvious abnormality is identified.

The patient was referred for magnetic resonance imaging (MRI) of the lumbar spine, which was performed on 04/15/15. As interpreted by Adil Mazhar, M.D., the following impressions were given:

MRI of the Lumbar Spine with Flexion and Extension:

1.) Disc desiccation at L2-L3 down to L5-S1.
2.) Modic type II end plate degenerative changes at L4-L5 and L5-S1.

3.) Straightening of the lumbar lordotic curvature. Restricted range of motion on flexion and extension.
4.) Tarlov cysts at S2/S3 level.
5.) L2-L3: Broad-based disc herniation. This finding is causing spinal canal stenosis. Disc measurements: NEUTRAL: 1.6 mm; FLEXION: 2.2 mm; EXTENSION: 2.2 mm.
6.) L3-L4: Broad-based disc herniation. This finding is causing spinal canal stenosis. There is associated stenosis of the right lateral recess. Disc measurements: NEUTRAL: 2.2 mm; FLEXION: 2.2 mm; EXTENSION: 3.3 mm.
7.) L4-L5: Broad-based disc herniation. This finding is causing spinal canal stenosis. There is associated stenosis of the bilateral lateral recess with contact on the bilateral L5 transiting nerve roots. Disc material also causes right neural foraminal narrowing. Disc measurements: NEUTRAL: 3.3 mm; FLEXION: 2.2 mm; EXTENSION: 3.3 mm.
8.) L5-S1: Broad-based disc herniation. This finding is causing spinal canal stenosis. There is associated stenosis of the bilateral lateral recess with contact on the bilateral S1 transiting nerve roots. Disc material also causes bilateral neural foraminal narrowing. Disc measurements: NEUTRAL: 2.2 mm; FLEXION: 2.7 mm; EXTENSION: 3.8 mm.

The patient was referred for ultrasound of the left knee, which was performed on 11/05/14. As interpreted by George Mednik, M.D., the following impressions were given:

Ultrasound of the Soft Tissues of the Left Knee:

1.) There is evidence of a subcutaneous soft tissue density mass measuring 2.7 x 1.2 cm in the popliteal fossa. It appears to be slightly more pronounced in size since the report of MRI of the left knee dated August 05, 2014. Clinical correlation and correlation with a formal MRI of the subcutaneous soft tissues of the area is recommended.

The patient was referred for neurodiagnostic testing of the bilateral lower extremities, which was performed on 07/11/15. As interpreted by Allen Matin, M.D., results of these studies demonstrated the following:

EMG/NCV of the Bilateral Lower Extremities:	1.) Normal EMG of lower extremities with no acute or chronic denervation potentials. 2.) Normal NCV of the lower extremities did not reveal any electrophysiological evidence of Peripheral Nerve Entrapment in today's study.

The patient had surgery, performed by the undersigned, dated 09/25/2015. Procedures: 1) Left knee arthroscopy. 2) Left knee 3-compartment partial synovectomy. Pre-operative diagnosis: 1) Left knee pain. 2) Possible left knee medial meniscus tear. Post-operative diagnosis: 1) Left knee 3-compartment synovitis. 2) Left knee superior patella grade IV chondromalacia. 3) Left knee lateral patellar subluxation.

REVIEW OF RECORDS

I have reviewed a set of records on Ms. Santillan. I spent approximately 1 hour and 45 minutes reviewing these records and preparing this report. The following is my review:

02/02/2015 PRECISION OCCUPATIONAL MEDICAL GROUP
Nahida Nazir, M.D.
Secondary Treating Physician's Neurologic Initial Report
Date of Injury: 01/01/2012
Employer: Premier Staffing
Chief Complaints: The patient presented with chief complaints of headaches that first started two months ago. History of the Present Injury/ Illness: The patient stated that she had an injury to her low back on 01/01/12 and also cumulative injury to her neck, back, and left knee for which she had been receiving physical therapy. However, she first started with headaches two months ago. These have continued since and have recently gotten more frequent. She stated that the headaches always start bilaterally in the biparietal region, then go to the back of the head and frequently generalize. The headaches were daily. They occurred usually later in the day or late

morning. She had to take medication for the same or otherwise she will have a headache for the whole day. She described the pain as severe in intensity and she graded it 8 to 9/10 when severe and around 6/10 when moderate, with 10 being the most severe pain. The pain was described as a throbbing and sometimes pressure-like pain. It was associated with nausea when the pain was severe. She had 3 episodes of vomiting in the past. She reported blurriness of vision with the headaches and she described photo/phono phobia with the headaches. The headaches were relieved by medications, lying down, staying still and icepacks. Lying down helped; however, she was unable to fall asleep because of the pain. The patient reported that the headaches severely interfere with activities of daily living. Headaches increased with stress. She took Tylenol and/or Ibuprofen for the pain. It mildly alleviated the headache from an 8 to a 6 and the headaches continued throughout the day. Mood: The patient noted a lot of sadness and a lot of stress. She described anxiety and reported episodes where she felt palpitations and sweaty. She cried frequently. She reported weight changes and sleep difficulties. She reported being constantly tired and difficulty with concentration. Sleep: The patient also reported difficulty sleeping. She reported 5 to 6 hours of total sleep time. She woke up 2 to 3 times in the night with pain, or to go to the bathroom, or stayed up worrying about her situation. Relevant Medical History: The patient has history of right inguinal hernia removal in 1993. Medications: The patient was taking Tylenol/Ibuprofen 1 to2 times per day, 4 to 5 times per week. Social & Family History: The patient's father has history of diabetes and her mother has history of asthma. Physical Examination: Examination of the head revealed mild scalp tenderness in the bilateral occipital head region. Temporal artery pulses were palpable and non-tender. Examination of the neck revealed mild tenderness and moderate spasm of the cervical paraspinals. Range of motion was limited on flexion. Neurologic Examination: Mental status

