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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 2/25/16 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

(T) MV

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

DIAGNOSES (Include ICD-9 code, if possible)

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 _____

☐ 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.

☑ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 2/25/16

Specialty: Lic G43382 Signature _____

Executed at: USHW of California-Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 2/25/16 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES/GALLAGHER BASSETT Tel.: (213) 612-5400 Fax: _____

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

- ☐ Improved as expected
- ☒ improved, but slower than expected
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☐ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES

M17.9 Osteoarthritis of knee, unspecified

TREATMENT

☒ Office Visit / Injury Treatment ☐ Start / ☒ Continue ☒ Therapy: 2 times / week for 5 weeks. ☐ Ergonomic Eval

☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☒ Other HOME PT FOR 2WEEKS

☐ Meds / Supplies Dispensed _____

☐ 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.

☒ Off work until (Date) 3/24/16 Estimated period of total temporary disability 28 days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

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

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 2/25/16

Specialty _____ Signature Signature on File

Issued at: **USHW of California-Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 1:45 PM Checkout Time 2:16 PM Next Visit Date 3/24/16 Time 1:45 PM

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

February 25, 2016

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-WC-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Maria Velarde.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for postop evaluation of her right knee. She is status post right total knee arthroplasty on 02/08/16. Postoperatively, she has been at Skilled Nursing Facility. She continues to improve. She comes in today for follow-up evaluation, indicates her therapist was able to achieve 120 degrees of flexion for the knee. She is still using Norco for pain relief.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 56
Blood Pressure: 95/59
Respirations: 16
Temperature: 98.6

Examination of the Right Knee

Visual Inspection

There is no effusion noted. There is no obvious gross deformity or malalignment.

Skin

Incisions continues to heal in nicely. There is no sign of infection.

Range of Motion

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	15 degrees	0 degrees	0 degrees

Palpation

The patient is nontender over the lateral joint line or over the medial joint line and the anterior aspect of the knee.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Osteoarthritis, right knee, status post total knee arthroplasty.

PLAN

Plan will be to remove the remaining surgical staples. She will going home from skilled nursing facility tomorrow. I would like to arrange home therapy to do for the next two weeks, two to three times for week and then transition to an outpatient physical therapy facility for further rehabilitation and care using a total knee arthroplasty protocol.

WORK STATUS

Temporary total disability.

FOLLOW-UP APPOINTMENT

Reevaluation will be in four to six weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gtj.BGP
D: 02/26/16
T: 02/27/16
PerezC0225Graham2272

Recv'd Date: 20160229 Bill DCN: 2016060GJ004669

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

February 18, 2016

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Alejo Velarde.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post right total knee arthroplasty on 02/08/16. Postoperatively, she is now at Rowntree Nursing Facility for rehabilitation. She is now making slow steady progress. She indicates the therapist has achieved 99 degrees of flexion. She is walking with assistance of walker. She is taking Norco 5 mg strength that does not seem to be effective.

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.

Recvd Date: 20160229 Bill DCN: 2016060GJ004669
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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 58
Blood Pressure: 95/61
Respiration: 16
Temperature: 98.0

Examination of the Right Knee

There is noted moderate swelling of the knee with swelling of the leg including ecchymosis. There is no sign of infection or drainage. Neurovascular is intact. She demonstrates range of motion from 15 degrees to 90 degrees.

DIAGNOSTIC TESTING

X-rays, three views, taken today, which showed a knee replacement in good position and alignment with no evidence for loosening.

DIAGNOSIS

Osteoarthritis, right knee, status post total knee arthroplasty.

PLAN

The patient will have every other staple removed at this point. She will continue with rehab program. She has nobody to care for home; therefore, it is advisable to keep her at Rowntree for at least one more week to further improve her situation and allow for further independence. Norco 10/325 will be ordered for pain relief to use q.4-6h. p.r.n. She will return in one week for reevaluation and removal of remaining staples.

WORK STATUS

Temporary total disability.

Recvd Date: 20160229 Bill DCN: 2016060GJ004669

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:ftg.BGP
D: 02/19/16
T: 02/20/16
PerezC0218Graham2272

Provider Discharge - Perez, Consuelo - Injury - 032251644/032/25 - 02/08/16 10:15

Provider: GRAHAM, STEPHEN, M.D.
Provider of Record:

Diagnosis

	Icd-10	Ref #	Diagnosis Description
1	M17.9	16097	Osteoarthritis of knee, unspecified

Add diagnosis:

Therapy Visit Sub-types

- ☐ Evaluation and treatment
- ☐ Evaluation Only
- ☐ Follow-up treatment
- ☐ Follow-up treatment w/ROM/MMT/PPT
- ☐ Re-evaluation
- ☐ Re-evaluation w/ROM/MMT/PPT
- ☐ Ergonomic evaluation with report (Inclusive of onsite, travel and report completion)
- ☐ FCE w/report (4,5 or 6 hours) [ ] Hours
- ☐ PAT/Post-offer - level 1 (up to 30 min)
- ☐ PAT/Post-offer - level 2 (more than 30 min)
- ☐ Chiro - Manipulation only
- ☐ Other [ ] Mins [ ]

Notes [ ]

2016-02-17 14:22:15

Recvd Date: 20160229 Bill DCN: 2016060GJ004669

ROOM #6

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 2/18/16 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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: post op

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)

PO TKA R PT -> 99° needs 1 med + extend SNF

Xray (R) Knee 3V

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

15/95 early resolving N.V.D.

XRay #18

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

D/C every other staple cont rehab

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 Rx norco 10/325
☐ Consultation / ☐ Referral ☑ Requested / ☐ Pending. Specialty extend SNF ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks 1 week

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions.
☑ Off work until (Date) _____ Estimated period of total temporary disability _____ days POST OP VISIT
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 2/18/16
Specialty: _____ Signature S Graham MD
Executed at: USHW of California-Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 1 COPY

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 2/18/16 Case #: 32251644

Occupation Laundry Attendant SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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: post op

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)

PO TKA R PT -> 99° needs 1 mod + extend SNF

Xray (R) knee 3V

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

15 | 95 early resolving N-V DK

XRay #18

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

D/C every other staples cont rehab

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 Rx norco 10/325
☐ Consultation / ☐ Referral ☑ Requested / ☐ Pending. Specialty extend SNF ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks 1 week

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions.
☑ Off work until (Date) _____ Estimated period of total temporary disability _____ days. POST OP VISIT
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 2/18/16
Specialty: _____ Signature S Graham MD
Executed at: USHW of California-Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 1 CM

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 2/18/16 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES/GALLAGHER BASSETT Tel.: (213) 612-5400 Fax: _____

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

- ☐ improved as expected
- ☒ improved, but slower than expected
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☐ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES

M17.9 Osteoarthritis of knee, unspecified

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 _____

☐ Consultation / ☒ Referral ☒ Requested / ☐ Pending. Specialty EXTEND 1 WEEK SNF ☐ 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.

☒ Off work until (Date) 2/25/16 Estimated period of total temporary disability 7 days.

☐ Off the balance of this shift only. Then RTW on (Date)_____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date)_____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

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

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 2/18/16

Specialty _____ Signature Signature on File

Issued at: **USHW of California-Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 3:30 PM Checkout Time 4:10 PM

D:\PrintImageBundler\Temp\658617\Original\189DB3E7-76A9-4C0C-80DE-20E729BABC8B-24183-IF.PDF

Form 852/2 (if 2 part set) or Form 852/3 (if 3 part set)

REPORT OF CONSULTATION

Last Name	First	Middle	Room No.	Record No.
Perez	Consuelo		16A	

From: Attending Physician To: Consulting Physician Date 2/18/16

Report Requested Regarding

Signature of Attending Physician

REPORT

Findings

PO total knee R

improving

PT -> 99° flex

walk c walker

PE alert oriented no acute distress

R knee dressing c/d/i

resolving ecchymosis

ROM 15-95°

N-V DIC

Diagnosis DJD R knee s/p total knee

Recommendations D/c any other therapy

cont TKA rehab

Date of Consultation: 2-18-16 Dr. Page 196 A Grahamm

D:\PrintImageSpooler\Temp\658317\Original\189DB3E7-76A9-4C0C-80DE-20E729BABC8B-24183-IF.PDF
Feb. 19. 2016 2:16PM

HISTORY

Transfered from Los Alamitos MC p (R) total knee arthroplasty 2° Progressive OA
Participated c PT today. Currently (R) knee pain & other complaints
(Include Present Illness, pertinent Past and Family History)

& vision Δ
Isolated HA / dizziness which resolved
& CP / SOB
& abd pain.
& diarrhea (+) constipation
& melena / hematochezia
& dysuria

PHYSICAL EXAMINATION

Pain: _____ B.P. 154/82 Temp. 97.1 Pulse 85 Resp. 18 Wt. _____

A. General Appearance:
B. Skin:
C. Head:

Alert x3, NAD

Eyes: Nose: Oral Cavity:
Ears: Throat: Teeth:

D. Neck and Lymph Glands: supple & JVD & goiter/lobes
E. Thorax:
Breasts:
Lungs: CTA (B) & clear
Heart: RRR
F. Abdomen: (+) BS soft NT/ND & CVA tenderness
G. Back and Extremities:
H. Pelvis:
Genitalia (External)
Rectal:
I. Neuro-Muscular: (R) knee: Dressing dry (+) edema (+) ecchymosis limited ROM PME/LUE/LLE FROM, MS 5/5

PMH
OA of knee
HTN

PSHx
Cholecystectomy
Caesarean Section
(R) knee surgery x 2

SH: denies ETOH/drug, Lives alone

FH:
M. d DM, HTN
B(3) HTN

DIAGNOSIS: OA s/p [illegible] back →

This resident:

A. ☑ has the capacity to understand and make decisions.
B. ☐ does ***NOT*** have the capacity to understand and make decisions
C. ☐ has fluctuating capacity to understand and make decisions.

Reason: _____
Surrogate Decisionmaker: _____
Relationship: _____

REHABILITATION POTENTIAL: (Include Impression, plans for continuing care, prognosis and goals)

Good

Resident/Responsible Party informed of Medical Condition and Plan of Treatment: Yes ☑ No ☐

If no, state reason why: _____

COPIED Date: COPIED

2/11/16
Date

Physician's Signature

Last Name	First	Middle	Room	Physician	Hosp. No.
PEREZ,	CONSUELO		16A	DR. TRAN	

ARTISTIC PRESS (323) 660-8085

Rowntree Gardens

EOCBA 02/12/2016 12:10

PHYSICIAN'S ORDERS FOR 02/12/2016

Order #	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
Order Type: Appointment								
10	02/12/16	02/12/16	APT	Follow up appointment with Dr. Graham on 2/18/16 @ 3 :30 pm @ Irvine Office pick up @ 3 pm -; Dr. Ky Tran				00/00/00
e-Sign Nurse: e-Sign MPPI				e-Sign Therapist: e-Sign Physician:				
Order Type: Consults								
20	02/12/16	02/12/16	C	DISCONTINUE as of 02/12/2016: Follow up appointment with Dr. Graham on 2/25/16, call office for appointment time -; Dr. Ky Tran				00/00/00
e-Sign Nurse: e-Sign MPP:				e-Sign Therapist: e-Sign Physician:				

Resuscitate:

Nurse _____ Date: 2 / 19 / 16

Physician _____ Date: ___/___/___

Nurse _____ Date: ___/___/___

Physician	UPIN #	Office #	Alternate Physician	UPIN #	Office #
Tran, Ky	H74389	(562) 430-1235			( ) -

Pager # ( ) - Mobile # ( ) - Fax # (562) 452-8972

E-Mail:

Allergies — Food / Environ.: | Medical: PENICILLINS

Diagnoses:

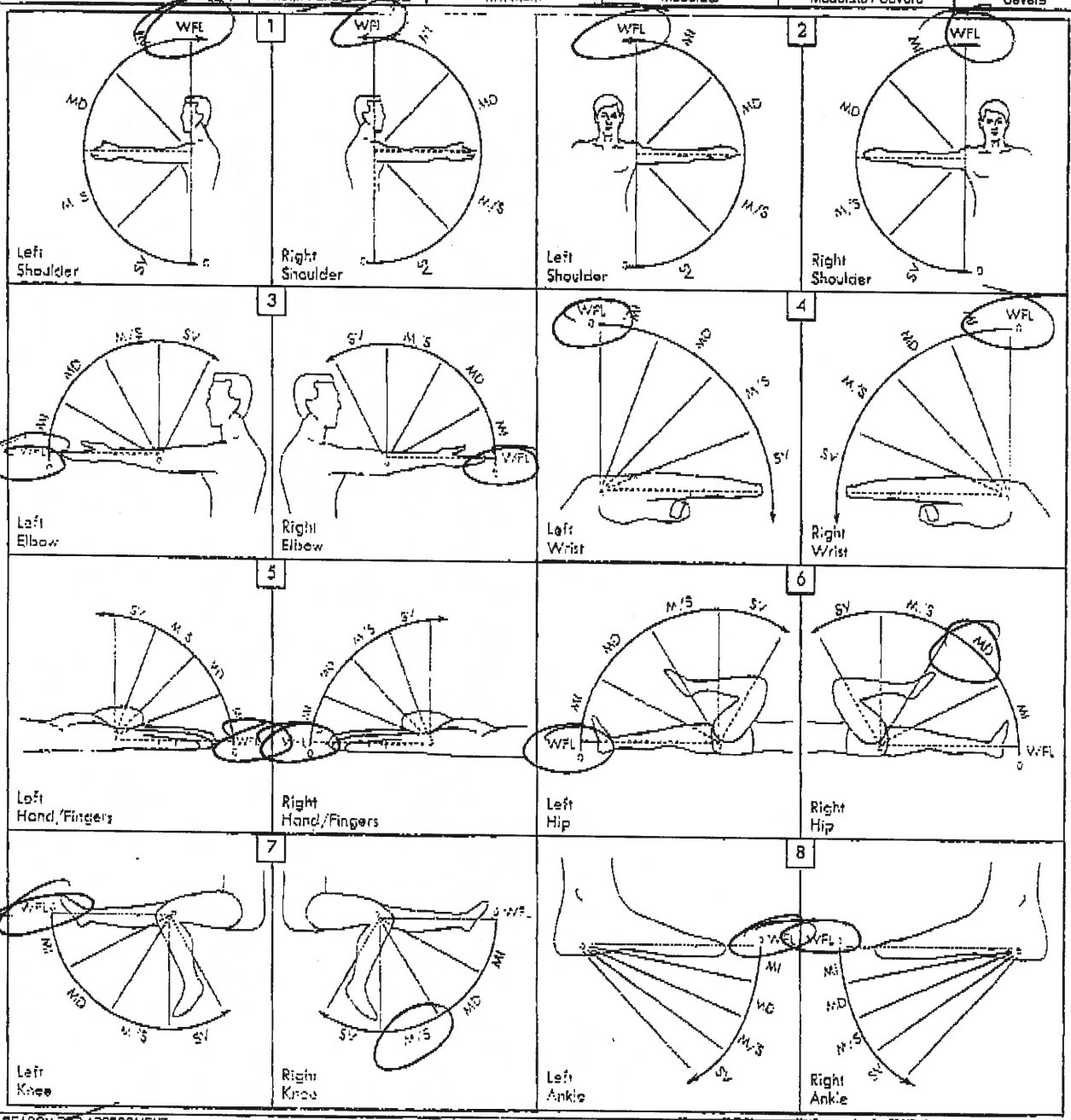
Name Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 1

COPIED Date: COPIED

JOINT MOBILITY ASSESSMENT

Circle joint range which closest represents approximate range. Variance within range is common and may be due to normal aging process.

