

**VLAD GENDELMAN, M.D., Q.M.E., F.A.A.O.S.**  
**Orthopaedic Surgeon**

6200 Wilshire Boulevard, Suite 910  
Los Angeles, CA 90048

Tel: (323) 933-3434  
Fax: (323) 954-8666

**CONFIDENTIAL**

Patient's Name:	<b>SANTILLAN, Maria Del Rosario</b>
Social Security No:	XXX-XX-3894
Date of Birth:	03/26/1967
Date of Injury:	CT 01/01/2012 TO 04/08/2014
Employer:	Premier Staffing
Claims Administrator:	York Claims Services
Claim No:	TWCS-3293
WCAB No:	ADJ9569723
Date of Examination:	06/23/2016
Date of Report:	06/23/2016

**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. 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.

**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

Date of Report: 06/23/2016

representing the worst, her headaches are rated as 4/10 per the VAS scale, which have remained the same since her last visit; 6/10 in the neck, which has increased from 5/10 on the last visit; 2-3/10 in the mid/upper back, which has decreased from 3/10 on the last visit; 7/10 in the lower back, which has increased from 6-7/10 on the last visit; and 7/10 in the left knee, which has remained the same since her last visit.

**OBJECTIVE FINDINGS:**

**Cervical Spine:** There is grade 2 tenderness to palpation over the paraspinal muscles, which has increased from grade 1 to 2 on the last visit. There is grade 2 palpable spasm, which has remained the same since her last visit. There is restricted range of motion. Cervical compression test is positive.

**Thoracic Spine:** There is grade 2 tenderness to palpation over the paraspinal muscles, which has remained the same since her last visit. There is grade 2 palpable spasm, which has remained the same since her last visit. There is restricted range of motion.

**Lumbar Spine:** There is grade 2 tenderness to palpation over the paraspinal muscles, which has remained the same since her last visit. There is grade 2 palpable spasm, which has remained the same since her last visit. There is restricted range of motion. Straight leg raise test is positive bilaterally.

**Left Knee:** There is grade 2 tenderness to palpation, which has remained the same since her last visit. There is restricted range of motion. McMurray's test is positive on the left knee.

**COMMENTS:**

- The patient states that acupuncture therapy helps to decrease her pain.
- She is now able to do more house chores.
- She reports using less pain medications with acupuncture therapy.
- She is pending follow-up with Dr. Friedman on 07/05/16; she is possible candidate for pain stimulator device.

Date of Report: 06/23/2016

**DIAGNOSTIC IMPRESSION:**

1. Headaches (R51).
2. Cervical strain/sprain (S16.1XXA, S13.4XXA).
3. Thoracic strain/sprain (S23.3XXA)
4. Lumbosacral strain/sprain with radiculitis (S39.012A, S33.9XXA, M54.17).
5. Lumbosacral disc protrusions, per MRI dated 04/15/15 (M51.27).
6. Left knee strain/sprain, degenerative joint disease, per MRI dated 12/15/14 (S86.912A, S83.92XA, M17.12).
7. Status post left knee arthroscopy and partial synovectomy on 09/25/15 (Z98.89).

**TREATMENT PLAN:**

The patient is to continue acupuncture therapy of the cervical spine, thoracic spine and lumbar spine, 3 times a week for 4 weeks.

"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 from 06/23/16 until 07/28/16. She needs current and future medical care.

"In order to adequately address the patient's return-to-work status, please provide a current job description, RU-90 or job analysis to our office for review. Upon receipt of same, the patient's current disability status and ability to return to modified duties will be addressed".

**SANTILLAN, MARIA DEL ROSARIO**

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Date of Report: 06/23/2016

**RETURN APPOINTMENT:**

The patient is scheduled for a follow-up examination on 07/28/16.

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.

A handwritten signature in black ink, appearing to read "Vlad Gendelman M.D.", with a horizontal line drawn through the signature.