examination revealed that the patient was attentive to months of the year backwards, although slow. Long-term memory was intact. Recall was 2 out of 3 after five minutes without any clues. Cranial nerve examination revealed normal findings. Diagnoses: 1) Chronic daily headaches. 2) Analgesic overused and rebound headaches. 3) Tension muscle contraction headaches. 4) Stress/ anxiety, rule out depression. 5) Sleep initiation and maintenance insomnia, secondary to orthopedic situation. 6) Chronic neck pain, rule out radiculopathy. Discussion: The patient had daily headaches. Given the history of analgesic overuse, there was a component of analgesic rebound to these headaches. For this reason the patient had been asked to reduce all analgesic use to no more than 3 days per week. She was also prescribed Flexeril 7.5 mg, 1 tablet by mouth every bedtime twice a day for muscle spasm which can be contributing to the headaches also. Side effects of same were explained to the patient. Patient was referred to Psychiatry for stress management and biofeedback. Also better sleep hygiene was recommended to the patient. She will be re-evaluate on follow up need for brain imaging, such as an MRI, given the chronicity of symptoms and need to rule out any intracranial pathology. The patient was recommended to follow-up with the Primary Treating Physician.

I am in receipt of an Initial Orthopedic Panel Qualified Medical Evaluation from Scott Goldman, M.D., dated 03/18/15. Date of Injury: 02/22/13. Employer: Premier Staffing Management. History of Injury as Related by the Patient: The patient sustained injuries to her low back and left knee while performing her usual and customary duties as a packer for Premier Staffing. An incident on 02/22/13 had her attempting to lift a box of clothing of unknown weight when she felt pain in the low back that radiated down the right lower extremity. She spoke to her manager about it, a report was made, and she was eventually sent for medical treatment. Another incident in 03/2014 saw her sustaining a subsequent injury to her left knee when she twisted it while performing some kneeling and squatting activities, and she had since had swelling and instability about the left knee. She did deny any injury to the low back and left knee prior or subsequent to the mentioned work-related injury

dates. Treatment Course: The patient was initially evaluated in an industrial medical group. X-rays were obtained and pain medication was prescribed. Physical therapy had been received, consisting of massage and electrical stimulation. Chiropractic therapy and acupuncture treatment had been received as well. A lumbar spine MRI had also been received. There was mention of being given one injection to the lumbar spine by a pain management specialist without benefit, with her noting continuing symptoms. An evaluation by one physician in LA had her taking pain medication, getting x-rays, and being placed on temporary disability; a consultation with a chiropractor had her treating with sessions of massage and electrical stimulation; and a visit with another physician in Paramount had her being examined once and prescribed pain medication. She eventually came under the care of the undersigned, from whom were received treatments consisting of x-rays, pain medication, left knee MRI, physical therapy, with her being placed on temporary disability. She was noted last evaluated on 03/12/15, with a requested lumbar spine MRI at that time. Her medical history noted use of Motrin and antibiotics, as well as her having undergone a right inguinal hernia surgery. Current Complaints: The patient reported low back pain. She complained of numbness and tingling sensations in the right leg. She also complained of pain in the left knee. Both knees were described to be weak and unstable. Swelling was noted in her left knee. Physical Examination: Palpation over the medial joint line of the left knee revealed tenderness. McMurray test elicited pain in the medial compartment. Left knee range of motion was decreased with extension and flexion. An MRI scan of the left knee demonstrated abnormal signal in the medial meniscus consistent with some degenerative changes and some tearing. Diagnoses: 1) Left knee medial meniscus tear. 2) Lumbar spine, disc bulge with right-sided L5 radiculopathy. Treatment Recommendations: Recommended were epidural steroid injections in the lumbar spine to treat radicular symptoms, medications to control inflammation and pain, and a left knee arthroscopic surgery. The lumbar spine MRI report was requested. Summary and Conclusions: Dr. Goldman was of the opinion that the patient's lumbar spine injury and left knee injury were work-related in nature, that her history indicated a specific industrial injury sustained to the lumbar spine on 02/22/13 and another specific industrial injury sustained to the left knee on 03/2014, while working as a packer for Premier Staffing. She was considered temporarily totally disabled and was to be off work. She had not yet reached maximum medical improvement. Impairment rating, apportionment, and future medical care were all noted deferred until she has reached maximum medical improvement. Comments on her ability to perform activities of daily living and ability to return to her usual and customary work were likewise deferred. A re-evaluation was to be set once she has completed the recommended treatment.

I am in receipt of a Supplemental Orthopedic Panel Qualified Medical Evaluation Report from Scott Goldman, M.D., dated 09/17/15. Date of Injury: 02/22/13. Employer: Premier Staffing Management. Comment: The available medical records showed that the patient sought treatment from 02/25/13 until 12/18/14. She was seen by various doctors including Drs. Arnush, Coppelson, and the undersigned. She had a deposition taken on 10/07/14. Furthermore, the medical records revealed that an MRI scan of the lumbar spine performed in 08/2013 was unremarkable. Dr. Goldman was of the opinion that the patient would benefit from left knee arthroscopy surgery after taking into consideration the left knee examination and the MRI scan of the left knee, which indicated an abnormal signal in the meniscus consistent with either degenerative change or acute tear. The assessment and plan was updated. Diagnoses: 1) Left knee, medial meniscus tear. 2) Musculoligamentous strain of the lumbar spine with non-verifiable right-sided radiculopathy. Treatment Recommendations: Left knee arthroscopy surgery. Inflammation and pain medications. Home exercise program for the low back.