JOINT MOBILITY LIMITATION KEY	WFL	MI	MD	M/S	SV
Approximate ROM % Available	Near to Normal	76% - 100%	51% - 75%	26% - 50%	0% - 25%
Definition	Within Functional Limits	Minimum	Moderate	Moderate / Severe	Severe



REASON FOR ASSESSMENT:
☐ Initial Assessment ☐ Quarterly Review ☐ Annual Review ☐ Change of Condition ☐ Other:

CURRENT PROGRAM:
☐ RNA ROM ☐ CNA ROM ☐ Splinting ☐ Positioning ☐ Other:

PROGRAM EFFECTIVENESS:
☐ Improved Joint Mobility ☐ Maintained Joint Mobility ☐ Decreased Joint Mobility ☐ Other:

RESIDENT TOLERANCE OF CURRENT PROGRAM:
☐ Good ☐ Fair ☐ Poor ☐ Refuses ☐ Other:

PROBLEM SUMMARY:
☐ Dr. Consultation Indicates Unavoidable Cx Due to Disease Process ☐ Refer to Medical Record ☐ Other:

PROGRAM ADJUSTMENTS:
☐ Refer to Medical Record ☐ Other:

COPIED Date: COPIED

LICENSED SIGNATURE	TITLE	RCP & Rx CONFIRMATION	DATE
	OTR	☐ Yes – Initials:	

RESIDENT LAST NAME:	RESIDENT FIRST NAME:	PHYSICIAN:	ROOM #
Perez	Consuelo		

PT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 R26.81 Unsteadiness on feet		**TREATMENT DX2**	
START OF CARE 02/12/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

DATE			02/14/2016	02/15/2016	02/16/2016	02/17/2016	02/18/2016	02/19/2016	02/20/2016
CPT Codes			Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97110	Therapeutic exercise	QTY		1	2	2			
		MIN		18	30	29			
		MOD							
		MOD							
		INIT		SS	SS	SS			
97112	Neuromuscular re-ed	QTY		1	1	1			
		MIN		11	12	12			
		MOD							
		MOD							
		INIT		SS	SS	SS			
97116	Gait training	QTY		1	1	1			
		MIN		17	17	17			
		MOD		-59	-59	-59			
		MOD							
		INIT		SS	SS	SS			
97530	Therapeutic activities	QTY		1	1	1			
		MIN		14	16	17			
		MOD							
		MOD							
		INIT		SS	SS	SS			
CONCURRENT MIN.									
CO-TREATMENT MIN.									
COUNTER INITIALS									
TOTAL MIN.				60	75	75			

Date: 02/15/2016

97110 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Completed B LE strengthening exercises with 2# wts to increase LE strength to improve functional activities.

97112 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Establishment of base of support in order to improve stance for transfers and gait.

97116 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Patient ambulated 100 feet x 2 using a FWW with min/CGA assist and cueing for proper AD management, posture, and gait safety/sequencing.

97530 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Patient required min/CGA assist for all functional transfers with cueing for proper safety, sequencing, and hand/foot placement. BP 144/78. Patient knee ROM 9 to 92 degrees.

Date: 02/16/2016

97110 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Completed B LE strengthening exercises with 2# wts to increase LE strength to improve functional activities.

97112 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Establishment of base of support in order to improve stance for transfers and gait.

97116 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Patient ambulated 110 feet x 2 using a FWW with CGA assist and occasional cueing for proper AD management, posture, and gait safety/sequencing. Patient requires increased distances to perform ADL's at home. Patient instructed in step training min/CGA assist with use of FWW to go up/down steps to simulate entrance at home.

97530 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Patient required CGA assist for all functional transfers with occasional cueing for proper safety, sequencing, and hand/foot placement. BP 104/64. Patient knee ROM 8 to 94 degrees.

Date: 02/17/2016

97110 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/17/2016 12:07PM)
Note: Completed B LE strengthening exercises with 2# wts to increase LE strength to improve functional activities.

97112 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/17/2016 12:07PM)
Note: Performed challenging balance outside base of support exercises in order to improve stance for transfers and gait.

97116 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/17/2016 12:07PM)
Note: Patient ambulated 125 feet x 2 using a FWW with CGA/SBA assist and occasional cueing for proper AD management, posture, and gait safety/sequencing. Patient required increased distances to perform ADL's at home. Patient instructed in step training CGA/SBA assist with use of FWW to go up/down steps to simulate entrance at home.

COPIED Date: COPIED

Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Sean Sato, PTA	SS				

PT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 2
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 R26.81 Unsteadiness on feet		**TREATMENT DX2**	
RT OF CARE 02/12/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

Date: 02/17/2016

97530 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/17/2016 12:07PM)

Note: Patient required CGA/SBA assist for all functional transfers with occasional cueing for proper safety, sequencing, and hand/foot placement. BP 123/68. Patient knee ROM 7 to 95 degrees.

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Date:
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Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Sean Sato, PTA	SS				

OT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 M62.81 Muscle weakness (generalized)		**TREATMENT DX2**	
START OF CARE 02/11/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

DATE			02/14/2016	02/15/2016	02/16/2016	02/17/2016	02/18/2016	02/19/2016	02/20/2016
CPT Codes			Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97110	Therapeutic exercise	QTY		1	2	1			
		MIN		22	26	21			
		MOD							
		MOD							
		INIT		KL	MU	KG			
97530	Therapeutic activities	QTY		1	1	2			
		MIN		13	21	28			
		MOD							
		MOD							
		INIT		KL	MU	KG			
97535	Self care training.	QTY		2	2	2			
		MIN		26	28	26			
		MOD		-59	-59	-59			
		MOD							
		INIT		KL	MU	KG			
CONCURRENT MIN.									
CO-TREATMENT MIN.									
COUNTER INITIALS									
TOTAL MIN.				61	75	75			

Date: 02/15/2016

97110 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: Pt completed therex with BUE 3 set x 15 using 2 lbs weight in different planes to increase strength for sit to stand transfers with FWW. Pt able to follow through all exercises. Pt needed rest breaks between sets.

97530 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: Pt completed standing balance activities with self dressing tasks. Pt able to maintain balance and safety with all mobility.

97535 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: g/h: IUB dress: SLB dress: Min Atoileting: Min Atransfers: CGA/Min A

Date: 02/16/2016

97110 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: Pt completed therex with BUE 3 set x 15 using 2 lbs weight in different planes to increase strength and activity tolerance to improve sit to stand during fxl transfers with FWW. Pt able to follow through all exercises.

97530 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: Compensatory strategy instruction for balance deficits to improve fxl stand balance during LB dressing and clothing management during toileting.

97535 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: g/h: IUB dress: SLB dress: Min/SB Atoileting: Min/SBA Atransfers: SBA/Min A

Date: 02/17/2016

97110 **Note Electronically Signed by Therapist:** Karen Ingrid Gamboa, COTA (2584) (02/17/2016 6:41PM)
Note: Patient seen for B UE exercises using 2 lbs dumbbell 2 sets 15 reps to all functional planes as tolerated with rest breaks in order to increase strength, activity tolerance, and ROM necessary for ADL performance.

97530 **Note Electronically Signed by Therapist:** Karen Ingrid Gamboa, COTA (2584) (02/17/2016 6:41PM)
Note: Patient instructed in transfer, dynamic functional standing balance activities, and functional mobility using FWW with emphasis on AD maneuvering/management in narrow spaces, direction changes, problem solving around obstacles, anticipating barriers, and correct hand/foot placement. No LOB noted with occasional verbal cues for safety techniques.

97535 **Note Electronically Signed by Therapist:** Karen Ingrid Gamboa, COTA (2584) (02/17/2016 6:41PM)
Note: Focused on increasing safety practices, EC techniques, and pacing skills:H/G: IUB dressing: Supervision/Set-UpLB dressing: SBAToileting: SBAADL transfers: CGA/SBADiscussed therapy progress and established goals.

COPIED Date: COPIED

Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Karen Ingrid Gamboa, COTA (2584)	KG	Katie Lee, OT (12379)	KL	Melinda Underwood, COTA (696)	MU

OT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 M62.81 Muscle weakness (generalized)		**TREATMENT DX2**	
START OF CARE 02/11/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

DATE			02/14/2016	02/15/2016	02/16/2016	02/17/2016	02/18/2016	02/19/2016	02/20/2016
CPT Codes			Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97110	Therapeutic exercise	QTY		1	2				
		MIN		22	26				
		MOD							
		MOD							
		INIT		KL	MU				
97530	Therapeutic activities	QTY		1	1				
		MIN		13	21				
		MOD							
		MOD							
		INIT		KL	MU				
97535	Self care training.	QTY		2	2				
		MIN		26	28				
		MOD		-59	-59				
		MOD							
		INIT		KL	MU				
CONCURRENT MIN.									
CO-TREATMENT MIN.									
COUNTER INITIALS									
TOTAL MIN.				61	75				

Date: 02/15/2016

97110 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: Pt completed therex with BUE 3 set x 15 using 2 lbs weight in different planes to increase strength for sit to stand transfers with FWW. Pt able to follow through all exercises. Pt needed rest breaks between sets.

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97535 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: g/h: IUB dress: SLB dress: Min Atoileting: Min Atransfers: CGA/Min A

Date: 02/16/2016

97110 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: Pt completed therex with BUE 3 set x 15 using 2 lbs weight in different planes to increase strength and activity tolerance to improve sit to stand during fxl transfers with FWW. Pt able to follow through all exercises.

97530 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: Compensatory strategy instruction for balance deficits to improve fxl stand balance during LB dressing and clothing management during toileting.

97535 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: g/h: IUB dress: SLB dress: Min/SB Atoileting: Min/SBA Atransfers: SBA/Min A

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Date: -
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Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Katie Lee, OT (12379)	KL	Melinda Underwood, COTA (696)	MU		

HISTORY

Transfered from Los Alamitos MC p (R) total knee arthroplasty 2° Progressive OA
Participated in PT today. Currently (R) knee pain
(Include Present Illness, pertinent Past and Family History)

PHYSICAL EXAMINATION

Pain: _____ B.P. 154/82 Temp. 97.1 Pulse 87 Resp. 18 Wt. _____

A. General Appearance: A&Ox3. NAD
B. Skin:
C. Head:
Eyes:
Ears:
Nose:
Throat:
Oral Cavity:
Teeth:
D. Neck and Lymph Glands: supple & JVD & goiter/LAD
E. Thorax:
Breasts:
Lungs: CTA (B) & clear
Heart: RRR
F. Abdomen: (+)BS soft NT/ND & CVA tender
G. Back and Extremities:
H. Pelvis:
Genitalia (External)
Rectal:
I. Neuro-Muscular: (R) knee: Dressing dry (+) edema (+)ecchymosis limited ROM RUE/LUE/LLE FROM, MS 5/5

DIAGNOSIS:

on back →

This resident:

A. ☑ has the capacity to understand and make decisions.
B. ☐ does ***NOT*** have the capacity to understand and make decisions
C. ☐ has fluctuating capacity to understand and make decisions.

Reason: _____
Surrogate Decisionmaker: _____
Relationship: _____

REHABILITATION POTENTIAL: (Include Impression, plans for continuing care, prognosis and goals)

Good

Resident/Responsible Party informed of Medical Condition and Plan of Treatment: Yes ☑ No ☐

If no, state reason why: _____

2/11/16
Date

COPIED Date: COPIED
Physician's Signature

Last Name	First	Middle	Room	Physician	Hosp. No.
PEREZ,	CONSUELO		GA	DR. TRAN	

Form #1510 Rev. 1/15

HISTORY and PHYSICAL

& F/C/cough
& vision Δ
Isolated HA/dizziness which resolved
& CP/SOB
& abd pain
& diarrhea (+) constipation
& melena/hematochezia
& dysuria

PMH
OA of knee
HTN

PSHx
Cholecystectomy
Cesarean Section
(R) knee ∫x x 2
SH: ∅ tob/ETOH/drug, Lives alone

FH:
M. d DM, HTN
B(3) HTN

(R) knee OA s/p TKA

PT. F/u Ortho

HTN: BP ↑. Monitor C
outpt regimen

DVT prophylaxis: ASA

All: PCN

Meds

Norco

ASA

Carvedilol

Clonidine

Furosemide

Pantoprazole

Spironolactone

Diovan

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Date:
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PHYSICIAN'S ORDERS FOR 02/12/2016

EOCBA 02/12/2016 12:10

Order #	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
Order Type: Appointment								
10	02/12/16	02/12/16	APT	Follow up appointment with Dr. Graham on 2/18/16 @ 3 :30 pm @ Irvine Office pick up @ 3 pm -; Dr. Ky Tran				00/00/00
	e-Sign Nurse: e-Sign NPP:			e-Sign Therapist: e-Sign Physician:				
Order Type: Consults								
20	02/12/16	02/12/16	C	DISCONTINUE as of 02/12/2016: Follow up appointment with Dr. Graham on 2/25/16, call office for appointment time -; Dr. Ky Tran				00/00/00
	e-Sign Nurse: e-Sign NPP:			e-Sign Therapist: e-Sign Physician:				

Resuscitate:
Nurse
Physician
Nurse

Date: 2/12/16
Date:
Date:

Physician	UPIN #	Office #	Alternate Physician	UPIN #	Office #
an, Ky	H74389	(562) 430-1235			( ) -

Pager # ( ) - Mobile # ( ) - Fax # (562) 452-8972

E-Mail:

Allergies: Food / Environ.: | Medical: PENICILLINS

Diagnoses:

Name Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 1

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/12/2016

EDAVID 02/12/2016 10:59

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
				Order Type: Therapy				
46	12/16	02/12/16	THER	P.T. QD 6x/wk x4 wks for ther ex, thera act, NMR, gait trg. (Dx: Unsteadiness of feet R26.81) -; Dr. Ky Tran				00/00/00

e-Sign Nurse:
e-Sign NPP:
e-Sign Therapist: Elizabeth David-02/12/2016 10:58 AM
e-Sign Physician:

Resuscitate:

Therapist _____ Date: _____ Physician _____ Date: _____

Date: _____

Physician	UPIN #	Office #	Alternate Physician	UPIN #	Office #
Tran, Ky	H74389	(562) 430-1235			( ) -