**Vlad Gendelman, M.D., Q.M.E., F.A.A.O.S.**

Board Certified Orthopaedic Surgeon

Executed at Los Angeles, CA

Signed in the County of Los Angeles

VAG: rp

# 7343

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Signed in the County of Los Angeles

VAG: rp

# 7343



TVD

State Of California  
 Division of Workers' Compensation  
**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR - 2)**

Additional pages attached

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

cc: Patient: **SANTILLAN, MARIA** SEX: FEMALE DOI: CT 01/01/2012-04/08/2014 DOB: 03/26/1967

Occupation: **SS#: 620-20-3894**  
 Claims Administrator: **YORK CLAIMS SERVICES** Claim#: **TWCS-3293** Employer: **PREMIER STAFFING**

SUBJECTIVE COMPLAINTS:	PAIN										PAIN today										Radiation			
	Last visit					Last visit					Today					Today								
<input checked="" 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	<input type="checkbox"/> no	<input type="checkbox"/> yes
<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	<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	<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	<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	<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	<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	<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	<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	<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	<input type="checkbox"/> no	
<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	<input type="checkbox"/> no	Dermatomes
<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	<input type="checkbox"/> no	
<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	<input type="checkbox"/> no	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B.
<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	<input type="checkbox"/> no	C3 C4 C5 C6 C7 C8
<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	<input type="checkbox"/> no	
<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	<input type="checkbox"/> no	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> B.
<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	<input type="checkbox"/> no	L1 L2 L3 L4 L5 S1
<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	<input type="checkbox"/> no	
<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	<input type="checkbox"/> no	

Objective findings: (include significant physical examination, laboratory, imaging or **REQUEST FOR AUTHORIZATION**)

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

Patient Name: SANTIILLAN, MARIA  
Diagnosis:

1. HEADACHES
2. CERVICAL MUSCULOLIGAMENTOUS STR/SPR
3. THORACIC MUSCULOLIGAMENTOUS STR/SPR
4. LUMBOSACRAL MUSCULOLIGAMENTOUS STR/SPR WITH RADICULITIS
5. LUMBOSACRAL DISC PROTRUSIONS, PER MRI DATED 4/15/15
6. LEFT KNEE STR/SPR, DEGENERATIVE JOINT DISEASE, PER MRI DATED 12/15/14
7. STATUS POST LEFT KNEE ARTHROSCOPY AND PARTIAL SYNOVECTOMY 08/25/2015
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.
- 19.

- Treatment helps
- Decreased pain  
Meds PT Chiro Acu ECSWT
- Decreased tenderness  
Meds PT Chiro Acu ECSWT
- Decreased spasm  
Meds PT Chiro Acu ECSWT
- Increased ROM %  
10 20 30 40 50 60 70 80 90 100  
Meds PT Chiro Acu ECSWT
- Improved Self Care %  
10 20 30 40 50 60 70 80 90 100  
Meds PT Chiro Acu ECSWT
- Increased Strength (grade)  
0 1 2 3 4 5 of 5  
PT Chiro Acu ECSWT
- Improved ADL'S %  
10 20 30 40 50 60 70 80 90 100  
Meds PT Chiro Acu ECSWT
- Pt stated that he/she was able to lift \_\_\_\_\_ lbs at the last visit, but now he/she is able to lift \_\_\_\_\_ lbs.

**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. #CHIRO #ACUP

To \_\_\_\_\_ times a week for \_\_\_\_\_ weeks.

Acupuncture **REQUEST AUTHORIZATION** 3 times a week for 4 weeks.

Medications  Topical Med

Med. Supplies

Referral to:  MRI  CT / X-ray

E.C.S.W.T  EMG/NCV

Other

Consultation

Transportation

Work Status: JUL 28 2016  
This patient has continued to remain on temporary total disability/off work until \_\_\_\_\_

Return to modified work on \_\_\_\_\_ with the following limitations or restrictions.  see attached

Return to full duty on JUL 28 2016 with no limitations or restrictions

Follow up in 2/3/4 weeks JUL 28 2016 P&S in \_\_\_\_\_ weeks  Patient approaching MMI from conservative perspective  FCE

COMMENTS: (P) authorization for \_\_\_\_\_

(P) consultation with \_\_\_\_\_

(P) FIU with DR. FRANKMAN 7/15/16, passive continuous PW

PAIN STIMULATION DEVICE

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: \_\_\_\_\_ Cal. Lic. # A101034

Name: VLAD GENDELMAN, M.D. Specialty: Orthopedic Surgery  
Address: 6200 WILSHIRE BLVD # 910 LOS ANGELES C.A. 90048 Phone: (323)933-3434  
DWC Form PR-2 (Rev. 10/2015)

Executed at: County of Los Angeles

Date of Exam: 08/23/2016

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