I have also received a Functional Capacity Evaluation from Safetyworks Medical Inc. dated 05/10/16. Current Status: The patient was on disability. Work Recommendations: Modified duties with restrictions of limited lifting about shoulder level over 5 pounds, limited lifting from ground level over 5 pounds, limited stair climbing, squatting, kneeling or crawling and limited standing to 2 hours with a 15-minute change in position for an 8-hour shift.

Estimated Pre-Injury Physical Capacity:

In an attempt to determine the current loss of pre-injury lifting capacity, the patient gave the following estimation of maximum capacity ability just before the injury, before therapy without pain, and currently without pain:

Activity	Pre-Injury	Before Therapy Without Pain	Currently Without Pain
Single lift - ground to waist	40 lbs	0 lbs	5 lbs
Single lift - waist to overhead	40 lbs	0 lbs	5 lbs

Lifting capacity information was obtained through the patient's best estimate.

PRESENT COMPLAINTS

Neck Pain:

The pain occurs at the base of the skull, the middle and base of the neck, and the bilateral paraspinal region with radiation to the bilateral front of the neck,

bilateral shoulders, bilateral arms, bilateral elbows, bilateral forearms, bilateral wrists and bilateral hands. She describes the pain as constant in frequency. On a scale of 0 to 10, with 10 representing the worst, she rates the severity of pain at a level of 6/10 per the VAS. The pain is characterized as dull, aching and burning, accompanied by symptom of weakness. The pain is increased to a level of 7/10 with repetitive neck flexion, repetitive neck extension, repetitive lateral bending of the neck, repetitive shoulder abduction, repetitive shoulder flexion, repetitive overhead work, repetitive at or above shoulder level work, repetitive arm use, repetitive lifting of 5 pounds overhead, repetitive lifting of 5 pounds to the shoulder, repetitive lifting of 5 pounds to the waist, repetitive carrying of 5 pounds, repetitive pushing/pulling of 5 pounds, repetitive wrist motion, repetitive twisting/torquing, repetitive gripping motions, repetitive pinching, repetitive squeezing objects, repetitive twisting hand motion, repetitive opening and closing of the hand, repetitive manipulation, repetitive exposure to extreme temperature, typing, and writing. It takes varying amounts of time for the pain to return to pre-activity level following these activities.

Upper Back and Mid-Back Pain:

The pain occurs in the middle and bilateral sides of the upper back and mid-back. The patient describes her pain as constant in frequency. On a scale of 0 to 10, with 10 representing the worst, she rates the severity of her pain at a level of 5/10 per the VAS. The pain is characterized as dull, aching and sharp, accompanied by sensations of pins and needles, as well as pressure and tension. The pain is increased to the level of 6/10 with repetitive lifting of 5 pounds, walking for 30 minutes, standing for 30 minutes, repetitive walking on uneven ground, repetitive squatting/kneeling, repetitive climbing, repetitive crawling, repetitive crouching, repetitive stooping, repetitive carrying, sitting for 30 minutes, riding in a car for 30 minutes, repetitive pushing/pulling of 5 pounds, repetitive bending, repetitive twisting/turning, repetitive lifting of 5 pounds to shoulder level, repetitive lifting of 5 pounds to waist level, repetitive overhead work, and repetitive work above shoulder level. It takes varying amounts of time for the pain to return to pre-activity level following these activities.

Low Back Pain:

The pain occurs in the middle of the back at the waist, and the middle and bilateral sides of the sacroiliac region and lumbar region, as well as in the tailbone with radiation to the right buttock, right thigh, right knee, right lower leg, right calf, right ankle, right foot and right big toe. The patient describes her pain as constant in frequency. On a scale of 0 to 10, with 10 representing the worst, she rates the severity of pain at a level of 7/10 per the VAS. The pain is

characterized as dull, aching and shooting, accompanied by sensations of pins and needles, as well as, pressure and tension. The pain is increased to a level of 8/10 with repetitive lifting of 5 pounds, walking for 30 minutes, standing for 30 minutes, repetitive walking on uneven ground, repetitive squatting/kneeling, repetitive climbing, repetitive crawling, repetitive crouching, repetitive stooping, repetitive carrying, sitting for 30 minutes, riding in a car for 30 minutes, repetitive pushing/pulling of 5 pounds, repetitive bending, repetitive twisting/turning, repetitive lifting of 5 pounds to the shoulder, repetitive lifting of 5 pounds to the waist and repetitive overhead work. It takes varying amounts of time for the pain to return to pre-activity level following these activities.

Left Knee Pain:

The pain occurs in the left knee. The patient describes her pain as frequent in frequency. On a scale of 0 to 10, with 10 representing the worst, she rates the severity of pain at a level of 5/10 per the VAS. The pain is characterized as dull and aching. The pain is increased to a level of 6/10 with repetitive lifting of 5 pounds, walking for 30 minutes, standing for 30 minutes, repetitive walking on uneven ground, repetitive squatting/kneeling, repetitive sitting, repetitive weight bearing, repetitive climbing and repetitive ascending/descending stairs and ladders. It takes varying amounts of time for the pain to return to pre-activity level following these activities.