Pager # ( ) - Mobile # ( ) - Fax # (562) 452-8972

E-Mail:

Allergies — Food / Environ.: | Medical: PENICILLINS

Diagnoses:

Nam erez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 1

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Date: ____
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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/12/2016

RNAVIDAD 02/12/2016 01:09

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
Order Type: Edema Monitoring								
1[illegible]	/12/16	02/12/16	EDE	Edema Monitoring Site: Rt knee area. Depth of Edema1 = +1 Edema (2mm Indent)2 = +2 Edema (4mm Indent)3 = +3 Edema (6mm Indent)4 = +4 Edema(8mm Indent) 5 = Non-pitting Edema -; Dr. Ky Tran		QSHIFT	QSHFT#	00/00/00
	e-Sign Nurse: Rinna Navidad-02/12/2016 1:09 AM e-Sign NPP:			e-Sign Therapist: e-Sign Physician:				
20	02/12/16	02/12/16	EDE	Capillary Refill 0 = Normal (Capillary Refill return to pink color in less than 3 seconds) 1 = Abnormal (Capillary Refill return to red in less than 3 seconds) -; Dr. Ky Tran		QSHIFT	QSHFT#	00/00/00
	e-Sign Nurse: Rinna Navidad-02/12/2016 1:09 am e-Sign NPP:			e-Sign Therapist: e-Sign Physician:				
30	02/12/16	02/12/16	EDE	Tenderness 0 = Non-tender 1 = Present -; Dr. Ky Tran		QSHIFT	QSHFT#	00/00/00
	e-Sign Nurse: Rinna Navidad-02/12/2016 1:09 am NPP:			e-Sign Therapist: e-Sign Physician:				
4[illegible]	/12/16	02/12/16	EDE	Temperature 0 = Normal to touch 1 = Warm to touch 2 = Hot to touch 3 = Cold to touch -; Dr. Ky Tran		QSHIFT	QSHFT#	00/00/00
	e-Sign Nurse: Rinna Navidad-02/12/2016 1:09 am e-Sign NPP:			e-Sign Therapist: e-Sign Physician:				

rnavi 2/12/16 1099

Resuscitate:

Nurse _____ Date: 2 / 12 / 16

Physician _____ Date: / /

N[illegible] _____ Date: / /

Physician	UPIN #	Office #	Alternate Physician	UPIN #	Office #
Tran, Ky	H74389	(562) 430-1235			( ) -

Pager # ( ) - Mobile # ( ) - Fax # (562) 452-8972

E-Mail:

Allergies — Food / Environ.: | Medical: PENICILLINS

Diagnoses

Na[illegible] erez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 1

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/11/2016 KLEE 02/11/2016 13:59

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
				Order Type: Therapy				
30	11/16	02/11/16	THER	O.T. QD 5x/wk x2 wks for ther ex, ther act, ADL retraining (Dx: Muscle Weakness M62.81) -; Dr. Ky Tran		QD		00/00/00

e-Sign Nurse:
e-Sign NPP:
e-Sign Therapist: Katie Lee-02/11/2016 1:59 pm
e-Sign Physician:

noted Rezendi 2/11/16 2:22pm

Resuscitate:

Therapist _____ Date: _____ Physician _____ Date: _____

Date:

Physician	UPIN #	Office #	Alternate Physician	UPIN #	Office #
Tran, Ky	H74389	(562) 430-1235			( ) -

Pager # ( ) - Mobile # ( ) - Fax # (562) 452-8972

E-Mail:

Allergies — Food / Environ.: | Medical: PENICILLINS

Diagnoses:

Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 1

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/10/2016 JNBLFO 02/10/2016 22:16

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
				Order Type: Ancillary				
120	/10/16	02/10/16	ANC	Right knee immobilizer on at all times when in bed, check for skin intergrity and proper placement -; Dr. Ky Tran		INFO		00/00/00

e-Sign Nurse: Jonabel Olivares-02/10/2016 10:15 pm e-Sign Therapist:
e-Sign Nep: e-Sign Physician:

noted 2/10/16

Resuscitate:
Nurse
Physician
N

Date: 2 / 10 / 16
Date: / /
Date: / /

Physician: Tran, Ky | UPIN #: H74389 | Office #: (562) 430-1235 | Alternate Physician | UPIN # | Office #
Pager # ( ) - | Mobile # ( ) - | Fax # (562) 452-8972
Allergies | Food | Environmental | Medic
Diagnoses

Name: erez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 1

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/10/2016

JNBLFO 02/10/2016 21:29

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
Order Type: Antidepressant								
10	/10/16	02/10/16	ADP	Monitor episodes of Depression M/B verbalization of sadness due to medical condition Q shift and tally by hashmarks -; Dr. Ky Tran		QSHIFT	QSHIFT	00/00/00
20	02/10/16	02/10/16	ADP	Monitor Side Effects of Citalopram (Celexa) Q Shift: Headache, Dizziness, Anorexia (with Paxil), Anxiety, Insomnia, Fatigue, Diarrhea, Nausea, Excessive Sweating -; Depression; Dr. Ky Tran		QSHIFT	QSHIFT	00/00/00
30	02/10/16	02/10/16	ADP	Black Box Warning for Citalopram (Celexa) - All patients started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. There is increased risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder and other psychiatric disorders. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide.-; Dr. Ky Tran		INFO	INFO	00/00/00
40	02/10/16	02/11/16	ADP	Escitalopram 10 mg tablet [generic] < give 1 tab po QD > for Depression m/b verbalization of sadness due to medical condition. Informed consent obtained by Dr. Tran from the patient -; Dr. Ky Tran (NDC:00093585101) BBW	PO	QD	QD	00/00/00
Order Type: Ancillary								
10	02/10/16	02/10/16	ANC	Admit to Rowntree Gardens Elmwood Care Center -; Dr. Ky Tran				00/00/00
20	02/10/16	02/10/16	ANC	Admission Diagnosis: S/P Right TKR, Osteoarthritis Right knee -; Dr. Ky Tran				00/00/00
30	02/10/16	02/10/16	ANC	Allergies: Penicillin -; Dr. Ky Tran				00/00/00

Resuscitate:

Nurse

Physician

Date: 2 / 10 / 16

Date: / /

Date: / /

Physician: Tran, Ky | UPIN # H74389 | Office # (562) 430-1235 | Alternate Physician | UPIN # | Office # ( ) -

Pager # ( ) - | Mobile # ( ) - | Fax # (562) 452-8972

E-Mail:

Allergies: Food / Environ. | Medical

Diagnoses

Name: erez, Consuelo ID # 3551 Rm # 0016A *Primary Dx

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***CONTINUED ON NEXT PAGE >>>

Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/10/2016 JNBLFO 02/10/2016 21:29

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
40	02/10/16	02/10/16	ANC	The generic equivalent may be dispensed unless otherwise specified by the physician. -; Dr. Ky Tran				00/00/00
50	02/10/16	02/10/16	ANC	All orders valid for 45 days unless otherwise specified. -; Dr. Ky Tran				00/00/00
60	02/10/16	02/10/16	ANC	I certify that skilled nursing facility service are required to be given on an inpatient basis because the resident needs required nursing care. -; Dr. Ky Tran				00/00/00
70	02/10/16	02/10/16	ANC	I have reviewed and agree with current plan of care and treatment. -; Dr. Ky Tran				00/00/00
80	02/10/16	02/10/16	ANC	May be up on wheelchair as tolerated. -; Dr. Ky Tran				00/00/00
90	02/10/16	02/10/16	ANC	May participate in activity program not in conflict with treatment plan. -; Dr. Ky Tran				00/00/00
100	02/10/16	02/10/16	ANC	Full weight bearing on right LE -; Dr. Ky Tran				00/00/00
110	02/10/16	02/10/16	ANC	No shower until staples are removed -; Dr. Ky Tran				00/00/00
Order Type: Consults								
10	02/10/16	02/10/16	C	Follow up appointment with Dr. Graham on 2/25/16, call office for appointment time -; Dr. Ky Tran				00/00/00
Order Type: Diet Order								
	02/10/16	02/11/16	D	Regular diet -; Dr. Ky Tran		TID	MEALS	00/00/00
Order Type: Immunizations/Vaccines								
10	02/10/16	02/10/16	IMM	TB Skin Test (Mantoux) 0.1 CC ID, Read in 48 hours and repeat in 14 days if negative, then repeat annually. -; Dr. Ky Tran				00/00/00

Resuscitate:
Nurse
Physician
N

Date: 2 / 10 / 16
Date: / /
Date: / /

Physician: Tran, Ky | UPIN # H74389 | Office # (562) 430-1235 | Alternate Physician | UPIN # | Office #
Pager # ( ) - | Mobile # ( ) - | Fax # (562) 452-8972
E-Mail:

Allergies: Food / Environ. | Medical
Diagnoses

Name: Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 2

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/10/2016

JNBLFO 02/10/2016 21:29

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
Order Type: Medication								
10	10/16	02/11/16	M	Norco 5 mg-325 mg tablet [Hydrocodone-acetaminophen] < give 1 tab po QD > -; S/P right TKR; Dr. Ky Tran (NDC:52544091301) BBW	PO	QD	QD	00/00/00
20	02/10/16	02/11/16	M	Aspirin 325 mg tablet [generic] < give 1 tab po BID, give with food> -; DVT prophylaxis; Dr. Ky Tran	PO	BID	BID	00/00/00
30	02/10/16	02/11/16	M	Carvedilol 25 mg tablet [generic] < give 1 tab po BID, hold if SBP less than 110 or HR less than 60> -; Hypertension; Dr. Ky Tran	PO	BID	BIDBPH	00/00/00
40	02/10/16	02/11/16	M	Clonidine HCl 0.2 mg tablet [generic] < give 1 tab po BID, hold if SBP less than 110 > -; Hypertension; Dr. Ky Tran	PO	BID	BIDBP	00/00/00
50	02/10/16	02/11/16	M	Furosemide 20 mg tablet [generic] < give 1 tab po QD> -; Hypertension; Dr. Ky Tran (NDC:00054429725) BBW	PO	QD	QD	00/00/00
60	02/10/16	02/11/16	M	Pantoprazole 40 mg tablet,delayed release [generic] < give 1 tab po QD ac breakfast > -; GI prophylaxis; Dr. Ky Tran	PO	QD	QDAC	00/00/00
70	02/10/16	02/11/16	M	Spironolactone 25 mg tablet [generic] < give 12.5 mg po BID > -; Hypertension; Dr. Ky Tran (NDC:00228280311) BBW	PO	BID	BID	00/00/00
80	02/10/16	02/11/16	M	Diovan 320 mg tablet [Valsartan] < give 1 tab po QD, hold if SBP less than 110 > -; Hypertension; Dr. Ky Tran (NDC:00078036034) BBW	PO	QD	QDBP	00/00/00

Resuscitate:
Nurse [signature] / [illegible] RN Date: 2 . 10 . 16

Allergies: Food / Environ. | Medical

Diagnoses

Name: Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/10/2016

JNBLFO 02/10/2016 21:29

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
Order Type: Pain								
10	10/16	02/10/16	PAIN	Monitor for pain Q Shift using pain scale of 0 = No pain 1-3 = Mild pain 4-6 = Moderate pain 7-10 = Severe pain -; Dr. Ky Tran		QD	QSHFTP	00/00/00
Order Type: PRN Medications								
10	02/10/16	02/10/16	PRN	Tylenol 325 mg tablet [Acetaminophen] < Give 2 tabs PO Q 4hrs PRN for 1-3/10 Pain, NTE 3 gm/24 hrs > (additional admission order) -; Pain 1-3/10; Dr. Ky Tran	PO	Q4HPRN	PRN	00/00/00
20	02/10/16	02/10/16	PRN	Tylenol 325 mg tablet [Acetaminophen] <Give 2 tabs PO Q 4hrs PRN Temp greater than 100, NTE 3 gm/24 hrs> (additional admission order) -; Temperature greater than 100; Dr. Ky Tran	PO	Q4HPRN	PRN	00/00/00
30	02/10/16	02/10/16	PRN	Milk of Magnesia 400 mg/5 mL oral suspension [Magnesium hydroxide] < Give 30 mL PO QD PRN > (additional admission order) -; Bowel management; Dr. Ky Tran	PO	QDPRN	PRN	00/00/00
40	02/10/16	02/10/16	PRN	Norco 10 mg-325 mg tablet [Hydrocodone-acetaminophen] < give 1 tab po every 6 hrs prn 4-10/10 pain > -; Dr. Ky Tran (NDC:49999001920)	PO	Q6HPRN	PRN	00/00/00
Order Type: Siderails								
	02/10/16	02/10/16	SR	Both 1/2 side rails up to aid in bed mobility. -; Dr. Ky Tran				00/00/00
Order Type: Treatment								
10	02/10/16	02/10/16	T	Dulcolax (bisacodyl) 10 mg rectal suppository < Give 1 rectally QD If no BM for 3 Days > (additional admission order) -; Bowel management; Dr. Ky Tran	R	QDPRN	PRN	00/00/00

e-Sign Nurse: e-Sign NPP: e-Sign Therapist: e-Sign Physician:

DEW

Resuscitate:
Nurse [signature] LVN Date: 2 / 10 / 16
Physician [signature] Date: / /
N Date: / /

Physician	UPIN #	Office #	Alternate Physician	UPIN #	Office #
Tran, Ky	H74389	(562) 430-1235			( ) -

Pager # ( ) - Mobile # ( ) - Fax # (562) 452-8972

E-Mail:

Allergies: Food / Environ. | Medical

Diagnoses

Name: Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 4

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Date:

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Rowntree Gardens

PHYSICIAN'S ORDERS FOR 02/10/2016

JNBLFO 02/10/2016 21:29

Order No.	Order Date	Start Date	Type	Order Text	Rt of Admin	Freq	Time Code	Stop Date
20	02/10/16	02/10/16	T	Fleet Enema 19 gram-7 gram/118 mL < Give 1 rectally if no result from Dulcolax Supp > -; Dr. Ky Tran	R	QDPRN	PRN	00/00/00
30	02/10/16	02/10/16	T	Weekly Skin Check on Thursday -; Dr. Ky Tran		QWK	TX AM	00/00/00
40	02/10/16	02/10/16	T	Ice pack to right knee every 4 hours prn -; Dr. Ky Tran		Q4HPRN	PRN	00/00/00
50	02/10/16	02/11/16	T	Right knee incision site, cleanse with NSS and cover with dry dsg until healed -; Dr. Ky Tran		QD	TX AM	00/00/00
60	02/10/16	02/10/16	T	Staples to right knee incision site to be remove at MD's office -; Dr. Ky Tran		INFO		00/00/00
Order Type: Therapy								
10	02/10/16	02/10/16	THER	Occupational Therapy evaluation and treatment -; Dr. Ky Tran				00/00/00
20	02/10/16	02/10/16	THER	Physical Therapy evaluation and treatment -; Dr. Ky Tran				00/00/00
Order Type: Weight								
10	02/10/16	02/10/16	WT	Monitor weekly weights x4 then monthly -; Dr. Ky Tran		INFO	INFO	00/00/00

