

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

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

SUBJECTIVE COMPLAINTS:	PAIN Last visit										PAIN today										Radiation			
	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10	[] no	[] yes
<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	[] no	[] 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	[] no	[] 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	[] no	[] 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	[] no	[] 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	[] no	[] yes
<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	[] no	[] 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	[] no	[] 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	[] no	[] 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	[] no	[] 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	[] no	[] 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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes
<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	[] no	[] yes

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

REQUEST AUTHORIZATION

	TENDER		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	[] full	[] restr.	+ Cervical Compr.	[]
<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	[] full	[] restr.	+ Cervical distr.	[]
<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	[] full	[] restr.	+SLR	[] R [] L [] 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	[] full	[] restr.	+ Heel Walking (L5)	[] R [] L [] 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	[] full	[] restr.	+ Toe Walking (S1)	[] R [] L [] 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	[] full	[] restr.	+ Impingement	[] R [] L [] 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	[] full	[] restr.	+ Supraspinatus	[] R [] L [] 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	[] full	[] restr.	+ Codman's Drop	[] R [] L [] 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	[] full	[] restr.	+ Cozen's	[] R [] L [] 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	[] full	[] restr.	+ Mill's	[] R [] L [] 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	[] full	[] restr.	+ Tinel's Sign	[] R [] L [] 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	[] full	[] restr.	+ Phalen's (CTS)	[] R [] L [] 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	[] full	[] restr.	+ Finkelstein's	[] R [] L [] 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	[] full	[] restr.	+ Anterior Drawer	[] R [] L [] 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	[] full	[] restr.	+ Posterior Drawer	[] R [] L [] 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	[] full	[] restr.	+ McBurnay	[] R [] L [] 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	[] full	[] restr.	+ Valgus (MCL)	[] R [] L [] B
							+ Varus (LCL)	[] R [] L [] B
Wound:					Neurological	[] No Δ		
					Motor	[] N/L		
					Sensory	[] N/L		
					Reflexes	[] N/L		
					Trigger points	C/S T/S L/S		

Patient Name: SANTILLAN, MARIA

Diagnoses:

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 09/25/2015
- 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 CIS, NS, TK, O'Neil 3 times a week for 4 weeks.
- Acupuncture _____ times a week for _____ weeks.
- Medications _____ Topical Med _____
- Med. Supplies _____

- Pt stated that he/she was able to walk _____ blocks at around the last visit, but now he/she is able to walk _____ blocks without pain.
- Pt stated that he/she was able to stand for _____ mins at the last visit, but now he/she is able to stand for _____ mins.
- Pt is now able to do more house chores.
- Pt stated that he/she was able to drive for _____ mins at the last visit, but now he/she is able to drive for _____ mins.
- Pt reports using less pain meds with PT Chiro Acu ECSWT

- Referral to: MRI CT / X-ray E.C.S.W.T EMG/NCV Other _____
- Consultation Transportation

REQUEST AUTHORIZATION
9 SEP 01 2016

Work Status:

- 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 _____ with no limitations or restrictions
 - Follow up in 2/3/4 weeks 01 2016 P&S in _____ weeks Patient approaching MMI from conservative perspective FCE

COMMENTS:

- (P) authorization for _____
- (P) consultation with _____
- (P) FIU with Dr. Aronson on 8/30/16, pending passive pain stimulus - done.

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

Executed at: County of Los Angeles

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)

Date of Exam: 07/28/2016
Fax: (323)954-8666

Patient Name: SANTILLAN, MARIA
Diagnoses:

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
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- 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 CIS AS TR, @street 3 times a week for 4 weeks.
 Acupuncture _____ times a week for _____ weeks.
 Medications _____ Topical Med _____
 Med. Supplies _____

- Pt stated that he/she was able to walk
_____blocks at around the last visit, but now
he/she is able to walk _____blocks without
pain.
- Pt stated that he/she was able to stand for
_____mins at the last visit, but now he/she is
able to stand for _____mins.
- Pt is now able to do more house chores.
- Pt stated that he/she was able to drive for
_____mins at the last visit, but now he/she is
able to drive for _____mins.
- Pt reports using less pain meds with
PT Chiro Acu ECSWT

Referral to: MRI _____ CT / X-ray _____
 E.C.S.W.T _____ EMG/NCV _____
 Other _____

REQUEST AUTHORIZATION
9 SEP 01 2016

Work Status:
 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 _____ with no limitations or restrictions
 Follow up in 2/3/1 weeks 0 1 2016 P&S in _____ weeks Patient approaching MMI from conservative perspective FCE

COMMENTS:
 (P) authorization for _____
 (P) consultation with _____
 (P) FIU with Dr. Arunthorn on 8/30/16, pending passive pain
stimulation device

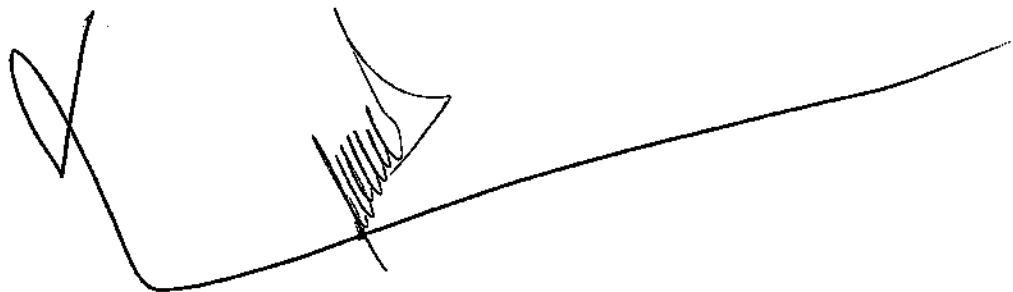
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Upcoming Appointments (Santillan, Maria Del Rosario)

Start Time	Name	Provider	Location
8/15/2016 9:30 AM	RPT FOLLOW UP	Hocutt, Ina Rpt	6200 Wilshire Blvd Suite 910
8/16/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/17/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/18/2016 11:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/23/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/24/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/25/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/30/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
8/31/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
9/1/2016 1:00 PM	WC FOLLOW UP	Gendelman, Vlad	6200 Wilshire Blvd Ste 910
9/6/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
9/7/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
9/8/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
9/13/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
9/14/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910
9/15/2016 9:30 AM	PT TREATMENT	Ofelia M.	6200 Wilshire Blvd Suite 910

A large, stylized handwritten signature or scribble is present at the bottom of the page. It consists of several overlapping loops and lines, with a prominent vertical stroke on the left side and a horizontal stroke extending to the right.