AARON COPPELSON, M.D.
Board Certified Pain Management
Board Certified Electrodiagnostic Medicine
Board Certified Physical Medicine and Rehabilitation
An Independent Contractor of
U.S. HealthWorks Medical Group
2499 South Wilmington Avenue • Compton CA 90220
Phone (310) 638-1113 • Fax (310) 638-8042

BIL

July 18, 2013

York Claims
Attention Claims Examiner
PO Box 619079
Roseville CA 95661-9079

RE: SANTILLAN, ROSARIO
Claim #: TWCS-1588

Inc. #:	156-238753
D.O.I.:	02/22/13
Employer:	Premier Personnel Resources

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I reviewed the patient's health history as documented in the first visit and it remains unchanged.

A Spanish interpreter, Yliana Chavez, was used throughout the whole examination.

SUBJECTIVE COMPLAINTS

The patient presents to me today with continued right hip pain, dull aching in nature. Squat, kneel, lift, push, and pull exacerbate the pain, baseline 2 to 5. Rest helps partially relieve the intermittent pain.

REVIEW OF SYSTEMS

A complete review of systems was performed and was all negative except for the systems as documented on the initial visit and those systems associated with the injury.

OBJECTIVE FINDINGS

General Appearance

The patient is a well-developed, well-nourished male, appearing his stated age and in no acute distress.

Examination of the Lumbosacral Spine

Visual Inspection

Upon visual inspection of the lumbosacral spine, thoracolumbar posture is noted to be well-preserved with no splinting.

Skin

No surgical or traumatic scars or burns are visible. The overlying skin is intact with no lacerations, abrasions, puncture wounds or skin breakdown. There is no ecchymosis or erythema.

Gait

The patient's gait pattern is normal. Heel and toe ambulation cause no increase in back pain.

Palpation

Lumbosacral palpation from L1 to the sacrum shows no areas of tenderness or spasm bilaterally.

Range of Motion

Range of motion of the lumbar spine is unrestricted.

			Normal
Forward flexion	60 degrees		60 degrees
Extension	25 degrees		25 degrees
	Right	Left	Normal
Lateral flexion	25 degrees	25 degrees	25 degrees
Lateral rotation	45 degrees	45 degrees	45 degrees

Lumbar spine motions are accomplished without the patient expressing any complaints of pain during the maneuvers. There is no evidence of radiating pain to the lower extremities on lumbar motion.

Straight Leg Raising

Straight leg raising from the supine position is negative at 90 degrees bilaterally.

Examination of the Right Hip

Gait

The patient's gait pattern is unremarkable with no limping.

Visual Inspection

The hip is well muscled with no deformity. There are no obvious masses or muscle atrophy.

Skin

No surgical or traumatic scars or burns are visible. The overlying skin is intact with no lacerations, abrasions, puncture wounds or skin breakdown. There is no ecchymosis or erythema.

Palpation

Tenderness to palpation over the right hip.

Range of Motion

Hip joint motion is full and equal to the opposite normal side. Passive motion ranges are equal to active motion ranges.

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

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch, pinprick and two-point discrimination in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
Hip flexors	5/5	5/5
Hip extensors	5/5	5/5
Hip abductors	5/5	5/5
Hip adductors	5/5	5/5
Knee flexors	5/5	5/5

Knee extensors	5/5	5/5
Ankle dorsiflexors	5/5	5/5
Ankle plantar flexors	5/5	5/5
Extensor hallucis	5/5	5/5

Deep Tendon Reflex Examination

	Right	Left
Knee jerks	2+	2+
Ankle jerks	2+	2+

Vascular Examination

The dorsalis pedis and posterior tibial pulses are 2+ bilaterally. The capillary refill is less than two seconds. The toes are warm and pink with good perfusion distally.

Special Tests

Babinski sign	Negative
Hoffmann sign	Negative
Clonus	Negative

DIAGNOSTIC IMPRESSION

Right SI joint inflammation, recalcitrant in nature.

DISCUSSION

The patient presents to me today for followup examination. At this point, I want to refill the Lodine and tramadol for the patient. The MRI is to be done tomorrow. I am seeing the patient on a periodic followup. I will see the patient as soon the MRI is read. I will maintain the same restrictions until then and reassess after the results of the MRI.