ACTIVITIES OF DAILY LIVING

In the area of self-care and personal hygiene, the patient reported that pain interferes moderately to severely with bathing, defecating, using the toilet, dressing, buttoning clothes, personal hygiene, combing hair, brushing teeth, preparing meals and eating. In the area of physical activity, the patient reported that pain interferes moderately to severely with walking, climbing stairs, standing, sitting, squatting/kneeling, reclining, arising from a chair, carrying grocery bag, lifting, pushing, pulling, household chores, getting in and out of the bed, grasping, opening jars, and turning faucets on and off. In the area of communication, the patient reported that pain interferes moderately to severely with using a telephone, typing a message on the computer, and writing a letter/note. In the area of travel, the patient reported that pain interferes moderately to severely with getting in and out of car, opening car doors, driving and being a passenger in a vehicle. In the area of sexual function, the patient reported that pain interferes moderately to severely with sexual activities. In the area of sleep, the patient reported that pain interferes moderately to severely with restful nocturnal sleep. In the area of sports and exercise, the patient reported that pain interferes moderately to severely with these activities.

PHYSICAL EXAMINATION:

Height:	5 feet, 3 inches
Weight:	155 pounds
Blood Pressure:	119/72 mmHg
Pulse:	73 bpm

OBSERVATIONS:

The patient is a well-developed female in no acute distress. She ambulates without a limp.

BEHAVIOR:

The patient is disclosive, cooperative, and attentive. There is no evidence of fabrication or inconsistency.

GENERAL NEUROLOGIC:

Mental Status: The patient's mentation is grossly intact in all the spheres of cognition.

CERVICAL SPINE:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, or masses.

Examination demonstrated muscle guarding in the cervical paraspinals, as well as tenderness on palpation of the spinal processes, bilateral paraspinal muscles, bilateral occipital muscles, bilateral suboccipital muscles, bilateral trapezius muscles and bilateral levator scapulae muscles. There was palpable spasm over the bilateral paraspinal muscles, bilateral occipital muscles, bilateral suboccipital muscles, bilateral trapezius muscles and bilateral levator scapulae muscles.

The following are the cervical spine ranges of motion in:

	Max	Normal
Forward Flexion:	35 degrees	50 degrees
Extension:	40 degrees	60 degrees
Right Lateral Flexion:	35 degrees	45 degrees
Left Lateral Flexion:	30 degrees	45 degrees
Right Rotation:	65 degrees	80 degrees
Left Rotation:	60 degrees	80 degrees

Note: All ROM measurements of the cervical spine were performed using Acumar Computerized Dual Inclinometers with automatic subtraction.

CLINICAL TESTS

Cervical Compression:	Positive
Cervical Distraction:	Negative

THORACIC SPINE:

Inspection of the surface revealed normal contour. The skin appeared to be intact without any visible lesions, rashes, bruises, abrasions, lacerations, and without any palpable masses or deformities.

Examination demonstrated tenderness on palpation of the paraspinal muscles in the bilateral upper, middle and lower thoracic region.

The following are the thoracic spine ranges of motion in:

	Max	Normal
Forward Flexion:	50 degrees	50 degrees
Right Rotation:	30 degrees	30 degrees
Left Rotation:	30 degrees	30 degrees

Note: All ROM measurements of the thoracic spine were performed using Acumar Computerized Dual Inclinometers with automatic subtraction.

LUMBOSACRAL SPINE:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, or masses.

Examination demonstrated tenderness on palpation over the bilateral paraspinal muscles, bilateral sacroiliac joints, bilateral sciatic notches, bilateral posterior iliac crests and bilateral gluteal muscles. There was palpable spasm over the bilateral paraspinal muscles and bilateral gluteal muscles. Trigger points are present over the bilateral paraspinal muscles.

The following are the lumbosacral spine ranges of motion in:

	Max	Normal
Forward Flexion:	35 degrees	60 degrees
Extension:	16 degrees	25 degrees
Right Lateral Flexion:	18 degrees	25 degrees
Left Lateral Flexion:	17 degrees	25 degrees

Note: All ROM measurements of the lumbar spine were performed using Acumar Computerized Dual Inclinometers with automatic subtraction.

Straight Leg Raising (supine):
Positive on the right at 40 degrees.

Straight Leg Raising (seated):
Positive on the right.

CLINICAL TESTS

Femoral Nerve Tension (Reversed SLR):	Negative bilaterally
Kemp's	Negative bilaterally
Braggard's	Negative bilaterally
Heel Walking:	Negative bilaterally
Toe Walking:	Negative bilaterally
Axial Trunk-Loading Test:	Negative
Hoover's (malingering):	Negative bilaterally

UPPER EXTREMITIES EXAMINATION:

SHOULDERS AND UPPER ARMS:

The inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, or masses. The examination of the shoulders and upper arms revealed them to be grossly symmetrical. Palpation revealed no tenderness. The ranges of motion in the right and left shoulders were within normal limits, and there was no pain with the ranges of motion.

The following are the shoulder ranges of motion:

	Right	Left	Normal
Forward Flexion	180 degrees	180 degrees	180 degrees
Extension	50 degrees	50 degrees	50 degrees

Internal Rotation	90 degrees	90 degrees	90 degrees
External Rotation	90 degrees	90 degrees	90 degrees
Abduction	180 degrees	180 degrees	180 degrees
Adduction	50 degrees	50 degrees	50 degrees

ELBOWS AND FOREARMS:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, or masses. Examination revealed them to be grossly symmetrical. Palpation revealed no tenderness. Ranges of motion were within normal limits, and there was no pain with ranges of motion.

