STATE OF CALIFORNIA DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

1. INSURER NAME AND ADDRESS York Risk Services/Ia Claims Po Box 619079, Roseville, CA 95661-9079			**PLEASE DO NOT USE THIS COLUMN**
2. EMPLOYER NAME PREMIER STAFFING			**Case No.**
3. Address No. and Street City Zip 10970 ARROW ROUTE STE:101, Rancho Cucamonga, CA 91730			**Industry**
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)			**County**
5. **PATIENT NAME** (first name, middle initial, last name) Maria Del Rosario Santillan	6. Sex F	7. Date of Birth Mo. Day Yr. 3/26/1967	**Age**
8. Address: No. and Street City Zip 9431 Nance Ave. #P, Downey, CA 90241		9. Telephone number (323) 517-7722	**Hazard**
10. Occupation (Specific job title) WAREHOUSE SUPERVISOR		11. Social Security Number 620203894	**Disease**
12. Injured at: No. and Street City County , JOB SITE			**Hospitalization**
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour 02/22/2013		14. Date last worked Mo. Day Yr.	**Occupation**
15. Date and hour of first examination or treatment Mo. Day Yr. Hour 07/24/2014		16. Have you (or your office) previously treated patient? ☐ No	**Return Date/Code**

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

ON 02/22/13, THE PATIENT LIFTED A BOX WEIGHING APPROXIMATELY 40-50 POUNDS AND FELT AN IMMEDIATE SHARP SHOOTING PAIN IN HER LOWER BACK. SHE STATES THAT SHE ALSO FELT A PULL IN HER LOWER BACK. SHE REPORTED HER SYMPTOMS TO HER EMPLOYER WHO SENT HER TO A CLINIC IN THE CITY OF COMPTON WHERE SHE WAS EVALUATED, X-RAYS WERE TAKEN OF HER LOWER BACK, MEDICATION WAS PRESCRIBED, AND STARTED ON A COURSE OF PHYSICAL THERAPY. SHE WAS RELEASED BACK TO WORK WITH RESTRICTIONS. SHE CONTINUED TO WORK DUE TO FINANCIAL NECESSITY UNTIL 04/08/14. SHE WAS ALSO SEEN AT A CLINIC IN THE CITY OF PARAMOUNT WHERE SHE WAS EVALUATED AND GIVEN SESSIONS OF THERAPY. PATIENT REMAINS OFF WORK AND STATES THAT HER SYMPTOMS PERSIST AND HAVE NOT IMPROVED. SHE NOW PRESENTS TO THIS FACILITY SEEKING FURTHER MEDICAL CARE.

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

LOWER BACK PAIN

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)

A. Physical examination

LUMBAR SPINE TENDERNESS TO PALPATION BILATERAL PARASPINAL MUSCLES/RIGHT SACROILIAC JOINT/RIGHT SCIATIC NOTCH/RIGHT POSTERIOR ILIAC CREST/RIGHT GLUTEAL MUSCLES, SPASMS BILATERAL PARASPINAL MUSCLES, DECREASED ROM, POSITIVE SLR (R 41); DECREASED MOTOR STRENGTH RIGHT HIP/LEFT KNEE AT 4/5; DECREASED SENSATION RIGHT ANTEROLATERAL THIGH/ LATERAL THIGH.

B. X-ray and laboratory results (State if none or pending.)

NONE

20. **DIAGNOSIS** (If occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? No

ICD-9 Code LUMBOSACRAL MUSCULOLIGAMENTOUS STRAIN/SPRAIN WITH RADICULITIS (847.2, 724.4); RULE OUT LUMBOSACRAL SPINE DISCOGENIC DISEASE (V71.9, 724.09).

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes If "no", please explain.

AOE/COE Issues: Based on the information provided by Ms. Santillan, there is no history of any unresolved prior injuries or disability to the lower back or prior disability resulting in work limitations. It is my professional opinion that Ms. Santillan's current diagnoses listed under the Initial Diagnostic Impressions are the direct result of the injuries she sustained on February 22, 2013, while working for Premier Staffing.

22. Is there any other current condition that will impede or delay patient's recovery? No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

PRESCRIPTION WAS GIVEN FOR NAPROXEN 550 MG #60, OMEPRAZOLE 20 MG #60, MOBIC 15 MG #30, LUMBOSACRAL BRACE, INTERFERENTIAL UNIT, AND MOIST HEAT PAD. AUTHORIZATION IS FORMALLY BEING REQUESTED FOR PHYSICAL PERFORMANCE-FCE. A PHYSICAL PERFORMANCE-FCE IS REQUESTED TO ENSURE THIS PATIENT CAN SAFELY MEET THE PHYSICAL DEMANDS OF THEIR OCCUPATION.