DISCLOSURE

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

Executed at Los Angeles County, California, on _____.

Physician Signature _____ CA Lic. #: A76120

Aaron Coppelson, M.D.

CUSHW:AC:TDY:fxj.FVI
D: 07/22/13
T: 07/23/13
SantillanR0718CoppelsonDS249357

U.S. HealthWorks
MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

☐ *Additional pages attached*

Patient Last Santillan First Rosario DOB 3/26/67 Date of Exam: 7/18/13 Case #: 156238753

Occupation Packing SS# 620-20-3894 Date of Injury 2/22/13 Claim # TWCS-1588

Employer: PREMIER PERSONNEL RESOURC Contact: MARINA PADILLA Tel: (310) 515-2632 Fax: 310 515-5317

Claims Administrator YORK CLAIMS Tel: (877) 751-0133 Fax: 866 548-2637

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

☐ Change in patient's condition ☐ Need for referral or consultation ☐ Info. requested by: ____
☐ Change in work status ☐ Need for surgery or hospitalization ☐ Released from Care ☐ Request for Authorization
☐ Change in treatment plan ☐ Periodic Report (45 days after last report) ☐ Other: ____

PATIENT STATUS Since the last exam, this patient's condition has:

☐ improved as expected ☐ improved, but slower than expected ☒ not improved significantly
☐ ~~worsened~~ ☐ reached plateau and no further improvement is expected ☐ been determined to be non-work related

SUBJECTIVE COMPLAINTS (Document and describe significant complaints)

LBP

OBJECTIVE FINDINGS (Document significant exam findings, lab, imaging, and other diagnositic testing)

TTP

DIAGNOSES (Include ICD-9 code, if possible)

LBS

TREATMENT

☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other
☐ Meds / Supplies Dispensed [illegible handwriting]
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty ____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now ____ weeks

MRI to be done [illegible]

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions. Same
☐ Off work until (Date) ____ Estimated period of total temporary disability ____ days.
☐ Off the balance of this shift only. Then RTW on (Date) ____ ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) ____ with the restri[ctions] ... [Est]imated duration of modified duty is ____ days.

( ) No work near moving machinery ... own job
( ) No / ( ) Limited use of R / L hand to ____ hrs ... [mus]t wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
( ) No / ( ) Limited standing or walking to ____ hrs ... ☐ Other ____
( ) No / ( ) Limited overhead work to ____ hrs/day ( ) Must keep ____ elevated
( ) No / ( ) Limited stooping and bending to ____ hrs/day ( ) Keep wound\bandage clean and dry
( ) No / ( ) Limited kneeling or squatting to ____ hr ... [Mu]st take a ____ minute stretch break every ____ minutes from
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push ( ) Keyboard / ( ) ____
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ____ lbs ... [Oth]er ____
( ) No climbing

☐ Medical status was discussed with employer representative ____

DISCHARGE STATUS

☐ Return to full duty on (Date) ____ with no limitations or restrictions. Released from care without ratable disability or need for future medical care.
☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care.
☐ **NON-INDUSTRIAL.** Patient instructed to see private physician at own expense. A PR-4 to follow.

PRIMARY TREATING PHYSICIAN

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 S 139.3.

Name ____ Cal. Lic # ____ Date of Exam 7/18/13
Specialty: ____ Signature ____

Executed at: USHW of California - Compton, 2499 S. Wilmington Avenue, Compton, CA 90220 Tel: (310) 638-1113

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: ____ TIME: ____ ☐ Before / After Shift

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DATE: ____ TIME: ____ ☐ Before / After Shift

PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO ...

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Executed at Los Angeles County, California, on _____.

Physician Signature _____ CA Lic. #: A76120

Aaron Coppelson, M.D.

CUSHW:AC:TDY:fxj.FVI
D: 07/22/13
T: 07/23/13
SantillanR0718CoppelsonDS249357

PREMIER PERSONNEL RESOURC 151202
DOS: 7/18/13 DOI: 2/22/13 DOB: 3/26/67
Patient: Santillan, Rosario
Case # : 156-238753 Ref # : EMR/ Yb

DATE: _____

Have you had any of the following symptoms?