The following are the elbows ranges of motion:

	Right	Left	Normal
Flexion	140 degrees	140 degrees	140 degrees
Extension (neutral)	0 degrees	0 degrees	0 degrees
Supination	80 degrees	80 degrees	80 degrees
Pronation	80 degrees	80 degrees	80 degrees

WRISTS:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, deformity, or masses. Palpation revealed no tenderness (including the anatomical snuff-box). Range of motion was within normal limits and there was no pain with range of motion.

The following are the wrist ranges of motion:

	Right	Left	Normal
Flexion	60 degrees	60 degrees	60 degrees
Extension (neutral)	60 degrees	60 degrees	60 degrees
Ulnar Deviation	30 degrees	30 degrees	30 degrees
Radial Deviation	20 degrees	20 degrees	20 degrees

HANDS, FINGERS, AND THUMBS:

The inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, deformities, or masses. Palpation revealed no tenderness or swelling. Ranges of motion were within normal limits, and there was no pain with ranges of motion. Finger spread was normal.

The following are the ranges of motion of the:

Thumbs

	Right	Left	Normal
Adduction (Thumb IP joint flexor crease over palm)	0 cm	0 cm	0 cm
Opposition (Thumb IP joint flexor crease over 3rd MP joint)	8 cm	8 cm	8 cm
Abduction	50°	50°	50°
Flexion (MCP)	60°	60°	60°
Flexion (ICP)	80°	80°	80°
Extension (MCP)	0°	0°	0°
Extension (IP)	0°	0°	0°

The following are the ranges of motion of the:

Fingers

	Right			Left		
Flexion (in degrees)	MCP	PIP	DIP	MCP	PIP	DIP
Normal	90°	100°	70°	90°	100°	70°
Index	90°	100°	70°	90°	100°	70°
Middle	90°	100°	70°	90°	100°	70°
Ring	90°	100°	70°	90°	100°	70°
Little	90°	100°	70°	90°	100°	70°

Extension (in degrees)	MCP	PIP	DIP	MCP	PIP	DIP
Normal	0°	0°	0°	0°	0°	0°
Index	0°	0°	0°	0°	0°	0°
Middle	0°	0°	0°	0°	0°	0°
Ring	0°	0°	0°	0°	0°	0°
Little	0°	0°	0°	0°	0°	0°

LEGEND: Index=Digit 2; Middle=Digit 3; Ring=Digit 4; Little=Digit 5
MCP=Metacarpophalangeal joint; IP=Interphalangeal joint; PIP=Proximal interphalangeal joint; DIP=Distal interphalangeal joint.

Muscular Atrophy: No muscular atrophy was noted on visual inspection.

Circumferential Measurements (In centimeters):

	Right	Left	Difference
Arms (mid-biceps):	29 cm	29.5 cm	0.5 cm
Forearms (proximal 1/3):	27 cm	25 cm	2 cm

Upper Extremities Deep Tendon Reflexes Examination:

	Right	Left	Normal
Biceps (C5):	+2	+2	+2
Triceps (C6):	+2	+2	+2
Brachioradialis (C7):	+2	+2	+2

Upper Extremities Motor Strength Testing:

	Right	Left	Normal
Shoulders			
Flexion:	5	5	5
Abduction:	5	5	5
Extension:	5	5	5
Adduction:	5	5	5
Internal Rotation:	5	5	5
External Rotation:	5	5	5
Elbows			
Flexion:	5	5	5
Extension:	5	5	5
Pronation:	5	5	5
Supination:	5	5	5
Wrists			
Wrist Extensors:	5	5	5
Wrist Flexors:	5	5	5
Hands			
Finger Flexors:	5	5	5
Finger Extensors:	5	5	5
Finger Abduction:	5	5	5

Upper Extremities Sensory Examination

Sensation was intact to light touch, pinprick, and two-point discrimination in the upper extremities.

Two-Point Discrimination: Normal

Grip Strength (in kg/cm^2; measured by the Jamar dynamometer, slot #2): The patient is right-hand dominant.

	#1	#2	#3
Right:	6 kg	5 kg	4 kg
Left:	6 kg	6 kg	6 kg

Upper Extremities Vascular Examination

The brachial, ulnar, and radial pulses were within normal limits in the upper extremities.

LOWER EXTREMITIES EXAMINATION

HIPS AND THIGHS:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, or masses. Examination revealed them to be grossly symmetrical. Palpation revealed no tenderness. The ranges of motion are within normal limits, and there is no pain with the ranges of motion.

The following are the hip ranges of motion in:

	Right	Left	Normal
Flexion:	100 degrees	100 degrees	100 degrees
Extension:	30 degrees	30 degrees	30 degrees
Internal Rotation:	40 degrees	40 degrees	40 degrees
External Rotation	50 degrees	50 degrees	50 degrees
Abduction:	40 degrees	40 degrees	40 degrees
Adduction:	20 degrees	20 degrees	20 degrees

KNEES AND LOWER LEGS:

Inspection of the surface revealed well-healed surgical scars over the left knee.

Examination demonstrated tenderness to palpation over the anterior, posterior and lateral aspects on the left. There was tenderness on palpation of the left lateral femoral condyle, left lateral tibial condyle, left medial joint line, left medial femoral condyle, left medial tibial condyle and left proximal calf muscles.

