TTD

State Of California
Division of Workers' Compensation

Additional pages attached ☐

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 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	
■ Headache	0 1 2 3 4 5 (6) 7 8 9 10	0 1 2 3 4 5 6 7 (8) 9 10		
■ 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
■ 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
■ 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
☐ 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	
☐ 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	
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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	
☐ 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	Dermatomes
☐ 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	
■ 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	[ ]R. [ ]L. [ ]B.
☐ 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	C3 C4 C5 C6 C7 C8
☐ 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	
☐ 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	[ ]R. [ ]L. [ ]B.
☐ 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	L1 L2 L3 L4 L5 S1
☐ Other _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	[ ]no	

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

	TENDER Last visit	TENDER today	SPASM Last visit	SPASM Today	ROM				
■ Neck	0 1 (2) 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	[ ]full [X] restr.	+ Cervical compr.	[ ]		
■ 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 [X] restr.	+ Cervical distr.	[ ]		
■ 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 [X] restr.	+SLR	[ ]R	[ ]L	[ ]B
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
■ 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 [X] restr.	+ Finkelstein's	[ ]R	[ ]L	[ ]B
☐ 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
☐ L Lower Leg	0 1 2 3 4	1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	[ ]full [ ]restr.	+ Posterior Drawer	[ ]R	[ ]L	[ ]B
☐ 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.	+ McMurray	[ ]R	[ ]L	[ ]B
☐ 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: (L) Knee Flexion 130° Ext. -10
Quads 4-/5, Hamstrings 4-/5

Neurological [ ] No Δ
Motor [ ] N/L
Sensory [ ] N/L
Reflexes [ ] N/L
Trigger points C/S T/S L/S

Diagnoses: Santillan, Maria

1. HEADACHES
2. CERVICAL MUSCULOLIGAMENTOUS STR/SPR
3. THORACIC MUSCULOLIGAMENTOUS STR/SPR
4. LUMBOSACRAL MUSCULOLIGAMENTOUS STR/SPR WITH RADICULITIS
5. LUMBOSACRAL DISC PROTRSUIONS, 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 SURGERY DATED 09/25/2015
8.
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19.

[ ] Treatment helps

[X] Decreased pain
Meds (PT) Chiro Acu ECSWT LINT

[X] 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

[X] Improved Function %
(10) 20 30 40 50 60 70 80 90 100
Meds (PT) Chiro Acu ECSWT LINT

[X] 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. ___#CHIRO ___#ACUP

To _____, ___ times a week for ___ weeks.

☑ Acupuncture c/s, t/s, l/s, (L) Free, 2 times a week for 4 weeks.
2 x/wk

☐: Medications _____ ☐ Topical Med

☐: Med. Supplies _____

Referral to: ☐ MRI _____ ☑ CT / X- ray _____ ☐ EMG/NCV _____
☐ E.C.S.W.T _____ ☑ LINT [ ] T/S [ ] L/S
☐ Other _____
☑ Consultation _____
JAN 2 1 2016 ☐ Transportation

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 / (6) weeks _____ P&S in _____ weeks ☐ Patient approaching MMI from conservative perspective ☐ FCE

COMMENTS: JAN 2 1 2016
(P) authorization for _____
(P) consultation with _____
(P) F/U with _____
☐ _____

☑ 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. # 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: 1. DEC 10 2015

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:	**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 Management
Claims Administrator:	York Claims Services, Inc.
Claim No:	TWCS-3293; TWCS-1588
WCAB No:	ADJ9569723; ADJ9569722
Date of Examination:	12/10/2015
Date of Report:	12/10/2015

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. 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 "Premium Interpreting, Inc." 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 representing the worst, her headaches are rated as 8/10 per the VAS

scale, which have increased from 6/10 on the last visit; 7/10 in the neck, which has increased from 5/10 on the last visit; 5/10 in the mid/upper back, which has increased from 0/10 on the last visit; 8/10 in the lower back, which has increased from 7/10 on the last visit; and 7/10 in the left knee, which has increased from 5-6/10 on the last visit.

OBJECTIVE FINDINGS:

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

Thoracic Spine: There is grade 1 tenderness to palpation over the paraspinal muscles, 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 restricted range of motion.

Left Knee: There is grade 2 tenderness to palpation, which has remained the same since her last visit. There is restricted range of motion including flexion of 130 degrees and extension of 10 degrees. There is 4-/5 strength in the quadriceps and hamstrings.

COMMENTS:

- The patient states that physical therapy helps to decrease her pain and tenderness.
- She indicates that her function and activities of daily living have improved by 10% with physical therapy.

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 04/15/14 (M51.27).

6. Left knee strain/sprain, degenerative joint disease, per MRI dated 12/15/14 (S86.912A, S83.92XA, M17.9).
7. Status post left knee surgery dated 09/25/15.

TREATMENT PLAN:

The patient is prescribed acupuncture therapy for evaluation and treatment of the cervical spine, thoracic spine, lumbar spine, and left knee, 2 times a week for 4 weeks. She has completed sessions of acupuncture therapy.

"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 is placed on temporary total disability from 12/10/15 until 01/21/16. 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."

RETURN APPOINTMENT:

The patient is scheduled for a follow-up examination on 01/21/16.

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.

