

VLAD GENDELMAN, M.D., QME

6200 Wilshire Boulevard, Suite 910, Los Angeles, CA 90048

Tel: (323) 933-3434

Fax: (323) 954-8666

CONFIDENTIAL

Patient's Name:	SANTILLAN, Maria Del Rosario
Social Security No:	XXX-XX-3894
Date of Birth:	03/26/1967
Date of Injury:	CT 01/01/2012 TO 04/08/2014; 02/22/2013
Employer:	Premier Staffing
Claims Administrator:	York Claims Services
Claim No:	TWCS-1588
WCAB No:	ADJ9569723
Date of Examination:	03/12/2015
Date of Report:	03/12/2015

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR2) WITH REQUEST FOR AUTHORIZATION

Periodic Report (required 45 days after last report)
Request for authorization

TO WHOM IT MAY CONCERN:

The above referenced patient was seen for follow-up evaluation today.

SUBJECTIVE COMPLAINTS:

The patient complains of headaches, as well as pain in the neck, mid/upper back, lower back, and left knee. On a scale of 0 to 10, with 10 representing the worst, her headaches are rated as 7/10 per the VAS scale, which have remained the same since her last visit; 7/10 in the neck, mid/upper back, and lower back, which has decreased from 8/10 on the last visit; and 8/10 in the left knee, which has remained the same since her last visit.

OBJECTIVE FINDINGS:

Cervical Spine: There is grade 2-3 tenderness to palpation over the paraspinal muscles, which has decreased from grade 3 on the last visit. There is restricted range of motion.

Date of Report: 03/12/2015

Thoracic Spine: There is grade 2-3 tenderness to palpation over the paraspinal muscles, which has decreased from grade 3 on the last visit.

Lumbar Spine: There is grade 2-3 tenderness to palpation over the paraspinal muscles, which has decreased from grade 3 on the last visit. There is restricted range of motion. Straight leg raise test is positive bilaterally.

Left Knee: There is grade 3 tenderness to palpation, which has remained the same since her last visit. McMurray's test is positive.

Neurological: There are no changes on neurocirculatory examination.

COMMENTS:

- The patient states that treatment helps.
- She also states that chiropractic therapy helps to decrease her pain and tenderness.
- She is pending follow-up with a neurologist.

DIAGNOSTIC IMPRESSION:

1. Headaches.
2. Cervical spine musculoligamentous strain/sprain.
3. Thoracic spine musculoligamentous strain/sprain.
4. Lumbosacral spine musculoligamentous strain/sprain with radiculitis.
5. Rule out lumbosacral spine discogenic disease.
6. Left knee strain/sprain, degenerative joint disease, per MRI dated 12/15/14.

TREATMENT PLAN:

1. The patient is to continue chiropractic therapy of the cervical spine, thoracic spine, lumbar spine, and left knee, 2 times a week for 6 weeks.
2. She is prescribed FLURBI(NAP) Cream - LA (Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%) 180 gm to apply a thin layer to the affected areas 2-3 times a day and GABACYCLOTRAM (Gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%) 180 gm to apply a thin layer to the affected areas 2-3 times a day.
3. She is referred for MRI of the lumbar spine.

Topical medications were prescribed in order to minimize possible neurovascular complications; and to avoid complications associated with the use of narcotic medications, as well as upper GI bleeding from the use of NSAID's medications.

Date of Report: 03/12/2015

"Based on the patient's degree of progress with current treatment, I respectfully request timely authorization for the treatment plan outlined above. This request is per the Medical Treatment Utilization Schedule (MTUS/ACOEM) which was adopted by the Administrative Director pursuant to Labor Code Section 4610 and 5307.27 and set forth in California Code of Regulations, Title 8, Section 9792.20 et seq. The treatment plan is necessary in order to cure or relieve this patient's injury, and is consistent with MTUS/ACOEM. For all injuries not covered by the MTUS/ACOEM, treatment plans are in accordance with other evidence based medical treatment guidelines recognized by the national medical community and are scientifically based, such as the Official Disability Guidelines."