24. If further treatment required, specify treatment plan/estimated duration Requesting authorization for:

PHYSICAL THERAPY EVALUATION AND TREATMENT FOR THE LUMBAR SPINE, 2 TIMES A WEEK FOR 6 WEEKS.

25. If hospitalized as inpatient, give hospital name and location Date

26. WORK STATUS -- Is patient able to perform usual work? ☐No TTD UNTIL 08/28/2014

If "no", date when patient can return to: Regular work

Doctor's Signature Date: 07/30/2014 CA License Number A101034

Doctor Name and Degree (please type) Gendelman, Vlad MD IRS Number 271414640

Address 6200 Wilshire Blvd Ste 910, Los Angeles, CA 90048 Telephone Num: (323) 933-3434

FORM 5021 (Rev. 4)
1992

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STATE OF CALIFORNIA DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

1. INSURER NAME AND ADDRESS
York Risk Services/la Claims Po Box 619079, Roseville, CA 95661-9079

PLEASE DO NOT USE THIS COLUMN: Case No. / Industry / County / Age / Hazard / Disease / Hospitalization / Occupation / Return Date/Code

2. EMPLOYER NAME
PREMIER STAFFING

3. Address No. and Street City Zip
10970 ARROW ROUTE STE:101, Rancho Cucamonga, CA 91730

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)

5. PATIENT NAME (first name, middle initial, last name)
Maria Del Rosario Santillan

6. Sex F

7. Date of Birth Mo. Day Yr. 3/26/1967

8. Address: No. and Street City Zip
9431 Nance Ave. #P, Downey, CA 90241

9. Telephone number
(323) 517-7722

10. Occupation (Specific job title)
WAREHOUSE SUPERVISOR

11. Social Security Number
620203894

12. Injured at: No. and Street City County
JOB SITE

13. Date and hour of injury or onset of illness Mo. Day Yr. Hour
CT 1/1/2012 - 4/8/2014

14. Date last worked Mo. Day Yr.

15. Date and hour of first examination or treatment Mo. Day Yr. Hour
07/24/2014

16. Have you (or your office) previously treated patient? ☐ No

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical. Use reverse side if more space is required.)
CT 01/01/12-04/08/14. AS A WAREHOUSE SUPERVISOR, THE PATIENT WAS RESPONSIBLE FOR SUPERVISING WORKERS, GIVING WORKERS MERCHANDISE TO PACK AS WELL AS PACKING AND LIFTING MERCHANDISE. HER JOB-RELATED PHYSICAL ACTVITIES INCLUDE LIFTING, CARRYING, PUSHING AND PULLING OF UP TO 30-50 POUNDS, BENDING AT THE NECK, PROLONGED STANDING, CONSTANT WALKING, BENDING, KNEELING, STOOPING, HAND MANIPULATION AND OTHER ACTIVITIES. AS A RESULT, SHE GRADUALLY DEVELOPED PAIN IN HER NECK, UPPER BACK, AND LOWER BACK. SHE REPORTED HER SYMPTOMS TO HER EMPLOYER WHO SENT HER TO A CLINIC IN THE CITY OF COMPTON WHERE SHE WAS EVALUATED, X-RAYS WERE TAKEN OF HER LOWER BACK, MEDICATION WAS PRESCRIBED AND A COURSE OF PHYSICAL THERAPY WAS STARTED. SHE WAS ALSO GIVEN WORK RESTRICTIONS. SHE ALSO STATES THAT DUE TO CONSTANT WALKING AND BENDING, SHE BEGAN TO FEEL PAIN IN HER LEFT KNEE. SHE DID NOT REPORT HER PAIN TO HER EMPLOYER AND SOUGHT CARE ON HER OWN AT LOS ANGELES COMMUNITY HOSPITAL WHERE SHE WAS EVALUATED AND X-RAYS WERE TAKEN OF HER LEFT KNEE. PATIENT RETURNED TO WORK BUT THE PAIN IN HER LEFT KNEE WAS UNBEARABLE AND WAS ONLY ABLE TO WORK FOR 3 HOURS. SHE HAS NOT WORKED SINCE 04/08/14. SHE WAS LATER SEEN AT CHUEVAS CHIROPRACTIC AS WELL AS A CLINIC IN THE CITY OF PARAMOUNT. PATIENT REMAINS OFF WORK AND STATES THAT HER SYMPTOMS PERSIST AND HAVE NOT IMPROVED. SHE NOW PRESENTS TO THIS FACILITY SEEKING FURTHER MEDICAL CARE.