☐ Headache	☐ Visual Disturbances	☐ Difficulty Speaking
☐ Difficulty with Swallowing	☐ Weakness	☐ Numbness
☐ Bowel Incontinence	☐ Bladder Incontinence	☐ Stomach Pain
☐ Heartburn	☐ Bleeding Ulcers	☐ Hemorrhoids
☐ Inflammatory Bowel Disease	☐ Irritable Bowel Disease	☐ Nausea
☐ Vomiting	☐ Chest Pain	☐ Chest Pain at Rest
☐ Chest Pain with Activity	☐ Chest Pain with Breathing	☐ Coughing
☐ Coughing Up Blood	☐ Fevers	☐ Chills
☐ Night Sweats	☐ Recent Weight Loss	☐ Recent Weight Gain

1-How would you describe your PAIN DULL ACHING (SHARP) STABBING BURNING _____

2-On the scale of 1-10 (10 being the worst pain ever) what would you rate your pain range 8

3-What makes the symptoms WORSE any constant movement & lifting.

4-What makes the symptoms BETTER resting.

5-Are there any Radiating or Shooting Symptoms, if yes where do the symptoms radiate: no .

6-Are you BETTER , WORSE, or the SAME from the last visit

Please detail any of the above symptoms or any other new symptoms that may concern you.

BP: 102/80 Temp: 96.4 Resp: 15 Pulse: 64

Please be sure to see your primary care non-industrial physician for positive review of systems and vital signs.

PATIENT SIGNATURE: _____ DATE: 7/12/13

U.S. HealthWorks
MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation

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

☐ *Additional pages attached*

Patient Last Santillan First Rosario DOB 3/26/67 Date of Exam: 7/18/13 Case #: 156238753

Occupation Packing SS# 620-20-3894 Date of Injury 2/22/13 Claim # TWCB-1588

Employer: PREMIER PERSONNEL RESOURC Contact: MARINA PADILLA Tel: (310) 515-2632 Fax: 310 515-5317

Claims Administrator YORK CLAIMS Tel: (877) 751-0133 Fax: 866 548-2637

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

☐ Change in patient's condition ☐ Need for referral or consultation ☐ Info. requested by: _____
☒ Change in work status ☐ Need for surgery or hospitalization ☐ Released from Care ☐ Request for Authorization
☐ Change in treatment plan ☐ Periodic Report (45 days after last report) ☐ Other: _____

PATIENT STATUS Since the last exam, this patient's condition has:

☐ improved as expected ☐ improved, but slower than expected ☒ not improved significantly
☐ worsened ☐ reached plateau and no further improvement is expected ☐ been determined to be non-work related

SUBJECTIVE COMPLAINTS (Document and describe significant complaints)

LBP

OBJECTIVE FINDINGS (Document significant exam findings, lab, imaging, and other diagnositic testing)

TTP

DIAGNOSES (Include ICD-9 code, if possible)

BSI

TREATMENT

☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks ☐ Other _____
☐ Meds / Supplies Dispensed Ibuprofen 600 mg #30 / Tramadol #30 / Omeprazole #30
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions. Same
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restri[illegible] timated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs own job
( ) No / ( ) Limited standing or walking to _____ hrs t wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
( ) No / ( ) Limited overhead work to _____ hrs/day ☐ Other _____
( ) No / ( ) Limited stooping and bending to _____ hrs/day ( ) must keep _____ elevated
( ) No / ( ) Limited kneeling or squatting to _____ hr ( ) Keep wound\bandage clean and dry
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push st take a _____ minute stretch break every _____ minutes from
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs ( ) Keyboard / ( ) _____
( ) No climbing her _____

☐ Medical status was discussed with employer representative _____

DISCHARGE STATUS

☐ Return to full duty on (Date) _____ with no limitations or restrictions. Released from care without ratable disability or need for future medical care.
☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

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 S 139.3.

Name _____ Cal. Lic # _____ Date of Exam 7/18/13
Specialty: _____ Signature _____
Executed at: USHW of California - Compton, 2499 S. Wilmington Avenue, Compton, CA 90220 Tel: (310) 638-1113

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☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
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