DISABILITY STATUS:

The patient remains temporarily totally disabled until her next follow-up evaluation in 4 weeks.

RETURN APPOINTMENT:

The patient is scheduled for a follow-up examination on 04/23/15.

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code Section 139.3.



Vlad Gendelman, M.D., Cal.Lic #: A1010434

Specialty: Orthopaedic Surgery

Executed at Los Angeles, CA

VG: dr

7343

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR - 2)

<input checked="" type="checkbox"/> Periodic Report (required 45 days after last report)	<input type="checkbox"/> Change in treatment plan	<input type="checkbox"/> Release from care
<input type="checkbox"/> Change in work status.	<input type="checkbox"/> Need for referral or consultation.	<input type="checkbox"/> Response to request for information
<input type="checkbox"/> Change in patient's condition.	<input type="checkbox"/> Need for surgery or hospitalization.	<input checked="" type="checkbox"/> Request for authorization
<input type="checkbox"/> Other:		

CC:
 Patient: SANTILLAN, MARIA DEL ROSARIO DOB: 03/26/1967 DOI: 02/22/2013, CT 01/01/12-04/8/14
 SEX: F SS #: 620-20-3894 Occupation: WAREHOUSE SUPERVISOR
 Claims Administrator: YORK/RISK SERVICES Address: PO BOX 619079 City: ROSEVILLE State: CA Zip: 95661
 Employer Name: PREMIER STAFFING CLAIM# TWCS-01588 Tel: Fax:

SUBJECTIVE COMPLAINTS:	PAIN	Last visit	PAIN today	Radiation
<input type="checkbox"/> Headache	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	
<input checked="" type="checkbox"/> Neck Pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input checked="" type="checkbox"/> Mid/Upper back pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input checked="" type="checkbox"/> Lower back pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input type="checkbox"/> R Shoulder/ Arm pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no
<input type="checkbox"/> L Shoulder/ Arm pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input type="checkbox"/> R Elbow/Forearm pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input type="checkbox"/> L Elbow/Forearm pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input type="checkbox"/> R Wrist/Hand pain/numb	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input type="checkbox"/> L Wrist/Hand pain/numb	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> yes
<input type="checkbox"/> R Hip/Thigh pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no
<input type="checkbox"/> L Hip/Thigh pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no Dermatomes
<input type="checkbox"/> R Knee pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no
<input checked="" type="checkbox"/> L Knee pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> R. <input type="checkbox"/> L. <input type="checkbox"/> B.
<input type="checkbox"/> R Lower Leg pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no C3 C4 C5 C6 C7 C8
<input type="checkbox"/> L Lower Leg pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no
<input type="checkbox"/> R Ankle/Foot pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no <input type="checkbox"/> R. <input type="checkbox"/> L. <input type="checkbox"/> B.
<input type="checkbox"/> L Ankle/Foot pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no L1 L2 L3 L4 L5 S1
<input type="checkbox"/> Other	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> no

Objective findings: (Include significant physical examination, laboratory, imaging or other diagnostic findings)

	TENDER	TENDER	SPASM	SPASM	ROM		
	Last visit	today	Last visit	Today			
<input checked="" type="checkbox"/> Neck	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Cervical compr.	<input type="checkbox"/>
<input checked="" type="checkbox"/> Mid/Upper	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Cervical distr.	<input type="checkbox"/>
<input checked="" type="checkbox"/> Lower back	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+SLR	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Shoulder/ Arm	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Heel Walking (L5)	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> L Shoulder/ Arm	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Toe Walking (S1)	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Elbow/Forearm	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Impingement	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> L Elbow/Forearm	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Supraspinatus	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Wrist/Hand	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Codman's Drop	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> L Wrist/Hand	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Cozen's	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Hip/Thigh	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Mill's	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> L Hip/Thigh	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Tinel's Sign	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Knee	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Phalen's (CTS)	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input checked="" type="checkbox"/> L Knee	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Finkelstein's	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Lower Leg	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Anterior Drawer	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> L Lower Leg	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Posterior Drawer	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
<input type="checkbox"/> R Ankle/Foot	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ McMurray	<input type="checkbox"/> R <input checked="" type="checkbox"/> L <input type="checkbox"/> B
<input type="checkbox"/> L Ankle/Foot	0 1 2 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	<input type="checkbox"/> full <input checked="" type="checkbox"/> restr.	+ Valgus (MCL)	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
						+ Varus (LCL)	<input type="checkbox"/> R <input type="checkbox"/> L <input checked="" type="checkbox"/> B
Wound:					Neurological	No Δ	
					Motor	<input checked="" type="checkbox"/> N/L	
					Sensory	<input type="checkbox"/> N/L	
					Reflexes	<input type="checkbox"/> N/L	
					Trigger points	C/S T/S L/S	