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)
NECK PAIN, UPPER BACK PAIN, LOWER BACK PAIN, LEFT KNEE PAIN.

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination
CERVICAL SPINE TENDERNESS TO PALPATION BILATERAL PARASPINAL MUSCLES/BILATERAL TRAPEZIUS MUSCLES, SPASMS BILATERAL TRAPEZIUS MUSCLES, DECREASED ROM; THORACIC SPINE TENDERNESS TO PALPATION & SPASM BILATERAL UPPER/ LOWER THORACIC REGION R>L, TRIGGER POINTS RIGHT LOWER THORACIC REGION, DECREASED ROM; LUMBAR SPINE TENDERNESS TO PALPATION BILATERAL PARASPINAL MUSCLES/RIGHT SACROILIAC JOINT/RIGHT SCIATIC NOTCH/RIGHT POSTERIOR ILIAC CREST/RIGHT GLUTEAL MUSCLES, SPASMS BILATERAL PARASPINAL MUSCLES, DECREASED ROM, POSITIVE SLR (R 41); LEFT KNEE TENDERNESS TO PALPATION ANTERIORLY/POSTERIORLY / PATELLA/MEDIAL JOINT LINE, DECREASED ROM, POSITIVE MCMURRAY TEST; DECREASED MOTOR STRENGTH RIGHT HIP/LEFT KNEE AT 4/5; DECREASED SENSATION RIGHT ANTEROLATERAL THIGH/ LATERAL THIGH.
B. X-ray and laboratory results (State if none or pending.)
NONE

20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? No
ICD-9 Code CERVICAL MUSCULOLIGAMENTOUS STRAIN/SPRAIN (847.0); THORACIC MUSCULOLIGAMENTOUS STRAIN/SPRAIN (847.1); LUMBOSACRAL MUSCULOLIGAMENTOUS STRAIN/SPRAIN WITH RADICULITIS (847.2, 724.4); RULE OUT LUMBOSACRAL SPINE DISCOGENIC DISEASE (V71.9, 724.09); LEFT KNEE STRAIN/SPRAIN (844.9); RULE OUT LEFT KNEE INTERNAL DERANGEMENT (V71.9, 717.8).

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes If "no", **please explain.**
AOE/COE Issues: Based on the information provided by Ms. Santillan, there is no history of any unresolved prior injuries or disability to the neck, mid/upper back, lower back, and left knee or prior disability resulting in work limitations. It is my professional opinion that Ms. Santillan's current diagnoses listed under the Initial Diagnostic Impressions are the direct result of the injuries she sustained on a continuous trauma from January 1, 2012 to April 8, 2014, while working for Premier Staffing.

22. Is there any other current condition that will impede or delay patient's recovery? No If "yes", please explain.

23. TREATMENT RENDERED (Use reverse side if more space is required.)
PRESCRIPTION WAS GIVEN FOR NAPROXEN 550 MG #60, OMEPRAZOLE 20 MG #60, MOBIC 15 MG #30, LUMBOSACRAL BRACE, INTERFERENTIAL UNIT, AND MOIST HEAT PAD. AUTHORIZATION IS FORMALLY BEING REQUESTED FOR MRI OF THE LEFT KNEE; AND PHYSICAL PERFORMANCE-FCE. A PHYSICAL PERFORMANCE-FCE IS REQUESTED TO ENSURE THIS PATIENT CAN SAFELY MEET THE PHYSICAL DEMANDS OF THEIR OCCUPATION.

24. If further treatment required, specify treatment plan/estimated duration Requesting authorization for:
PHYSICAL THERAPY EVALUATION AND TREATMENT FOR THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, AND LEFT KNEE, 2 TIMES A WEEK FOR 6 WEEKS.

25. If hospitalized as inpatient, give hospital name and location Date

26. WORK STATUS -- Is patient able to perform usual work? ☐No TTD UNTIL 08/28/2014
If "no", date when patient can return to: Regular work

Doctor's Signature Date:07/30/2014 CA License Number A101034

Doctor Name and Degree (please type): Sandelman, Vlad MD IRS Number 271414640
Address 6200 Wilshire Blvd Ste 910, Los Angeles, CA 90048 Telephone Num: (323) 933-3434

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14. Date last worked Mo. Day Yr.

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16. Have you (or your office) previously treated patient? □ No

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Hazard
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Doctor Name and Degree (please type) [illegible], Vlad MD IRS Number 271414640
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