The following are the knee ranges of motion in:

	Right	Left	Normal
Flexion:	150 degrees	130 degrees	150 degrees
Extension (neutral):	0 degrees	-5 degrees	0 degrees

CLINICAL TESTS

Right Knee

Patellar Apprehension Test:	Negative
Patella Femoral Grinding Test:	Negative
Anterior Drawer Test (ACL) 6mm:	Negative
Posterior Drawer Test (PCL) 6mm:	Negative
Lachman's Test:	Negative
McMurray Test:	Negative
Valgus Stress Test (MCL):	Negative
Varus Stress Test (LCL):	Negative

Left Knee

Patellar Apprehension Test:	Negative
Patella Femoral Grinding Test:	Positive
Anterior Drawer Test (ACL) 6mm:	Negative
Posterior Drawer Test (PCL) 6mm:	Negative
Lachman's Test:	Negative
McMurray Test:	Positive
Valgus Stress Test (MCL):	Negative
Varus Stress Test (LCL):	Negative

ANKLES:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, edema, cyanosis, or masses. Examination of both ankles revealed them to be grossly symmetrical. Palpation revealed no tenderness. Range of motion of both ankles was within normal limits and there was no pain with active range of motion.

The following are the ankle ranges of motion in:

	Right	Left	Normal
Flexion:	40 degrees	40 degrees	40 degrees
Extension:	20 degrees	20 degrees	20 degrees
Inversion:	30 degrees	30 degrees	30 degrees
Eversion:	20 degrees	20 degrees	20 degrees

CLINICAL TESTS

Right Ankle

Tinel's Sign at the Ankle:	Negative
Anterior Drawer Test:	Negative
Thompson's Test:	Negative
Talar Tilt Test (inversion):	Negative
Talar Tilt Test (eversion):	Negative
Homan's Sign:	Negative

Left Ankle

Tinel's Sign at the Ankle:	Negative
Anterior Drawer Test:	Negative
Thompson's Test:	Negative
Talar Tilt Test (inversion):	Negative
Talar Tilt Test (eversion):	Negative
Homan's Sign:	Negative

FEET:

Inspection of the surface showed the complete integrity of the skin, without rashes, bruises, scars, abrasions, lacerations, swelling, or masses. Examination of both feet revealed them to be grossly symmetrical. Palpation revealed no tenderness.

Circumferential Measurements (in centimeters):

	Right	Left	Difference
Mid-thigh (10 cm above patella):	43 cm	44 cm	1 cm
Calves (at greatest circumference):	39.5 cm	40 cm	0.5 cm

Lower Extremities Deep Tendon Reflexes Examination:

	Right	Left	Normal
Knee (L4):	+2	+2	+2
Ankle (S1):	+2	+2	+2

Lower Extremities Motor Strength Testing:

	Right	Left	Normal
Hips			
Hip Flexors:	5	5	5
Hip Extensors:	5	5	5
Hip Abductors:	5	5	5
Knees			
Knee Flexors:	5	4	5
Knee Extensors:	5	4	5
Ankles/Feet			
Ankle/Foot Extensors:	5	5	5
Ankle/Foot Flexors:	5	5	5
Ankle/Foot Inverters:	5	5	5
Ankle/Foot Everters:	5	5	5
Toes			
Great Toe Flexors:	5	5	5
Great Toe Extensors:	5	5	5

Lower Extremities Sensory Examination:

Sensation was intact to light touch, pinprick, and two-point discrimination in the lower extremities.

Lower Extremities Vascular Examination:

The posterior tibial and dorsalis pedis pulses were palpable and within normal limits in the lower extremities.

DIAGNOSTIC IMPRESSION

1. CERVICAL STRAIN/SPRAIN WITH RADICULITIS.
2. THORACIC STRAIN/SPRAIN.
3. LUMBOSACRAL STRAIN/SPRAIN WITH RADICULITIS.
4. LUMBAR SPINE DISC HERNIATIONS PER MRI DATED 04/15/15.
5. LEFT KNEE INTERNAL DERANGEMENT PER MRI DATED 12/15/14.
6. STATUS POST LEFT KNEE SURGERY DATED 09/25/15, WITH RESIDUALS.

DISCUSSION

Having had the opportunity to examine the patient, and having reviewed the mechanism of injury, subjective complaints, and objective findings, including diagnostic testing consisting of MRIs and neurodiagnostic test, as well as, having had the opportunity to review available medical records by Dr. Nazir and PQME, Dr. Goldman, I have arrived at the above-noted diagnoses.

CAUSATION

Based on the information provided by the patient that there is no history of any unresolved prior injuries, or prior disability resulting in work limitations, it is my opinion that the patient's current diagnoses listed under the Diagnostic Impression are the direct result of the injuries this patient sustained on a cumulative trauma basis from 01/01/2012 to 04/08/2014 and on 02/22/2013, while working for Premier Staffing.

CURRENT DISABILITY STATUS

Treatment provided to the patient was structured to deliver maximal relief in pain and suffering and to restore occupational and functional capacity to the highest level possible. After treating the patient and being able to evaluate treatment effectiveness, I concluded that her condition has reached maximum medical improvement from a conservative perspective and therefore permanent and stationary status for rating purposes.

The patient is placed on permanent and stationary status as of 02/02/17. Her recommended work restrictions include no lifting/carrying over 15 pounds, no prolonged bending/stooping, no prolonged walking on uneven ground (including stair-climbing) and no prolonged squatting/kneeling. She is a qualified injured worker if recommended work restrictions cannot be provided.

FACTORS AND FINDINGS OF DISABILITY

Subjective Factors:

- Neck pain.
- Upper back pain.
- Low back pain.
- Left knee pain.

Objective Findings:

Cervical Spine:

- Decreased/limited range of motion as demonstrated on physical examination.
- Spasm on palpation of the cervical paravertebral muscles as demonstrated on physical examination.
- Abnormal clinical tests as demonstrated on physical examination.