Resuscitate:
Nurse
Physician
Nurse

Date: 2 / 10 / 16
Date: / /
Date: / /

Physician: Tran, Ky | UPIN # H74389 | Office # (562) 430-1235 | Alternate Physician | UPIN # | Office # ( ) -

Pager # ( ) - | Mobile # ( ) - | Fax # (562) 452-8972

E-Mail:

Allergies: Food / Environ. | Medical

Diagnoses

Name: Perez, Consuelo ID # 3551 Rm # 0016A *Primary Dx Page 5

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Date: ____

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- ☐ PERRY R. SECOR, M.D. — CSL G48048 — DEA AS1790535
- ☐ CHRISTOPHER J. WOODSON, M.D. — CSL A80613 — DEA BW8078873
- ☑ GRIETJE VAN DYK, M.D. — CSL G61231 — DEA BV4004975
- ☑ STEPHEN P. GRAHAM, M.D. — CSL G43382 — DEA AG9686527
- ☐ PAUL J. CASEY, M.D. — CSL G61380 — DEA BC4575025
- ☐ ANDREW J. WASSEF, M.D. — CSL A120617 — DEA FW3157042

3851 Katella Avenue, Suite 150 • Los Alamitos, CA 90720
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℞ NAME Consuelo Perez DOB 3-15-52

ADDRESS _____ DATE 2-10-16

PHONE _____ ☐ M ☐ F

1) Norco 10/325 #60
Sig: 1 q 6 hrs PRN pain

Quantity: ☐ 1-24 ☐ 25-49 ☑ 50-74 ☐ 75-100 ☐ 101-150 ☐ 151 and Over
☑ 60 Units Refills 0-1-2-3-4-5
☐ Do not Substitute Initial SPG

2)

Quantity: ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 151 and Over
☐ _____ Units Refills 0-1-2-3-4-5
☐ Do not Substitute Initial _____

3)

Quantity: ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 151 and Over
☐ _____ Units Refills 0-1-2-3-4-5
☐ Do not Substitute Initial _____

Prescription is void if number of drugs is not noted ____ ☑ 1 ☐ 2 ☐ 3

SP 163

S Graham MD, M.D.

Prescription is void if number of drugs prescribed is not noted.

COPIED Date: ____ COPIED

Physical Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
PEREZ	Consuelo			
PROVIDER NAME			**PROVIDER NO.**	**MRN NO.**
Rowntree Gardens				
PHYSICIAN Ky Tran (1053313270)			**PAYOR** HMO/MCO	
MEDICAL DIAGNOSIS 1	**ONSET**		**MEDICAL DIAGNOSIS 2**	**ONSET**
Z96.651 Presence of right artificial knee joint	02/08/2016			
TREATMENT DIAGNOSIS				
R26.81 Unsteadiness on feet (02/12/2016)				
START OF CARE 02/12/2016			**END OF CARE**	

Qualifying Hospital Stay: From Date: 02/08/2016 To Date: 02/10/2016 ☐ NA

Reason For Referral:
weakness with decline in mobility

Therapy Necessity:
Therapy necessary for progressive strengthening and mobility training. Without therapy patient at risk for further decline in mobility.

Medical History Related to Diagnosis/Condition:
Patient admitted for R TKR for work related injury which occurred 3/10/13. She was found to have evidence for a significant osteochondral defect, medial femoral condyle and was treated with arthroscopic surgery. She underwent more surgeries 6/17/13 and 5/3/15. X-ray: progressive narrowing of the joint space with progressive OA of the R knee which did not respond to conservative treatments. PMH: knee surgery x 2, cholecystectomy, appendectomy, C-section, HTN under control with meds

Medications:
per MAR

Environmental Factors / Social Support:
Patient lived alone at home prior to admission and will have assist from fiend as needed.

Prior Residence and Living Arrangement:
Patient lived in a condo with roommates and ambulating independently with FWW. Pt was still working full time and driving.

Previous Therapy:
Patient received Physical Therapy during the recent inpatient hospitalization.

Precautions:
R L FWB, R knee immobilizer in bed,

Discharge Plans:
Discharge to home with patient continuing therapy with Home Health.

Initial Assessment

Functional Deficits	Prior Level	Current Level
Bed Mobility, Rolling side to side	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Bed Mobility, Supine-sit	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Transfers, Bed/Chair	modified independence (assistive device or extra time needed)	minimal assistance (1-25% assist)
Transfers, Sit-stand	modified independence (assistive device or extra time needed)	minimal assistance (1-25% assist)
Balance, Static Sitting	G+ static (able to maintain balance against moderate/maximal resistance)	G static (able to maintain balance against moderate resistance)
Balance, Dynamic Sitting	G+ dynamic (able to maintain balance against moderate/maximal resistance and able to weight shift and cross midline mod/full)	G dynamic (able to maintain balance against moderate resistance and abale to weight shift and cross midline mod)
Balance, Static Standing	G static (able to maintain balance without handhold support, limited postural sway)	F static (able to maintain balance with handhold support; may require occasional min assist)
Balance, Dynamic Standing	G dynamic (accepts moderate challenge; able to maintain balance while picking object off floor.)	F dynamic (accepts minimal challenge; able to maintain balance while turning head and trunk)
Gait, Weight Bearing Status - RLE	full weight bearing	full weight bearing
Gait, Distance	300 feet or more	75 feet
Gait, Assistive Device	front wheeled walker	front wheeled walker
Gait, Level Surfaces	modified independence (assistive device or extra time needed)	minimal assistance (1-25% assist)

COPIED Date: COPIED

Physical Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
PEREZ	Consuelo			
PROVIDER NAME			**PROVIDER NO.**	**MRN NO.**
Rowntree Gardens				
PHYSICIAN Ky Tran (1053313270)			**PAYOR** HMO/MCO	

MEDICAL DIAGNOSIS 1	ONSET	MEDICAL DIAGNOSIS 2	ONSET
Z96.651 Presence of right artificial knee joint	02/08/2016		

TREATMENT DIAGNOSIS
R26.81 Unsteadiness on feet (02/12/2016)

START OF CARE 02/12/2016 **END OF CARE**

Underlying Impairments

Cognition, Orientation
person, facility, nursing/family, and time (x4)

Cognition, Safety Awareness
intact

Strength, Strength Right LE
3/5

Strength, Strength Left LE
4+/5

Range of Motion, Right LE
completes up to 75% of normal range

Range of Motion, Left LE
WFL

Range of Motion, Specific Measurements
See Narrative Box

Underlying Impairments Other
-R knee at 10-80 degrees flexion

Short Term Goal (s) Current Level of Function	Goal	Goal Date
The patient is able to safely transition from supine <> sitting position requiring minimal assist/moderate assistance .	The patient will safely transition from supine <> sitting position increasing to stand by assist/contact guard assist .	02/26/2016
The patient ambulates 75 feet x 2 with FWW requiring minimal assistance (1-25% assist) with verbal instructions for safety.	The patient will progress during gait training to 200 feet and on a variety of surfaces requiring stand by assist/contact guard assist with front wheeled walker in order to increase level of independence .	02/26/2016
The patient demonstrates PROM of right knee from 10 to 80 degrees.	The patient will increase right knee ROM to 5 to 90 degrees.	02/26/2016
The patient is able to safely complete all functional transfers requiring minimal assistanct (routinely requires 25% assistance to transfer.) .	The patient will safely perform all functional transfers increasing to CGA/SBA .	02/26/2016

Long Term Goal(s)	Goal Date
The patient will complete bed mobility with modified independence (assistive device or extra time needed) , functional transfers with modified independence (requires no physical assistance or verbal cues to transfer. Patient may require external support or the use of an assistive device, or require more than a reasonable amount of time to complete the task.) and ambulation x 300 feet with front wheeled walker with modified independence (assistive device or extra time needed) .	03/10/2016
The patient will achieve R knee ROM and strength WFL in order to improve functional mobility.	03/10/2016

Rehab Potential: Good **due to:** Demonstrated higher functional level compared to current condition.

Informed Consent: Treatment plan, including benefits, risk and alternatives discussed with patient and/or family, who agree to treatment.

Requires skilled services to focus on:

97001 - PT Evaluation
97110 - Therapeutic exercise
97112 - Neuromuscular re-ed
97116 - Gait training
97530 - Therapeutic activities

Frequency/Duration: 6 times a week for 4 weeks

Electronically Signed by Therapist: ElizabethM David, PT (24191) **Date:** 02/12/2016 8:36AM

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE **Certification:**

Physician Name: Ky Tran (1053313270) ☑ Signature Required **From 02/[redacted] To 03/12/2016**

Physician Signature: [redacted] **Date:**

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Date:
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PT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 R26.81 Unsteadiness on feet		**TREATMENT DX2**	
START OF CARE 02/12/2016	**END OF CARE**	**NED DX ONSET 1** 02/08/2016	

DATE			02/14/2016	02/15/2016	02/16/2016	02/17/2016	02/18/2016	02/19/2016	02/20/2016
CPT Codes			Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97110	Therapeutic exercise	QTY		1	2				
		MIN		18	30				
		MOD							
		MOD							
		INIT		SS	SS				
97112	Neuromuscular re-ed	QTY		1	1				
		MIN		11	12				
		MOD							
		MOD							
		INIT		SS	SS				
97116	Gait training	QTY		1	1				
		MIN		17	17				
		MOD		-59	-59				
		MOD							
		INIT		SS	SS				
97530	Therapeutic activities	QTY		1	1				
		MIN		14	16				
		MOD							
		MOD							
		INIT		SS	SS				
CONCURRENT MIN.									
CO-TREATMENT MIN.									
COUNTER INITIALS									
TOTAL MIN.				60	75				

Date: 02/15/2016

97110 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Completed B LE strengthening exercises with 2# wts to increase LE strength to improve functional activities.

97112 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Establishment of base of support in order to improve stance for transfers and gait.

97116 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Patient ambulated 100 feet x 2 using a FWW with min/CGA assist and cueing for proper AD management, posture, and gait safety/sequencing.

97530 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/15/2016 4:04PM)
Note: Patient required min/CGA assist for all functional transfers with cueing for proper safety, sequencing, and hand/foot placement. BP 144/78. Patient knee ROM 9 to 92 degrees.

Date: 02/16/2016

97110 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Completed B LE strengthening exercises with 2# wts to increase LE strength to improve functional activities.

97112 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Establishment of base of support in order to improve stance for transfers and gait.

Note: Patient ambulated 110 feet x 2 using a FWW with CGA assist and occasional cueing for proper AD management, posture, and gait safety/sequencing. Patient requires increased distances to perform ADL's at home. Patient instructed in step training min/CGA assist with use of FWW to go up/down steps to simulate entrance at home.

97530 **Note Electronically Signed by Therapist:** Sean Sato, PTA (02/16/2016 3:26PM)
Note: Patient required CGA assist for all functional transfers with occasional cueing for proper safety, sequencing, and hand/foot placement. BP 104/64. Patient knee ROM 8 to 94 degrees.

Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Sean Sato, PTA	SS				

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PT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 R26.81 Unsteadiness on feet		**TREATMENT DX2**	
START OF CARE 02/12/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

DATE			02/07/2016	02/08/2016	02/09/2016	02/10/2016	02/11/2016	02/12/2016	02/13/2016
CPT Codes			Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97001	PT Evaluation	QTY						1	
		MIN						15	
		MOD							
		MOD							
		INIT							
97110	Therapeutic exercise	QTY						ED	
		MIN						2	2
		MOD						26	25
		MOD							
		INIT							
97112	Neuromuscular re-ed	QTY						ED	RP
		MIN						1	1
		MOD						13	18
		MOD							
		INIT							
97116	Gait training	QTY						ED	RP
		MIN						1	1
		MOD						17	21
		MOD						-59	-59
		INIT							
97530	Therapeutic activitie s	QTY						ED	RP
		MIN						1	1
		MOD						19	11
		MOD							
		INIT							
CONCURRENT MIN.								ED	RP
CO-TREATMENT MIN.									
COUNTER INITIALS									
TOTAL MIN.								**90**	**75**

Date: 02/12/2016

97001 **Note Electronically Signed by Therapist:** ElizabethM David, PT (24191) (02/12/2016 10:56AM)
Note: PT evaluation completed. Plan of care developed and skilled treatment recommended for progressive strengthening and mobility training.

97110 **Note Electronically Signed by Therapist:** ElizabethM David, PT (24191) (02/12/2016 10:56AM)
Note: Pt. received sustained or prolonged stretch to improve ROM and decrease potential for contracture. R knee at 10-80 degrees.

97112 **Note Electronically Signed by Therapist:** ElizabethM David, PT (24191) (02/12/2016 10:56AM)
Note: Establishment of base of support in order to improve stance for transfers and gait.

97116 **Note Electronically Signed by Therapist:** ElizabethM David, PT (24191) (02/12/2016 10:56AM)
Note: Patient ambulated 75 feet x 2 using a FWW with min assist. Facilitation of R knee flexion and to increase B step length for step through gait pattern.

97530 **Note Electronically Signed by Therapist:** ElizabethM David, PT (24191) (02/12/2016 10:56AM)
Note: Facilitation of optimal positioning for improved performance in bed mobility and transfers. Patient required minA for all functional transfers.

Date: 02/13/2016

97110 **Note Electronically Signed by Therapist:** Rhea Pineda, PT (33901) (02/13/2016 1:18PM)
Note: Completed B LE thera ex using 2lbs weights to B and 1.5 lbs weights to R 10 reps 2 sets in sitting and standing and nustep activities for 15 mins to strngthen B LE

97112 **Note Electronically Signed by Therapist:** Rhea Pineda, PT (33901) (02/13/2016 1:18PM)
Note: Dynamic standing balance activities using FWW were performed to improve functional mobility

97116 **Note Electronically Signed by Therapist:** Rhea Pineda, PT (33901) (02/13/2016 1:18PM)
Note: Gait trng with FWW 100 feet x 1 75 feet x 1 Min/CGA with cuing for safety

97530 **Note Electronically Signed by Therapist:** Rhea Pineda, PT (33901) (02/13/2016 1:18PM)
Note: Require Min/CGA with bed mobility and transfers with the use of FWW. Patient is pre-medicated for pain prior to tx

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Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	
ElizabethM David, PT (24191)	ED	Rhea Pineda, PT (33901)	RP		

Occupational Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
PEREZ	Consuelo			
PROVIDER NAME			**PROVIDER NO.**	**MRN NO.**
Rowntree Gardens				
PHYSICIAN Ky Tran (1053313270)			**PAYOR** HMO/MCO	
MEDICAL DIAGNOSIS 1	**ONSET**		**MEDICAL DIAGNOSIS 2**	**ONSET**
Z96.651 Presence of right artificial knee joint	02/08/2016			
TREATMENT DIAGNOSIS				
M62.81 Muscle weakness (generalized) (02/11/2016)				
START OF CARE 02/11/2016			**END OF CARE**	

Qualifying Hospital Stay: From Date: 02/08/2016 To Date: 02/10/2016 ☐ NA

Reason For Referral:

This 63 year old female presents to therapy with a decline in ADLs due to R knee replacement. Patient has noticed a decrease in self care/ADL ability, resulting in decreased safety and an increased need for assistance. Patient requires skilled therapy in order to improve safety and function.