Diagnoses:

- 1. HEADACHES
- 2. CERVICAL MUSCULOLIGAMENTOUS STR/SPR
- 3. THORACIC MUSCULOLIGAMENTOUS STR/SPR
- 4. LUMBOSACRAL MUSCULOLIGAMENTOUS STR/SPR WITH RADICULITIS
- 5. R/O LUMBOSACRAL DISCOGENIC DISEASE
- 6. LEFT KNEE STR/SPR, RULE-OUT INTERNAL DERANGMENT *DJP, per MRPT 12/25/14*
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.
- 19.

- Treatment helps
- Decreased pain
Meds PT Chiro Acu ECSWT LINT
- Decreased tenderness
Meds PT Chiro Acu ECSWT LINT
- Decreased spasm
Meds PT Chiro Acu ECSWT LINT
- Increased ROM %
10 20 30 40 50 60 70 80 90 100
Meds PT Chiro Acu ECSWT LINT
- increased Flexibility %
10 20 30 40 50 60 70 80 90 100
Meds PT Chiro Acu ECSWT LINT
- increased Strength (grade)
0 1 2 3 4 5 of 5
PT Chiro Acu ECSWT LINT
- Increased Endurance %
10 20 30 40 50 60 70 80 90 100
Meds PT Chiro Acu ECSWT LINT
- Improved Function %
10 20 30 40 50 60 70 80 90 100
Meds PT Chiro Acu ECSWT LINT
- Improved ADL'S %
10 20 30 40 50 60 70 80 90 100
Meds PT Chiro Acu ECSWT LINT

THIS IS A FORMAL AUTHORIZATION REQUEST FOR THE FOLLOWING TREATMENT PLAN:

- Chiropractic Physical Therapy (Land Aquatic) Evaluate and Treat Continue Therapy:
- HOLD P.T. _____ #P.T. 2 #CHIRO _____ #ACUP

To CU MR LU Knee 2 times a week for 6 weeks.

- Acupuncture _____ times a week for _____ weeks.
- Medications _____ Topical Med
- Med. Supplies _____

Referral to: MRI 4/5 CT/X-ray _____ EMG/NCV _____
 E.C.S.W.T. _____ LINT [] T/S [] L/S _____
 Other _____
 Consultation _____ Transportation _____

Work Status: This patient has continued to remain on temporary total disability/off work until 4/2
 Return to modified work on _____ with the following limitations or restrictions _____ see attached
 Return to full duty on _____ with no limitations or restrictions.
 Follow up in 2 / 3 / 4 weeks APR 23 2015 P&S in _____ weeks Patient approaching MMI from conservative perspective FCE

COMMENTS:
 (P) authorization for _____
 (P) consultation with _____
 (P) FIU with request

This visit was performed with aid of an interpreter.
 Treating Physician: _____
 I declare under the penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code Section 139.3.
 Signature: _____ *[Signature]* Cal. Lic. # A1010434

Name: Vlad Gendelman, M.D.
 Address: 6200 Wilshire Blvd. # 910 Los Angeles, CA 90048 Phone: (323) 933-3434
 DWC Form PR-2 (Rev. 1/1/05)
 Date of Exam: **MAR 12 2015**