Lumbar Spine:

- Decreased/limited range of motion as demonstrated on physical examination.
- Spasm on palpation of the lumbar paravertebral muscles as demonstrated on physical examination.
- Abnormal findings as demonstrated on magnetic resonance imaging.
- Abnormal clinical tests as demonstrated on physical examination.

Left Knee:

- Surgical scars as demonstrated on physical examination.
- Decreased/limited range of motion as demonstrated on physical examination.
- Abnormal findings as demonstrated magnetic resonance imaging.
- Abnormal clinical tests as demonstrated on physical examination.
- Decreased motor strength as demonstrated on physical examination.

PERMANENT IMPAIRMENT RATING

Cervical Spine Impairment

Based on the patient's examination, review of diagnostic studies, and clinical findings including cervical muscle guarding, cervical muscle spasm, asymmetric loss of range of motion, non-verifiable radicular complaints, and no alteration of structural integrity, the patient qualifies for DRE Category II: 5% Impairment of the Whole Person. The impairment rating was determined using the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Table 15-5, p. 392.

DRE method was utilized based on the fact that, as per section 15.2 (p. 379) of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, "*DRE method is the principal methodology used to evaluate an individual who has had a distinct injury.*" Section 15.3 (pp. 381-384) describes the process of determining the appropriate DRE category. In determining the impairment rating for this patient, I have followed the above quoted recommendations.

Thoracic Spine Impairment

Based on the American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition, this patient has 0% impairment for the thoracic spine.

Lumbosacral Spine Impairment

Based on examination of the patient, review of diagnostic studies and clinical findings, this patient qualifies for DRE Category II - 8% impairment of the whole person. The impairment rating was determined using the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Table 15-3, p. 384.

DRE method was utilized based on the fact that, as per Section 15.2 (page 379) of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, "*DRE method is the principal methodology used to evaluate an individual who has had a distinct injury.*" Section 15.3, pp. 381-384, describes the process of determining the appropriate DRE category. In determining the impairment rating for this patient, I have followed the above quoted recommendations.

Left Knee Impairment

It was determined that the patient has muscle weakness of knee flexion Grade 4, which qualifies for 5% Whole Person Impairment.

It was determined that the patient has muscle weakness of knee extension Grade 4, which qualifies for 5% Whole Person Impairment.

Impairment due to muscles weakens about the knee was determined to be 10 % WPI by combining impairment of flexion and extension using the Combined Values Chart on p. 604.

It was determined to be 10% by utilizing the muscle strength method.

Whole Person Impairment

Using the Combined Values Chart on pp. 604-606 of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, the Whole Person Impairment percentage was determined to be 21% by combining the Whole Person Impairment percentages of 5% for the cervical spine, 8% for the lumbar spine and 10% for the left knee. An additional 3% was added due to pain-related impairment that has increased the burden of this patient's condition. The level of

pain, however, did not meet criteria for formal pain-related impairment, as listed in Chapter 18 of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. With this addition, the resultant total Whole Person Impairment for this patient is 24%.

The permanent impairment rating due to the industrial injury of the patient was determined to be 24%, based on the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.

APPORTIONMENT

Based on the history given to me by the patient, and available medical records, there is no indication of prior history of industrial or non-industrial factors, occurring both before and subsequent to the industrial injury, that contributed to this patient's current disability. The patient did not experience any limitations or impairments of Activities of Daily Living (ADL) or work-related impairments prior to the industrial injury she sustained on a cumulative trauma basis from 01/01/2012 to 04/08/2014 and on 02/22/2013.

Due to the fact that the patient sustained more than one industrial injury to the same body parts, apportionment of the disability between those injuries is indicated as per the Benson En Banc Decision.

In my opinion, 50% of the patient's permanent disability for the injuries to her lumbar spine should be apportioned to the cumulative trauma industrial injury from 01/01/2012 to 04/08/2014 and 50% should be apportioned to the 02/22/2013 date of injury.

One hundred percnet of the patient's permanent disability to the cervical spine, thoracic spine and left knee should be apportioned to the cumulative trauma industrial injury from 01/01/2012 to 04/08/2014.

If additional medical records become available for my review, I will be glad to re-evaluate my present conclusions.

FUTURE WORK RESTRICTIONS

Since the Whole Person Impairment rating discussed herein is not intended to account for the diversity and complexity of work activities, the following work restrictions are warranted as they apply to potential employment in an open labor market. If a formal job description should become available for this patient, I will be happy to comment on restrictions of specific job requirements.

The purpose of giving work restrictions is solely to prevent unnecessary exacerbation of pain and re-aggravation of injury, which may lead to repeated periods of temporary disability, and/or result in increased permanent disability. The following specific work restrictions may also prevent further requirements for medical care. These are recommended on a **prophylactic** basis.

Cervical Spine: Preclusion from the performance of very heavy work, which contemplates the individual has lost approximately one-quarter of the pre-injury capacity for bending, stooping, lifting, pushing, and climbing or other activities involving comparable physical effort.

Lumbar Spine: Preclusion from the performance of heavy lifting, repetitive bending and stooping, which contemplates the individual has lost approximately one-half of the pre-injury capacity for lifting, bending and stooping.

Left Knee: Preclusion from the performance of prolonged climbing, walking over uneven ground, squatting, crouching, crawling, pivoting, or other activities involving weight bearing, which contemplates the individual can do work approximately 75% of the time in a standing or walking position, and uneven ground, squatting, kneeling, crouching, crawling, pivoting, or other activities involving comparable physical effort.