Therapy Necessity:

Physician and therapist evaluation and assessment of this resident/patient verify that, due tot he significant declines in function resulting from complications/conditions which recently occurred/exacerbated, spontaneous recovery of their condition is not possible without skilled intervention to achieve stated goals

Medical History Related to Diagnosis/Condition:

63 year old female admitted for right knee replacement. Pt had a work related injury 3/10/13 and found to have significant osteochondral defect, medial femoral condyle. She was treated with a arthroscopic surgery (6/17/13 and 5/3/15), however condition deteriorated. Pt started to show progressive narrowing of joint space with osteoarthritis of R knee. Pmhx: HTN

Medications:

see MAR for details

Environmental Factors / Social Support:

d/c back to condo

Prior Residence and Living Arrangement:

Patient lived in a condo with roommates and was independent in self care and household activities. Pt was still working full time.

Previous Therapy:

Patient has not received OT for this same condition the past year.

Precautions:

immobilizer on at all times when in bed

Discharge Plans:

Discharge home with friend support

Initial Assessment

Functional Deficits	Prior Level	Current Level
ADL Self Care, Toileting	Independence (0% assist, no assistive device or extra time needed)	moderate assistance (26-75% assist)
ADL Self Care, Self Feeding	Independence (0% assist, no assistive device or extra time needed)	set-up (assist for device retrieval or modification of environment)
ADL Self Care, Hygiene	Independence (0% assist, no assistive device or extra time needed)	moderate assistance (26-75% assist)
ADL Self Care, Upper Body Dressing	Independence (0% assist, no assistive device or extra time needed)	contact guard assist (contact with patient due to unsteadiness)
ADL Self Care, Lower Body Dressing	Independence (0% assist, no assistive device or extra time needed)	moderate assistance (26-75% assist)
ADL Self Care, Grooming	Independence (0% assist, no assistive device or extra time needed)	set-up (assist for device retrieval or modification of environment)
Bed Mobility, Rolling	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Bed Mobility, Bridging	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Bed Mobility, Supine/Sit	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Bed Mobility, Sit/Stand	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Balance, Dynamic Sitting	G+ dynamic (able to maintain balance against moderate/maximal resistance and able to weight shift and cross midline mod/full)	F dynamic (able to maintain balance without balance loss or UE support and min weight shift ipsilaterally/front, difficulty crossing midline without balance loss)
Balance, Static Sitting	G+ static (able to maintain balance against moderate/maximal resistance)	F static (able to maintain balance without balance loss or UE support)
Balance, Dynamic Standing	G+ dynamic (accepts maximal challenge; able to maintain balance while picking object off floor)	F dynamic (accepts minimal challenge; able to maintain balance while turning head and trunk)
Balance, Static Standing	G+ static (able to maintain balance without handhold support, sporadic postural sway)	F static (able to maintain balance with handhold support; may require occasional min assist)
Funct Transfers, Shower/Tub	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Funct Transfers, Wheelchair/Bed	Independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)

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Occupational Therapy Plan Of Care

PATIENT LAST NAME	FIRST NAME	MI	DATE OF BIRTH	HIC NO.
PEREZ	Consuelo			
PROVIDER NAME			**PROVIDER NO.**	**MRN NO.**
Rowntree Gardens				
PHYSICIAN Ky Tran (1053313270)			**PAYOR** HMO/MCO	
MEDICAL DIAGNOSIS 1	**ONSET**		**MEDICAL DIAGNOSIS 2**	**ONSET**
Z96.651 Presence of right artificial knee joint	02/08/2016			
TREATMENT DIAGNOSIS				
M62.81 Muscle weakness (generalized) (02/11/2016)				
START OF CARE 02/11/2016			**END OF CARE**	

Functional Deficits	Prior Level	Current Level
Funct Transfers, Toilet	independence (0% assist, no assistive device or extra time needed)	minimal assistance (1-25% assist)
Upper Extremity Strength, Right UE	5/5 normal (full ROM against maximum resistance and gravity)	3+/5 fair plus (full ROM against gravity and takes minimal resistance but then breaks suddenly)
Upper Extremity Strength, Left UE	5/5 normal (full ROM against maximum resistance and gravity)	3+/5 fair plus (full ROM against gravity and takes minimal resistance but then breaks suddenly)
Cognition, Standardized Cognition Test	6.0 (Normal Cognitive processing or no cognitive decline)	6.0 (Normal Cognitive processing or no cognitive decline)

Standardized Tests

barthel

Short Term Goal (s) / Current Level of Function	Goal	Goal Date
The patient is able to safely don/doff lower body clothing articles using walker with F dynamic (able to maintain balance without balance loss or UE suport and min weight shift ipsilaterally/front, difficulty crossing midline without balance loss) balance requiring moderate assistance (26-75% assist) while standing .	The patient will utilize walker to safely don/doff lower body clothing articles increasing to minimal assistance (1-25% assist) with F dynamic (able to maintain balance without balance loss or UE suport and min weight shift ipsilaterally/front, difficulty crossing midline without balance loss) balance while standing .	02/25/2016
The patient is able to safely don/doff upper body clothing using no assistive device with F dynamic (able to maintain balance without balance loss or UE suport and min weight shift ipsilaterally/front, difficulty crossing midline without balance loss) balance requiring stand by assistance (close enough to reach patient if assist needed) while sitting .	The patient will utilize no assistive device with G-/F+ static (able to maintain balance against minimal resistance) balance to safely don/doff upper body clothing increasing to supervision (needs verbal cueing but no physical assist) while sitting .	02/25/2016
The patient is able to safely perform all toileting tasks utilizing grab bars requiring moderate assistance (26-75% assist) .	The patient will safely perform all toileting tasks utilizing grab bars increasing to minimal assistance (1-25% assist) .	02/25/2016

Long Term Goal(s)	Goal Date
The patient will be S in all aspects of self-cares and ADL activities within the home in order to return home alone safely.	02/24/2016
The patient will complete all functional transfers safely with supervision (needs verbal cueing but no physical assist) .	02/24/2016

Rehab Potential: Excellent **due to:** Able to imitate. Able to follow routines. Motivated to return to PLOF. Strong social support at home. Stable medical condition.

Informed Consent: Treatment plan, including benefits, risk and alternatives discussed with patient and/or family, who agree to treatment.

Requires skilled services to focus on:

97003 - OT Evaluation
97110 - Therapeutic exercise
97530 - Therapeutic activities
97535 - Self care training.

Frequency/Duration: 5 times a week for 2 weeks

Electronically Signed by Therapist: Katie Lee, OT (12379) **Date:** 02/11/2016 12:46PM

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE

Physician Name: Ky Tran (1053313270) ☑ Signature Required **Certification:** **From 02/11/2016 To 03/11/2016**

Physician Signature: **Date:**

COPIED Date: COPIED

OT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
TREATMENT DX1 M62.81 Muscle weakness (generalized)		**TREATMENT DX2**	
START OF CARE 02/11/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

DATE			02/14/2016	02/15/2016	02/16/2016	02/17/2016	02/18/2016	02/19/2016	02/20/2016
CPT Codes			Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97110	Therapeutic exercise	QTY		1	2				
		MIN		22	26				
		MOD							
		MOD							
		INIT		KL	MU				
97530	Therapeutic activities	QTY		1	1				
		MIN		13	21				
		MOD							
		MOD							
		INIT		KL	MU				
97535	Self care training.	QTY		2	2				
		MIN		26	28				
		MOD		-59	-59				
		MOD							
		INIT		KL	MU				
CONCURRENT MIN.									
CO-TREATMENT MIN.									
COUNTER INITIALS									
TOTAL MIN.				61	75				

Date: 02/15/2016

97110 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: Pt completed therex with BUE 3 set x 15 using 2 lbs weight in different planes to increase strength for sit to stand transfers with FWW. Pt able to follow through all exercises. Pt needed rest breaks between sets.

97530 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: Pt completed standing balance activities with self dressing tasks. Pt able to maintain balance and safety with all mobility.

97535 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/15/2016 1:12PM)
Note: g/h: IUB dress: SLB dress: Min Atoileting: Min Atransfers: CGA/Min A

Date: 02/16/2016

97110 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: Pt completed therex with BUE 3 set x 15 using 2 lbs weight in different planes to increase strength and activity tolerance to improve sit to stand during fxl transfers with FWW. Pt able to follow through all exercises.

97530 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: Compensatory strategy instruction for balance deficits to improve fxl stand balance during LB dressing and clothing management during toileting.

97535 **Note Electronically Signed by Therapist:** Melinda Underwood, COTA (696) (02/16/2016 1:05PM)
Note: g/h: IUB dress: SLB dress: Min/SB Atoileting: Min/SBA Atransfers: SBA/Min A

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Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Katie Lee, OT (12379)	KL	Melinda Underwood, COTA (696)	MU		

OT DAILY TREATMENT NOTE

4000 - Rowntree Gardens

PATIENT Consuelo Perez	**ID**	**PAYOR** HMO/MCO	**PAGE** 1
PHYSICIAN Tran, Ky	**MED DX1** Z96.651 Presence of right artificial knee joint		**February 2016**
EATMENT DX1 M62.81 Muscle weakness (generalized)		**TREATMENT DX2**	
START OF CARE 02/11/2016	**END OF CARE**	**MED DX ONSET 1** 02/08/2016	

DATE		02/07/2016	02/08/2016	02/09/2016	02/10/2016	02/11/2016	02/12/2016	02/13/2016
CPT Codes		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97003 OT Evaluation	QTY					1		
	MIN					15		
	MOD							
	MOD							
	INIT							
97110 Therapeutic exercise	QTY					KL		
	MIN					1	2	
	MOD					16	27	
	MOD							
	INIT							
97530 Therapeutic activitie s	QTY					KL	CM	
	MIN					2	1	
	MOD					26	24	
	MOD							
	INIT							
97535 Self care training.	QTY					KL	CM	
	MIN					1	2	
	MOD					18	24	
	MOD					-59	-59	
	INIT							
CONCURRENT MIN.						KL	CM	
CO-TREATMENT MIN.								
COUNTER INITIALS								
TOTAL MIN.						75	75	

Date: 02/11/2016

97003 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/11/2016 12:49PM)
Note: OT evaluation completed. Plan of care developed and skilled treatment recommended for increase in function with ADL's and transfers.

97110 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/11/2016 12:49PM)
Note: see eval for details

97530 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/11/2016 12:49PM)
Note: see eval for details

97535 **Note Electronically Signed by Therapist:** Katie Lee, OT (12379) (02/11/2016 12:49PM)
Note: g/h: SUB dress: CGALB dress: Mod Atoileting: Mod Atransfers: Min A

Date: 02/12/2016

97110 **Note Electronically Signed by Therapist:** Crystal Morrison, COTA (1561) (02/12/2016 3:30PM)
Note: Pt. Performed progressive BUE therapeutic exercises with 2lb weights in all available planes of motion for 3 sets of 10 to develop strength, activity tolerance, ROM and flexibility. Pt also used arm ergometer x 10 minutes to improve shoulder joint mobility and endurance. Tolerated tx well with rest breaks. VS: BP: 150/88 HR 72

97530 **Note Electronically Signed by Therapist:** Crystal Morrison, COTA (1561) (02/12/2016 3:30PM)
Note: Pt seen for functional transfer training with instruction provided for proper hand placement to improve safety and independence.

35 **Note Electronically Signed by Therapist:** Crystal Morrison, COTA (1561) (02/12/2016 3:30PM)
Note: g/h: S UB dress: CGA LB dress: Mod A toileting: Mod A transfers: Min A with fww ADL retraining with emphasis on instruction for use of dressing stick, sock aid and reacher to improve lb dressing.

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Date: ____

Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials	Rehab Personnel Electronic Signature	Initials
Crystal Morrison, COTA (1561)	CM	Katie Lee, OT (12379)	KL		

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Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016

Operative Report

SURGEON: Stephen P. Graham, M.D.
ASSISTANT: Michelle Shin, PA, student
ANESTHESIOLOGIST: Dr. Zhang.

DATE OF SURGERY: 2/8/2016

PREOPERATIVE DIAGNOSIS: Progressive osteoarthritis, right knee.

POSTOPERATIVE DIAGNOSIS: Progressive osteoarthritis, right knee.

PROCEDURE PERFORMED: Right total knee arthroplasty.

ANESTHESIA: Spinal with sedation.

FINDINGS: osteochondral defect med femoral condyle and OA medial and patellofemoral

ESTIMATED BLOOD LOSS: Tourniquet.