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:ja

#7343

TTD

State Of California
Division of Workers' Compensation

Additional pages attached ☐

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 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	
☒ Headache	0 1 2 3 4 5 (6) 7 8 9 10	0 1 2 3 4 5 6 7 (8) 9 10		
☒ 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
☒ 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
☒ 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
☐ 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	
☐ 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	
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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	
☐ 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	Dermatomes
☐ 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	
☒ 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	[ ]R. [ ]L. [ ]B.
☐ 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	C3 C4 C5 C6 C7 C8
☐ 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	
☐ 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	[ ]R. [ ]L. [ ]B.
☐ 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	L1 L2 L3 L4 L5 S1
☐ Other _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	[ ]no	

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

	TENDER Last visit	TENDER today	SPASM Last visit	SPASM Today	ROM				
☒ Neck	0 1 (2) 3 4	0 1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	[ ]full [X] restr.	+ Cervical compr.	[ ]		
☒ 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 [X] restr.	+ Cervical distr.	[ ]		
☒ 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 [X] restr.	+SLR	[ ]R	[ ]L	[ ]B
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☐ 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
☒ 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 [X] restr.	+ Finkelstein's	[ ]R	[ ]L	[ ]B
☐ 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
☐ L Lower Leg	0 1 2 3 4	1 2 3 4	0 1 1+ 2 3 4	0 1 1+ 2 3 4	[ ]full [ ]restr.	+ Posterior Drawer	[ ]R	[ ]L	[ ]B
☐ 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.	+ McMurray	[ ]R	[ ]L	[ ]B
☐ 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: ② Knee Flexion 130° Ext. -10
Quads 4-/5, Hamstrings 4-/5

Neurological	[ ] No Δ
Motor	[ ] N/L
Sensory	[ ] N/L
Reflexes	[ ] N/L
Trigger points	C/S T/S L/S

Diagnoses: Santillan, Maria

1. HEADACHES
2. CERVICAL MUSCULOLIGAMENTOUS STR/SPR
3. THORACIC MUSCULOLIGAMENTOUS STR/SPR
4. LUMBOSACRAL MUSCULOLIGAMENTOUS STR/SPR WITH RADICULITIS
5. LUMBOSACRAL DISC PROTRSUIONS , 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 SURGERY DATED 09/25/2015
8.
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19.

[ ] Treatment helps

[X] Decreased pain
Meds (PT) Chiro Acu ECSWT LINT

[X] 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

[X] Improved Function %
(10) 20 30 40 50 60 70 80 90 100
Meds (PT) Chiro Acu ECSWT LINT

[X] 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. ___#CHIRO ✓ #ACUP

To _____, ____ times a week for ____ weeks.

☒ Acupuncture c/s, t/s, l/s, (L) Knee, 2 times a week for 4 weeks. (2 x wks)

☐: Medications _____ ☐ Topical Med

☐: Med. Supplies _____

Referral to: ☐ MRI _____ ☐ CT / X- ray _____ ☐ EMG/NCV _____
☐ E.C.S.W.T _____ ☒ LINT [ ] T/S [ ] L/S
☐ Other _____
☒ Consultation _____ JAN 2 1 2016 ☐ Transportation

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 _____ P&S in _____weeks ☐ Patient approaching MMI from conservative perspective ☐ FCE

JAN 2 1 2016

COMMENTS:
(P) authorization for _____
(P) consultation with _____
(P) F/U with _____
☐ _____

☒ 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. # 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: 1. DEC 10 2015

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:	**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 Management
Claims Administrator:	York Claims Services, Inc.
Claim No:	TWCS-3293; TWCS-1588
WCAB No:	ADJ9569723; ADJ9569722
Date of Examination:	12/10/2015
Date of Report:	12/10/2015

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. 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 "Premium Interpreting, Inc." 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 representing the worst, her headaches are rated as 8/10 per the VAS

scale, which have increased from 6/10 on the last visit; 7/10 in the neck, which has increased from 5/10 on the last visit; 5/10 in the mid/upper back, which has increased from 0/10 on the last visit; 8/10 in the lower back, which has increased from 7/10 on the last visit; and 7/10 in the left knee, which has increased from 5-6/10 on the last visit.

OBJECTIVE FINDINGS:

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

Thoracic Spine: There is grade 1 tenderness to palpation over the paraspinal muscles, 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 restricted range of motion.

Left Knee: There is grade 2 tenderness to palpation, which has remained the same since her last visit. There is restricted range of motion including flexion of 130 degrees and extension of 10 degrees. There is 4-/5 strength in the quadriceps and hamstrings.

COMMENTS:

- The patient states that physical therapy helps to decrease her pain and tenderness.
- She indicates that her function and activities of daily living have improved by 10% with physical therapy.

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 04/15/14 (M51.27).

6. Left knee strain/sprain, degenerative joint disease, per MRI dated 12/15/14 (S86.912A, S83.92XA, M17.9).
7. Status post left knee surgery dated 09/25/15.

TREATMENT PLAN:

The patient is prescribed acupuncture therapy for evaluation and treatment of the cervical spine, thoracic spine, lumbar spine, and left knee, 2 times a week for 4 weeks. She has completed sessions of acupuncture therapy.

"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 is placed on temporary total disability from 12/10/15 until 01/21/16. 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."

RETURN APPOINTMENT:

The patient is scheduled for a follow-up examination on 01/21/16.

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.

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:ja

#7343

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

Orthopaedic Surgeon

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