FUNCTIONAL CAPACITY ASSESSMENT

Lifting Activities Allowed

- Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY 15 pounds.
- FREQUENTLY (3 to 6 hours) LIFT and/or CARRY 5 pounds.
- OCCASIONALLY (less than 3 hours) LIFT and/or CARRY 10 pounds.

Activities Allowed

- STAND and/or WALK a total of/less than 4 hours per 8 hour day.
- SIT a total of/less than 8 hours per 8 hour day.
- PUSH and/or PULL (including hand or foot controls) – Limited to no pushing or pulling over 20 pounds.

Activities Allowed (hours per day)

-	Climbing:	Occasionally	-	Reaching:	Not limited
-	Balancing:	Not limited	-	Handling:	Not limited

-	Stooping:	Occasionally	-	Fingering:	Not limited
-	Kneeling:	Occasionally	-	Feeling:	Not limited
-	Crouching:	Occasionally	-	Seeing:	Not limited
-	Crawling:	Occasionally	-	Hearing:	Not limited
-	Twisting:	Occasionally	-	Speaking:	Not limited

LEGEND: Frequently = 3 to 6 hours; Occasionally = up to 3 hours; Never = 0 hours.

Environmental Restrictions

There are no environmental restrictions with respect to heights, operation of machinery, or exposure to temperature extremes, dust, fumes humidity and vibration.

Usual and Customary Duties

It is the opinion of this examiner that this patient can now return to her usual occupation with the recommended restrictions.

Activities of Daily Living

At home, the patient had problems with cooking, washing dishes, mopping, sweeping, vacuuming, climbing steps, laundry and shopping. At present, she has anxiety of being re-injured. She reports having financial problems.

FUTURE MEDICAL CARE

Future medical care should be supportive in nature for periodic recurrent episodes of symptoms of exacerbation that may recur from time to time depending on level of physical activity of the patient. I believe that future medical care is required for the patient for the injured cervical spine, thoracic spine, lumbosacral spine and left knee.

Most importantly, the patient should maintain an active exercise program that she has been taught in our facility. This is designed to maintain and/or to increase range of motion in joints affected by the injuries. It also will increase muscle strength and improve endurance and level of occupational and social functioning, thus helping integration into a productive workforce. For minor pains, she was instructed to use moist heat applications and massage to the affected parts.

The patient may experience acute exacerbations of pain, which, if not treated timely and effectively, may lead to prolongation of temporary partial disability resulting in missed employment or in increase of permanent level of disability. Therefore, she should be awarded an opportunity to be evaluated by qualified medical/orthopedic practitioners in case of such exacerbations. If treatment is determined to be warranted, a short course of chiropractic and/or physical therapy, access to over-the-counter and prescription medications, trigger point and/or epidural injections or other necessary modalities such as acupuncture should be made available on a timely basis. Further diagnostic procedures could also be required to better guide treatment. These may include MRI, CT scan, electrodiagnostic testing, and/or other studies as deemed necessary by treating physicians.

It is recommended that the option for the revision of the left knee be made available for this patient in the future.

VOCATIONAL REHABILITATION

I have not had an opportunity to review a formal job analysis for this patient. I did, however, ascertain job duties from the patient. Based on information provided, it is reasonable to assume that the patient's occupation as a warehouse supervisor involves a variety of activities, which have been described in detail under the job description heading of this report.

In my opinion, the patient can return to work with restrictions.

RETURN APPOINTMENT

The patient will return to clinic on an as-needed basis.

AFFIDAVIT OF COMPLIANCE (LABOR CODE § 4061.5)

In compliance with § 10606 of California Code of Regulations, provisions of Labor Code § 4628 and the Rules of Practice and Procedure of the Appeals Board, the following disclosure is hereby made:

In compliance with Labor Code § 4628, I declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than clerical preparation, are as follows:

X-rays, if necessary, will be performed by x-ray technician Anna Maryanovsky, License # RHP42691.

Physical therapy was performed by Ina Hocutt, RPT (license #PT5300).

Chiropractic treatment and manipulations were performed by Carissa Hang, D.C. (license #DC27333).

Acupuncture was performed by Young Tae Kim, L.Ac., California licensed acupuncturist (license #AC9394).

A history of the patient's injury, present complaints, past medical history and other pertinent information was taken by a qualified medical historian.

The occupational history, past medical history, family history, school history and available medical records may have been compiled and arranged into chronological order by Brandon Le, D.C. (license #DC 25980).

Extensive training has been provided to all participants in the evaluation process. The physical examination was performed and findings recorded entirely by the undersigned on the date and at the location listed on page one of this report.

I further certify that this report is my work product and describes and expresses exclusively my professional findings, opinions and conclusions on the matters discussed.

Before the examination, the patient was informed of being evaluated exclusively in connection with the Workers Compensation Claim. The above report is for medical-legal assessment only and is not to be construed as a complete physical examination for general health purposes. Only these symptoms which I believe to have been involved in the injury or might relate to the injury have been assessed. Regarding the general health the patient is advised to obtain a physical examination for general purposes with her personal physician.

In compliance with Labor Code § 4628, I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I have not violated the provisions of Labor Code § 139.3 with regard to the evaluation of this patient or the preparation of this report.

The contents of this report are true and correct to the best of my knowledge. The time spent in performing this evaluation was in compliance with Labor Code § 139.2.

Sincerely,

Vlad Gendelman, M.D., Q.M.E., F.A.A.O.S.
Board Certified Orthopaedic Surgeon

Signed in the County of Los Angeles

VAG:rl

#7343