TOURNIQUET PRESSURE: 300 mm for 81 minutes.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and induced under spinal anesthetic. She was positioned supine. A Foley catheter was inserted. She was given a test dose of Ancef and had no problems and a full-dose Ancef was given intravenously for an antibiotic effect. A tourniquet was applied to the proximal aspect of the right leg. The right leg was then prepped and draped sterilely. The leg was exsanguinated with an Esmarch bandage and the tourniquet inflated to 300 mm of pressure. An anterior incision made over the knee joint, carried down through subcutaneous tissue and medial capsule incision was made into the knee joint. There was noted be significant deformity in the medial femoral condyle and osteophytes on the periphery of the patella. Portions of the menisci were removed as well as the fat pad. The patella was flipped over. The knee was hyperflexed. Further menisci was removed laterally as well as the ACL and tissue from the intercondylar area. A drill was used to make a hole in the intracondylar area and intramedullary guide was then inserted, referencing off the posterior condyles. It measured at slightly greater than a size 4. It was elected to go with a size 4. The anterior femoral cut was made off this guide. The distal cutting guide was then attached to this at a plus 0 position and distal cut was made at a 5-degree valgus angle. The size 4 cutting guide was then applied to the cut surfaces and the posterior condylar, posterior bevel, anterior and anterior bevel cuts were then made. The finishing guide was impacted into place and the intercondylar area was then reamed out. Bony debris was removed. Remnants of the PCL were then removed and the tibia was able to be translated anteriorly using a posterior retractor. The external tibial cutting guide was attached. The guide was referenced off the lateral

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Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016

Operative Report

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tibial plateau at a 9-mm level. This was pinned into place and the tibial cut was then made. The tibial surface was smoothed and measured size 3. The size 3 trial was placed on the cut surface and the centering hole was punched down with the impactor. A size 3 trial was then placed on the tibial surface. The size 4 trial at femoral surface and then a reduction was performed with 9-mm and 11-mm spacers. The 11-mm spacer allowed for more stability and still allowed for complete extension. The position of tibial tray was then marked on the front of the tibia. The patellar surface was then prepared. It was elected to use an inset biconvex patellar button 23 mm. A guide was placed directly over the patella centering off the median raphe. It was drilled down to a depth of 10.5 mm. The trial button was inserted and reduction was performed and the patella tracked nicely within the trial component. The trial components were removed except for the tibial tray, which was left in place until the keel cut could be made. This was then removed. The bone was then debrided with the irrigator aspirator. At the same time methyl methacrylate was then mixed on the back table. The methacrylate was then applied to the cut surface of the tibia and the tibial component, which was impacted into place. Excess cement was removed. Cement was then applied to the cut surface of the femur and the femoral component, which was impacted into place. Excess cement was removed. Cement was then applied to the inside part of the patella and patellar button compressed into place. Knee was brought out into full extension to compress the components together after the cement hardened. Protruding areas of cement on the rim were then removed using an osteotome. Once again, the trial was performed with an 11-mm spacer, which appeared to be the appropriate size. The final spacer was then inserted without difficulty and final reduction was performed. Full extension was obtained as well as flexion easily to 110 degrees without any instability. The tourniquet was released. Minor bleeding points were cauterized. There was no major bleeding encountered. It was elected not to insert a drain. The joint was thoroughly irrigated with irrigator aspirator and then closed. The capsule was reapproximated with interrupted sutures of #1 Vicryl using a figure-of-eight from the distal two-thirds and simple sutures to the proximal one-third, subcutaneous tissue was closed with interrupted sutures of 2-0 Vicryl and skin was closed with skin staples. Sterile dressings were applied using Xeroform, 4 x 4s, ABD, Sof-Rol and bias-cut stockinette. The patient was awakened. She tolerated the procedure well, was sent to the recovery room in satisfactory condition. It is planned that she will have a femoral nerve block in recovery room. It was also noted that she was given tranexamic acid before tourniquet went up for control of bleeding.

As an addendum, the components used are Smith-Nephew Genesis II posterior stabilized knee, size 4 femoral component cemented, size 3 tibial tray cemented, 11-mm spacer and 23 mm inset biconvex patellar button.

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Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016

Operative Report

STEPHEN P. GRAHAM, MD

cc: Michelle Shin

TR:SPG/IN
DD:02/08/2016 10:09 PST
DT:02/08/2016 10:57 PST
Dictation ID: 17821409/Confirmation #: 8506871

Work Type: Operative Report
T001

Work Type Code: OPT

Authenticated and Edited by STEPHEN GRAHAM, M.D. On 2/08/16 2:22:36 PM Central T
PRINTED BY: VeronicaQuijano
DATE: 03/01/2016

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016
DIS: 02/10/2016

Discharge Summary

HISTORY OF PRESENT ILLNESS: Consuelo Perez was a 63-year-old female admitted for right knee replacement. Patient has been followed by me for work-related injury in the past 2-3 years. She initially was found to have an osteochondral defect, medial femoral condyle and arthroscopic surgery was performed to debride it and to perform a microfracture procedure, she recovered incompletely and required a second operative procedure, but since that time has had increasing pain and discomfort. X-rays show progressive narrowing of the medial compartment of the joint. She has not responded to anti-inflammatory medications, injections including cortisone and Synvisc and physical therapy treatment with appropriate bracing. It was felt that the best form of treatment would be a knee replacement and she was admitted.

PAST HISTORY: PATIENT IS NOTED TO BE ALLERGIC TO PENICILLIN. Medically, she appeared to be stable. She was taking antihypertensive medications, but there was no history of MI or CVA.

PHYSICAL EXAMINATION:
GENERAL: The patient appeared to be medically stable.
HEART: Regular rate and rhythm.
LUNGS: Clear.
ABDOMEN: Soft.
EXTREMITIES: Knee showed effusion with some limitation of motion and pain, mostly medial.

DATA: X-rays show progressive osteoarthritis, medial compartment of the right knee joint.

HOSPITAL COURSE: Patient was brought to the operating room. On the day of admission, she underwent a right total knee replacement performed under spinal anesthesia with sedation and nerve block was provided postoperatively. No intraoperative complications were encountered. The equipment used was a Smith-Nephew Genesis II posterior stabilized knee. Components were cemented, size 4 femoral component, size 3 tibial component, 11-mm spacer and a 23-mm biconvex patellar button. Postoperatively, the patient remained stable. She had some bleeding, which required rather frequent dressing changes, but there were no signs of infection and neurovascular was intact. She was able to mobilize with physical therapy and did quite well. Pain was initially controlled with IV medications and switched to oral medications on the first postoperative day. By the second postoperative day, there was less bleeding. It was felt that patient's condition had stabilized to the point where she will be discharged to a skilled nursing facility for further rehabilitation and care as she was unable to care for herself at home and she lived alone.

CONDITION ON DISCHARGE: Stable.

Work Type: Discharge Summary
T001

Work Type Code: DGS

PRINTED BY: VeronicaQuijano
DATE: 03/01/2016

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016
DIS: 02/10/2016

Discharge Summary

RECOMMENDATIONS: To continue the rehab using a total knee protocol. Dressing changes will be performed as needed with anticipation that the bleeding will stop within the next 3-4 days. She will continue regular diet, her regular prehospitalization medications. She will be placed on Xarelto to use for an anticoagulation effect for the next 2-3 weeks. She is to return to the office in approximately 10 days to 2 weeks for wound inspection and probable staple removal. She may return sooner on a p.r.n. basis.

FINAL DIAGNOSES:
1. Osteoarthritis of the right knee.
2. Hypertension.

STEPHEN P. GRAHAM, MD

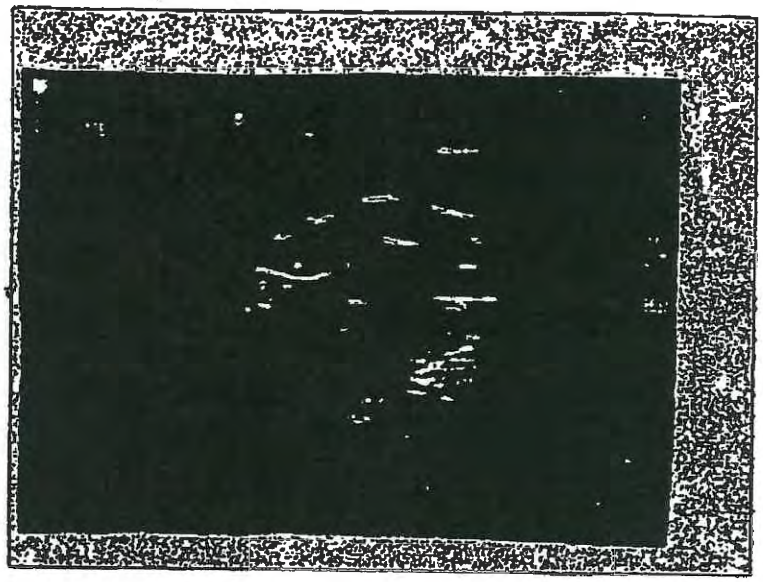
TR:SPG/IN
DD:02/15/2016 11:51 PST
DT:02/15/2016 18:02 PST
Dictation ID: 17885354/Confirmation #: 8541242

Work Type: Discharge Summary
T001

Work Type Code: DGS

Authenticated by STEPHEN GRAHAM, M.D. On 02/22/2016 11:57:12 AM
PRINTED BY: VeronicaQuijano
DATE: 03/01/2016

REGIONAL ANESTHESIA PROCEDURE NOTE



☒ RIGHT ☐ LEFT ☐ BILATERAL

- ☐ Interscalene brachial plexus block
- ☐ Supraclavicular brachial plexus block
- ☐ Infraclavicular brachial plexus block
- ☐ Femoral nerve block
- ☐ Lumbar plexus block (suprainguinal approach)
- ☒ Adductor canal block
- ☐ Sciatic nerve block
- ☐ Popliteal nerve block
- ☐ Other: _____

☒ SINGLE ☐ CONTINUOUS

INDICATION: ☐ Surgical Anesthesia
☐ Postop pain control, requested by Dr. VZh

POOR ORIGINAL

PROCEDURE DETAILS

☒ TIME OUT DONE • Correct patient identity • Correct side/site verified • Informed consent obtained

Position: ☒ Supine ☐ Prone ☐ Lateral

☒ Chlorhexidine ☐ Drape ☐ Monitors Applied ☐ Supplemental O_2

Pre-medication: ☐ None ☐ Midazolam _____ ☐ Fentanyl _____

☐ Meaningful verbal communication with the patient was maintained throughout procedure

☒ Ultrasound Guidance: Anatomy was scanned and major landmarks identified. The needle was visualized in close proximity to the nerve. The local anesthetic was injected under continuous ultrasound monitoring.

☐ Nerve Stimulation (Loss of motor response at ____ mAmp)

☐ Needle type _____ ☐ Catheter placed and taped at ____ cm to skin

☐ Intermittent aspiration and incremental injection of local anesthetic

Blood aspirated	N / Y – Action taken: _____
Paresthesias	N / Y – Action taken: _____
Pain on injection	N / Y – Action taken: _____
Resistance on injection	N / Y – Action taken: _____
Symptoms of intravascular injection	N / Y – Action taken: _____

Procedure:

☒ Completed ☐ Aborted ☐ Complications _____

Post Procedure Vital Signs: BP _____ HR _____ Sat O_2 _____ RR _____ Pain Score ____/10

LOCAL ANESTHETIC

Bolus: 0.5% Bupi E Epi 30ml

Continuous infusion: _____ at _____ ml/h

Dr. VZh — VZh — 2/8/16 1008
Signature — Print Name — Date/Time

START TIME: 1008 END TIME 1012

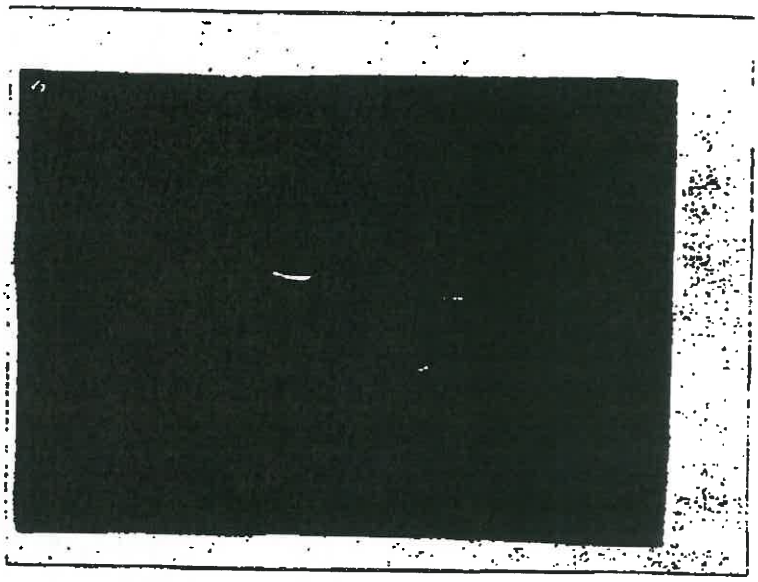
Acct 11725348
PEREZ, CONSUELO
GRAHAM STEPH
MR 001019121
02/08/2016
Pt 1
63Y F
DOB03/15/1952

PRINTED BY: VeronicaQuijano
DATE: 03/01/2016

REGIONAL ANESTHESIA PROCEDURE NOTE

RIGHT ☐ LEFT ☐ BILATERAL

- ☐ Interscalene brachial plexus block
- ☐ Supraclavicular brachial plexus block
- ☐ Infraclavicular brachial plexus block
- ☐ Femoral nerve block
- ☐ Lumbar plexus block (suprainguinal approach)
- ☒ Adductor canal block
- ☐ Sciatic nerve block
- ☐ Popliteal nerve block
- ☐ Other: _____



☒ SINGLE ☐ CONTINUOUS

INDICATION: ☐ Surgical Anesthesia
☐ Postop pain control, requested by Dr. VZh

POOR ORIGINAL

PROCEDURE DETAILS

☒ TIME OUT DONE • Correct patient identity • Correct side site verified • Informed consent obtained

Position: ☒ Supine ☐ Prone ☐ Lateral

☐ ChloraPrep ☐ Drape ☐ Monitors Applied ☐ Supplemental O2

Pre-medication: ☐ None ☐ Midazolam _____ ☐ Fentanyl _____

☐ Meaningful verbal communication with the patient was maintained throughout procedure

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☐ Intermittent aspiration and incremental injection of local anesthetic

Blood aspirated	N / Y – Action taken: _____
Paresthesias	N / Y – Action taken: _____
Pain on injection	N / Y – Action taken: _____
Resistance on injection	N / Y – Action taken: _____
Symptoms of intravascular injection	N / Y – Action taken: _____

Procedure:

☒ Completed ☐ Aborted ☐ Complications _____

Post Procedure Vital Signs: BP _____ HR _____ Sat O2 _____ RR _____ Pain Score 1/2

LOCAL ANESTHETIC

Bolus: 0.5% Bupi + Epi 30 ml

Continuous infusion: _____ at _____ ml/h

Dr. VZh — VZh — 2/9/16 1005
Signature — Print Name — Date Time

START TIME: 1005 END TIME 1012

Acct 11725348 02/08/2016
PEREZ, CONSUELO Pt 1
GRAHAM STEPH 63Y F
MR 001019121 DOB03/15/1952

PRINTED BY: VeronicaQuijano
DATE: 03/01/2016

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Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016
DIS: 02/10/2016

Discharge Summary

HISTORY OF PRESENT ILLNESS: Consuelo Perez was a 63-year-old female admitted for right knee replacement. Patient has been followed by me for work-related injury in the past 2-3 years. She initially was found to have an osteochondral defect, medial femoral condyle and arthroscopic surgery was performed to debride it and to perform a microfracture procedure, she recovered incompletely and required a second operative procedure, but since that time has had increasing pain and discomfort. X-rays show progressive narrowing of the medial compartment of the joint. She has not responded to anti-inflammatory medications, injections including cortisone and Synvisc and physical therapy treatment with appropriate bracing. It was felt that the best form of treatment would be a knee replacement and she was admitted.

PAST HISTORY: PATIENT IS NOTED TO BE ALLERGIC TO PENICILLIN. Medically, she appeared to be stable. She was taking antihypertensive medications, but there was no history of MI or CVA.

PHYSICAL EXAMINATION:
GENERAL: The patient appeared to be medically stable.
HEART: Regular rate and rhythm.
LUNGS: Clear.
ABDOMEN: Soft.
EXTREMITIES: Knee showed effusion with some limitation of motion and pain, mostly medial.

DATA: X-rays show progressive osteoarthritis, medial compartment of the right knee joint.

HOSPITAL COURSE: Patient was brought to the operating room. On the day of admission, she underwent a right total knee replacement performed under spinal anesthesia with sedation and nerve block was provided postoperatively. No intraoperative complications were encountered. The equipment used was a Smith-Nephew Genesis II posterior stabilized knee. Components were cemented, size 4 femoral component, size 3 tibial component, 11-mm spacer and a 23-mm biconvex patellar button. Postoperatively, the patient remained stable. She had some bleeding, which required rather frequent dressing changes, but there were no signs of infection and neurovascular was intact. She was able to mobilize with physical therapy and did quite well. Pain was initially controlled with IV medications and switched to oral medications on the first postoperative day. By the second postoperative day, there was less bleeding. It was felt that patient's condition had stabilized to the point where she will be discharged to a skilled nursing facility for further rehabilitation and care as she was unable to care for herself at home and she lived alone.

CONDITION ON DISCHARGE: Stable.

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MRN: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016
DIS: 02/10/2016

Discharge Summary

RECOMMENDATIONS: To continue the rehab using a total knee protocol. Dressing changes will be performed as needed with anticipation that the bleeding will stop within the next 3-4 days. She will continue regular diet, her regular prehospitalization medications. She will be placed on Xarelto to use for an anticoagulation effect for the next 2-3 weeks. She is to return to the office in approximately 10 days to 2 weeks for wound inspection and probable staple removal. She may return sooner on a p.r.n. basis.

FINAL DIAGNOSES:
1. Osteoarthritis of the right knee.
2. Hypertension.

_____
STEPHEN P. GRAHAM, MD

TR:SPG/IN
DD:02/15/2016 11:51 PST
DT:02/15/2016 18:02 PST
Dictation ID: 17885354/Confirmation #: 8541242

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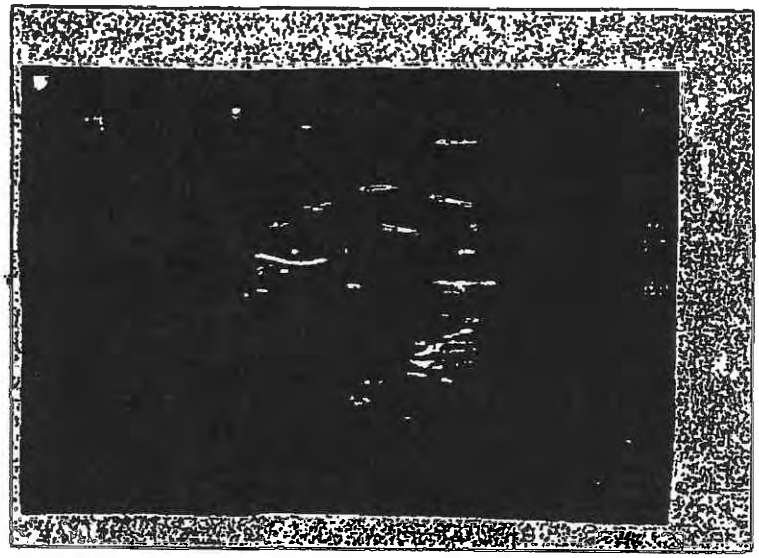
REGIONAL ANESTHESIA PROCEDURE NOTE



☒ RIGHT ☐ LEFT ☐ BILATERAL

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- ☐ Popliteal nerve block
- ☐ Other: _____

☒ SINGLE ☐ CONTINUOUS

INDICATION: ☐ Surgical Anesthesia
☐ Postop pain control, requested by Dr. VZh

POOR ORIGINAL

PROCEDURE DETAILS

☒ TIME OUT DONE · Correct patient identity · Correct side/site verified · Informed consent obtained

Position: ☒ Supine ☐ Prone ☐ Lateral

☒ Chlorhexidine ☐ Drape ☐ Monitors Applied ☐ Supplemental O_2

Pre-medication: ☐ None ☐ Midazolam _____ ☐ Fentanyl _____

☐ Meaningful verbal communication with the patient was maintained throughout procedure

☒ Ultrasound Guidance: Anatomy was scanned and major landmarks identified. The needle was visualized in close proximity to the nerve. The local anesthetic was injected under continuous ultrasound monitoring.

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Symptoms of intravascular injection	N / Y – Action taken: _____

Procedure:

☒ Completed ☐ Aborted ☐ Complications _____

Post Procedure Vital Signs: BP _____ HR _____ Sat O_2 _____ RR _____ Pain Score ____/10

LOCAL ANESTHETIC

Bolus: 0.5% Bupi + Epi 30ml

Continuous infusion: _____ at _____ ml/h

Dr. VZh — Signature

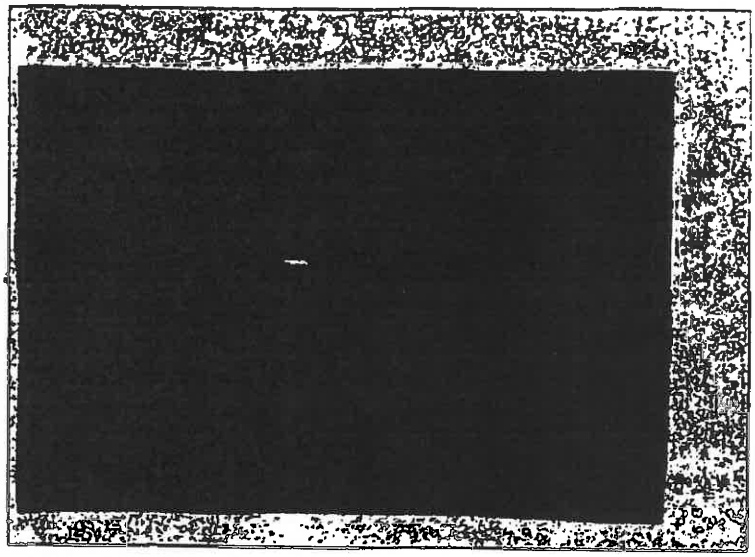
VZh — Print Name

2/8/16 1008 — Date/Time

START TIME: 1008 END TIME 1012

Acct 11725348 02/08/2016
PEREZ, CONSUELO Pt 1
GRAHAM STEPH 63Y F
MR 001019121 DOB03/15/1952

REGIONAL ANESTHESIA PROCEDURE NOTE



☒ RIGHT ☐ LEFT ☐ BILATERAL

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☒ SINGLE ☐ CONTINUOUS

INDICATION: ☐ Surgical Anesthesia
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POOR ORIGINAL

PROCEDURE DETAILS

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Procedure:

☒ Completed ☐ Aborted ☐ Complications _____

Post Procedure Vital Signs: BP _____ HR _____ Sat O_2 _____ RR _____ Pain Score ___/10

LOCAL ANESTHETIC

Bolus: 0.5% Bupi ~ Epi 30ml

Continuous infusion: _____ at _____ ml/h

Dr. VZh — Signature

VZh — Print Name

2/8/16 1008 — Date/Time

START TIME: 1008 END TIME 1012

Acct 11725348
PEREZ, CONSUELO
GRAHAM STEPH
MR 001019121
02/08/2016
Pt 1
63Y F
DOB03/15/1952

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Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720-3113

Patient:	**PEREZ, CONSUELO**	**Attending Provider:**	GRAHAM MD,STEPHEN P
MRN #:	1019121	**Admission Date:**	2/8/2016
Account #:	11725348	**Discharge Date:**	2/10/2016
DOB/Age/Sex:	3/15/1952 / 63 years / Female	**Lab Medical Director(s):**	Azar Daneshbod, M.D./ Indu Gupta, M.D./ Tac

Chemistry

Legend: (c)=Corrected, (A)=Abnormal, (!)=Critical, (H)=High, *=Result Comment, i=Interp Data

Routine Chemistry

Collected Date	2/9/2016		
Collected Time	06:02 PST		
Procedure		**Units**	**Reference Range**
Sodium Lvl	140 *1	mmol/L	[137-145]
Potassium Lvl	4.5 *1	mmol/L	[3.4-5.1]
Chloride Lvl	105 *1	mmol/L	[98-107]
CO2	26 *1	mmol/L	[20-30]
AGAP	14 *1	mmol/L	
Glucose Level	126 (H) *1	mg/dL	[74-106]
Calcium Lvl	8.3 (L) *1	mg/dL	[8.4-10.2]
BUN	20 *1	mg/dL	[8-20]
Creatinine Lvl	0.9 *1	mg/dL	[0.5-1.0]
BUN/Creat	22 *1	ratio	
GFR African Am	>60 *1	mL/min/1.73m2	
GFR Non AfrcnAm	>60 i1 *1	mL/min/1.73m2	

Interpretive Data
i1: GFR Non AfrcnAm

>60	1 or 2	Normal or mildly decreased
30-59	3	Moderately decreased
15-29	4	Severely decreased
<15	5	Kidney failure

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Hematology

Legend: (c)=Corrected, (A)=Abnormal, (!)=Critical, (H)=High, *=Result Comment, i=Interp Data

CBC

Collected Date	2/9/2016		
Collected Time	06:02 PST		
Procedure		**Units**	**Reference Range**
WBC	17.2 (H) *1	x10(3)/mcL	[3.8-10.8]
RBC	3.97 *1	x10(6)/mcL	[3.90-5.20]
Hgb	12.1 *1	g/dL	[12.0-15.6]

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720-3113

Patient:	**PEREZ, CONSUELO**	**Attending Provider:**	GRAHAM MD,STEPHEN P
MRN #:	1019121	**Admission Date:**	2/8/2016
Account #:	11725348	**Discharge Date:**	2/10/2016
DOB/Age/Sex:	3/15/1952 / 63 years / Female	**Lab Medical Director(s):**	Azar Daneshbod, M.D./ Indu Gupta, M.D./ Tac

Hematology

Legend: (c)=Corrected, (A)=Abnormal, (I)=Critical, (H)=High, *=Result Comment, i=Interp Data

CBC

Collected Date	2/9/2016		
Collected Time	06:02 PST		
Procedure		**Units**	**Reference Range**
Hct	35.0 *1	%	[35.0-46.0]
MCV	88.2 *1	fL	[80.0-100.0]
MCH	30.4 *1	pg	[27.0-33.0]
MCHC	34.4 *1	g/dL	[32.0-36.0]
RDW	12.8 *1	%	[9.0-15.0]
Platelet Count	172 *1	x10(3)/mcL	[130-400]
MPV	10.4 *1	fL	[7.2-11.1]

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Automated Differential

Collected Date	2/9/2016		
Collected Time	06:02 PST		
Procedure		**Units**	**Reference Range**
Neutrophil Rel	88.9 (H) *1	%	[51.0-71.0]
Lymphocyte Rel	5.5 (L) *1	%	[25.0-45.0]
Monocyte Rel	5.3 *1	%	[0.0-10.0]
Eosinophil Rel	0.0 *1	%	[0.0-5.0]
Basophil Rel	0.3 *1	%	[0.0-2.0]
Neutrophil Abs	15.3 (H) *1	x10(3)/mcL	[1.0-7.8]
Lymphocyte Abs	0.9 *1	x10(3)/mcL	[0.8-4.1]
Monocyte Abs	0.9 *1	x10(3)/mcL	[0.2-1.1]
Eosinophil Abs	0.0 *1	x10(3)/mcL	[0.0-0.6]
Basophil Abs	0.1 *1	x10(3)/mcL	[0.0-0.2]

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720-3113

Patient:	**PEREZ, CONSUELO**	**Attending Provider:**	GRAHAM MD,STEPHEN P
MRN #:	1019121	**Admission Date:**	2/8/2016
Account #:	11725348	**Discharge Date:**	2/10/2016
DOB/Age/Sex:	3/15/1952 / 63 years / Female	**Lab Medical Director(s):**	Azar Daneshbod, M.D./ Indu Gupta, M.D./ Tac

Hematology

Legend: (c)=Corrected, (A)=Abnormal, (!)=Critical, (H)=High, *=Result Comment, i=Interp Data

Manual Differential

Collected Date 2/9/2016
Collected Time 06:02 PST

Procedure		Units	Reference Range
Segs Man	77 (H) *1	%	[51-71]
Band Man	9 (H) *1	%	[0-6]
Lymphocyte Man	7 (L) *1	%	[25-45]
Monocyte Man	7 *1	%	[0-10]
Eos Man	0 (L) *1	%	[1-5]
Basophil Man	0 *1	%	[0-1]
Cells Counted	100 *1		

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Morphology

Collected Date 2/9/2016
Collected Time 06:02 PST

Procedure		Units	Reference Range
RBC Morph	Normal *1		[Normal]
Platelet Morph	Normal *1		[Normal]

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Microbiology

Procedure:	Urine Culture *1	Collected Date/Time:	2/8/2016 08:13 PST
Source:	U Catheter	Start Date/Time:	2/8/2016 11:35 PST
Body Site:	Bladder	Accession:	023-MB-16-004340
Free Text Source:	1. URINE FROM FOLEY		

FINAL REPORTS
Final Report
Verified Date/Time/Personnel: 2/10/2016 11:59 PST Morales,Gilbert
No growth in approximately 48 hours

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720-3113

Patient:	**PEREZ, CONSUELO**	**Attending Provider:**	GRAHAM MD,STEPHEN P
MRN #:	1019121	**Admission Date:**	2/8/2016
Account #:	11725348	**Discharge Date:**	2/10/2016
DOB/Age/Sex:	3/15/1952 / 63 years / Female	**Lab Medical Director(s):**	Azar Daneshbod, M.D./ Indu Gupta, M.D./ Tac

Microbiology

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Pathology

Accession:	023-SP-16-000522		
Collected Date/Time:	2/8/2016 08:13 PST		
Received Date/Time:	2/8/2016 10:26 PST	Pathologist:	LIM MD,SUSAN S

SURGICAL PATHOLOGY REPORT – 2/10/2016 14:48 PST – Auth (Verified)

DIAGNOSIS:
A. RIGHT KNEE BONE FRAGMENTS, TOTAL KNEE REPLACEMENT:
- BONE WITH GENERATIVE CHANGE.
- BENIGN FIBROCONNECTIVE TISSUE WITH REACTIVE CHANGE.

SUSAN S LIM, M.D
(Electronic Signature)
Signed on: 02/10/2016 14:48 PST
SSL/SSL

SPECIMEN SOURCE:
A. RIGHT KNEE BONE FRAGMENTS

CLINICAL INFORMATION:
Diagnosis/Clinical Information: DEGENERATIVE JOINT DISEASE OF RIGHT KNEE
Post-Op Diagnosis:
Procedure: RIGHT TOTAL KNEE REPLACEMENT

GROSS EXAMINATION:
A. The specimen is received in a container with formalin labeled with the patient's name and "right knee". The specimen consists of multiple fragments of bone measuring in aggregate 10.0 x 8.0 x 2.4 cm, the largest measuring 7.5 x 5.0 x 1.3 cm. A portion of meniscus is present measuring 3.5 x 1.5 x 0.9 cm. Recognizable portions of bone are the articular tibial plateau and portions of femoral condyles. The articular cartilage surface shows areas of granular cartilage with osteophyte formation. Representative sections submitted in three cassettes: A1 - meniscus; A2 and A3 - bone with articular cartilage surface, decalcified. (MM)

SSL/MM

MICROSCOPIC EXAMINATION:
A. 3 blocks, 3 H&E slides (decal).

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720-3113

Patient:	**PEREZ, CONSUELO**	**Attending Provider:**	GRAHAM MD,STEPHEN P
MRN #:	1019121	**Admission Date:**	2/8/2016
Account #:	11725348	**Discharge Date:**	2/10/2016
DOB/Age/Sex:	3/15/1952 / 63 years / Female	**Lab Medical Director(s):**	Azar Daneshbod, M.D./ Indu Gupta, M.D./ Ta

POC Testing

Legend: (c)=Corrected, (A)=Abnormal, (!)=Critical, (H)=High, *=Result Comment, i=Interp Data

Point of Care Tests

Collected Date: 2/8/2016 Collected Time: 06:12 PST Procedure		Units	Reference Range
Glucose POC	122 (H) f1 *1	mg/dL	[70-110]

Result Comments
f1: Glucose POC
Meter: UU13073613~Operator: 24297 Javien Myrna

Performing Locations
*1: This test was performed at:
LOM Laboratory, Los Alamitos Medical Center, 3751 Katella Ave, Los Alamitos, CA, 90720-3113

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720-3113

Patient:	**PEREZ, CONSUELO**	**Attending Provider:**	GRAHAM MD,STEPHEN P
MRN #:	1019121	**Admission Date:**	2/8/2016
Account #:	11725348	**Discharge Date:**	2/10/2016
DOB/Age/Sex:	3/15/1952 / 63 years / Female	**Lab Medical Director(s):**	Azar Daneshbod, M.D./ Indu Gupta, M.D./ Tac

Diagnostic Radiology

Accession #:	Exam Date/Time:	Procedure:	Ordering Provider:
023-XR-16-005426	2/8/2016 10:51 PST	XR Knee 1 or 2 Views Right	GRAHAM MD,STEPHEN P

Report
KNEE, 2 VIEW

REASON FOR EXAM: Postoperative evaluation.

TECHNIQUE: 2 views of the right knee are submitted for interpretation

COMPARISON: None available.

FINDINGS: Status post right total knee arthroplasty and patellar resurfacing with near-anatomic alignment. There is no evidence of periprosthetic lucency. No acute bony injury is identified. Adjacent postoperative soft tissue swelling and subcutaneous air is identified.

IMPRESSION:

Status post right total knee arthroplasty with near-anatomic alignment and expected postsurgical changes.

*****Final Report*****
Dictated: 02/08/2016 11:49 am Dictated By: ZAER MD, NAVID
Electronic Signature: 02/08/2016 11:53 am Signed By: ZAER MD, NAVID

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IMPLANT TRACKING LOG

170082

PLEASE NOTE: TISSUE IMPLANTS THAT ARE RINSED IN NORMAL SALINE MUST HAVE THE LOT NUMBER OF THE RINSE DOCUMENTED ON THIS FORM

DATE	SURGEON	RN CIRCULATOR
02/08/16	DR. S. GRAHAM	P. CHO

SURGICAL PROCEDURE: RIGHT TOTAL KNEE ARTHROPLASTY

MFG	CAT # / MODEL / DESCRIPTION	SIZE	QTY	LOT # / SERIAL	METHOD OF STERILIZATION
Simplex® P Bone Cement Radiopaque Bone Cement Distributed By: Stryker® Orthopaedics Full Dose USA REF 6191-1-001 LOT RJW136 2018-06-30					☐ Manufacturer ☐ In House Sterilization Load #
Simplex® P Bone Cement Radiopaque Bone Cement Distributed By: Stryker® Orthopaedics Full Dose USA REF 6191-1-001 LOT RKW143 2018-07-31					☐ Manufacturer ☐ In House Sterilization Load #
CHART-STIK® LABEL smith&nephew 71421509 15JM09302 STERILE EO 2025-09-11 SIZE 3-4 11 MM GENESIS® II PS HIGH FLEXION ARTICULAR INSERT (01) 03596010482384 (17) 250911 (10) 15JM09302 (11) 150914 T04HSTIK; 4 ATTACH TO PATIENT'S RECORD					☐ Manufacturer ☐ In House Sterilization Load #
CHART-STIK® LABEL smith&nephew 71420182 15KT59694 STERILE R 2025-10-02 SIZE 3 GENESIS® II RIGHT NON-POROUS TIBIAL BASEPLATE (01) 03596010203338 (17) 251002 (10) 15KT59694 (11) 151002 T04HSTIK; 4 ATTACH TO PATIENT'S RECORD					☐ Manufacturer ☐ In House Sterilization Load #
CHART-STIK® LABEL smith&nephew 71420566 15LM14627 STERILE EO 2025-11-16 23 MM GENESIS® II BICONVEX PATELLAR COMPONENT (01) 03596010206256 (17) 251116 (10) 15LM14627 (11) 151119 T04HSTIK; 4 ATTACH TO PATIENT'S RECORD					☐ Manufacturer ☐ In House Sterilization Load #
CHART-STIK® LABEL smith&nephew 71421114 11BM14812G STERILE R 2025-07-21 SIZE 4, RIGHT POSTERIOR STABILIZED GENESIS® II OXINIUM® FEMORAL COMPONENT (01) 03596010469281 (17) 250721 (10) 11BM14812G (11) 150724 T04HSTIK; 4 ATTACH TO PATIENT'S RECORD					☐ Manufacturer ☐ In House Sterilization Load #
					☐ Manufacturer ☐ In House Sterilization Load #
					☐ Manufacturer ☐ In House Sterilization Load #
					☐ Manufacturer ☐ In House Sterilization Load #
					☐ Manufacturer ☐ In House Sterilization Load #

TRC1002 (4-10) IMMS # 170082

IMPLANT TRACKING LOG

PATIENT ID

Acct 11725348 02/08/2016
PEREZ, CONSUELO Pt 1
GRAHAM STEPH 63Y F
MR 001019121 DOB03/15/1952

WHITE - MEDICAL RECORD CANARY - DEPARTMENT PINK - RISK MANAGEMENT / OTHER

D:\FilmImageBundle\Temp\053517\Originals\20160531-000001-012.tif

SURG

(Please have the patients fill out)

Name: Perez, Consuelo Date of Surgery: 2-8-16

Type of Surgery: _____ Surgeon: Dr. Graham Primary Care Physician: _____

Patient's Age: 63 Gender: ☐ Male ☑ Female BMI: 40 Risk Points: 1

For Staff Only
Notify Anesthesia provider/Nurse Practitioner for any patient with four (4) or more risk points. If providers are not available, notify Medical Doctor.

Please answer YES or NO to the following questions. Check any subcategories that apply:

1. **(Two or more boxes checked is one (1) risk point)**

Do you have a history of or being treated for: ☐ Atrial Fibrillation ☑ High Blood Pressure
☐ Chest Pain, Heart Attack ☐ Open Heart Surgery ☐ Valvular ☐ Abnormal EKG ☐ Heart Disease
☐ Heart Murmurs ☐ Irregular Heart Beat ☐ Ablation Procedure

If the answer is NO to #1, please go directly to question #2

- What is your Cardiologist's name? _____
- When was your last visit to the Cardiologist? _____
- Do you have an irregular pulse? ☐ Yes ☐ No
- If Yes, how often? _____ With or Without Activity? _____
- Do you have Angina or Chest Pain? ☐ Yes ☑ No
- Frequency (with or without activity) _____
- When was the last episode? _____
- Do you take nitroglycerine? ☐ Yes ☐ No
  Does it give you relief? ☐ Yes ☐ No
- Have you ever had a heart attack? ☐ Yes ☐ No
- Have you ever had a stroke? ☐ Yes ☐ No
- Did you have a cardiac catheterization? ☐ Yes ☐ No
- When and where was it done? _____
- Have you had a stress test? ☐ Yes ☐ No
  When and where was it done? _____
- Do you have a cardiac stent? ☐ Yes ☐ No
- Do you have a Pacemaker or Defibrillator? ☐ Yes ☐ No
- Have you had a CABG (coronary artery bypass graft)? ☐ Yes ☐ No
  When and where was it done? _____

2. **(Yes to any part of this question is one (1) risk point)**

Do you experience notable shortness of breath on exertion? how long as it been present? _____
When walking up _____ (how many) flights of stairs? When walking how far (_____) block(s)
or feet? Does shortness of breath occur at night? ☐ Yes ☑ No

How many pillows do you sleep on and why? _____
Do you smoke or have a history of smoking tobacco products? How many years? _____ ☐ Yes ☑ No

LOS ALAMITOS MEDICAL CENTER
169-0300 (5-15)

PRE-ADMISSION SCREENING QUESTIONS
Page 1 of 2

PATIENT ID

Acct11725348 02/08/2016
PEREZ, CONSUELO Pt 0
GRAHAM STEPH JS 63Y F
MR 001019121 DOB 03/15/1952

3. **(One or more boxes checked is one (1) risk point)**

Do you have difficulty breathing from: ☐ Asthma ☐ Emphysema ☐ Bronchitis
☐ Abnormal chest x-ray ☐ Chronic Obstructive Pulmonary Disease (COPD) ☑ N/A

4. **(One or more boxes checked is one (1) risk point)**

Are you taking: ☐ Aggrastat ☐ Coumadin ☐ Lovenox ☐ Plavix ☐ Any other blood thinner ☐ N/A
(Please specify _____)

5. **(One or more boxes checked is one (1) risk point)**

Have you ever had problems with anesthesia? Including: ☐ a reported history of difficult airway management
☐ difficulty with placement of breathing tube ☐ development of a high fever during or afterwards
☐ difficulty breathing after waking up ☐ severe nausea and/or vomiting that prolonged your hospital stay ☑ N/A

6. **(Yes to this question is one (1) risk point)**

Are you aware of any blood relative of yours who has had problems during or immediately following anesthesia to include: ☐ sudden death ☐ difficulty breathing ☐ development of a high fever (malignant hyperthermia)
☑ N/A

7. **(Yes to this question is one (1) risk point)**

Do you have diabetes? ☐ Type I ☐ Type II ☐ Take Diabetic Pills ☐ Byetta ☐ Insulin ☑ N/A

8. **(Three boxes checked (unless definitive diagnosis) indicates potential risk of Sleep Apnea and one (1) risk point)** sleep apnea

Sleep Apnea Screen: ☐ Do you have Sleep Apnea? ☐ Loud snoring ☐ Observed breathing pauses
☐ Daytime somnolence ☐ Male neck size > 17 inches, Female neck size > 16 inches ☐ Age > 50
☑ High Blood Pressure ☑ BMI > 30 ☐ CPAP/BiPAP Equipment ☐ N/A

1

(Yes to these questions below is one (1) risk point)

9. Liver problems: ☐ Hepatitis ☐ Jaundice ..... ☐ Yes ☑ No
10. Kidney Disease: ☐ Dialysis ..... ☐ Yes ☑ No
11. Epilepsy or convulsion: _____ ..... ☐ Yes ☑ No
12. Recreational drugs: _____ ..... ☐ Yes ☑ No
13. Broken Bones: ☐ Back ☐ Neck ☐ Facial ..... ☐ Yes ☑ No
14. Tuberculosis: HISTORY of _____ ..... ☐ Yes ☑ No
15. Could you be pregnant? Date of last menstrual period _____ ..... ☐ Yes ☑ No
16. Alcohol consumption: how much _____ ..... ☐ Yes ☑ No

HT: 5'1" 162.56
WT: lbs 230 kg 104.5

Allergies: Penicillin
MRSA: History of ..... ☐ Yes ☑ No

Patient Signature: _____ Date: _____ Time: _____

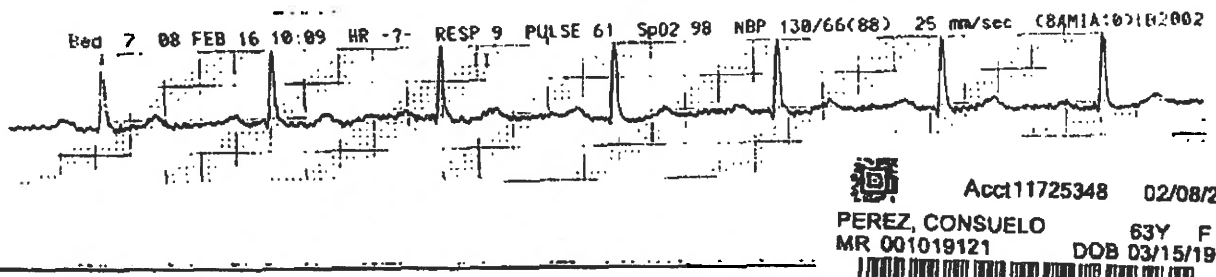
LOS ALAMITOS MEDICAL CENTER
169-0300 (5-15)

PRE-ADMISSION SCREENING QUESTIONS
Page 2 of 2

PATIENT ID

Acct 11725348
PEREZ, CONSUELO 02/08/2016
GRAHAM STEPH Pt 0
MR 001019121 JS 63Y F
DOB 03/15/1952

Place EKG strips inside the boxed area for proper HPF scanning.



LOS ALAMITOS MEDICAL CENTER

169-1384 (8-12)

EKG STRIP FLOW SHEET

PATIENT ID

Acct 11725348 02/08/2016
PEREZ, CONSUELO Pt 1
GRAHAM STEPH 63Y F
MR 001019121 DOB03/15/1952

Rec'd Date: 20160212 Brf1 DCN: 2016044GJ000825

U.S. HealthWorks MEDICAL GROUP

(7)

STATE OF CALIFORNIA
Division of Workers' Compensation

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

☑ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 2/04/16 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

Prog

(T) AV

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

H RRR no(m) L clear A-ō

all - PCN
T-ō
Et-ō
med - HTN
surg L knee
GS
apM
Cte

DIAGNOSES (Include ICD-9 code, if possible) DM II & knee

TREATMENT

☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other DM-ō

☐ Meds / Supplies Dispensed _____

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

Local
#8492251
2416

postop SNF

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 2/04/16

Specialty: Lic G43382 Signature _____

Executed at: USHW of California-Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

Post op

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

DATE: _____ TIME: _____ ☐ Before / After Shift

PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

DATE: _____ TIME: _____ ☐ Before / After Shift

PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

IRVINE CO./WORK COMP ONLY 164559
DOS: 2/04/16 DOI: 3/10/13 D[illegible]: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT: 5'1.5 WT: 239lbs PULSE: 59 BP: 114/67 RESP: 16 TEMP: 98.7

JAMAR: RIGHT: _____ _____ _____ LEFT: _____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

H&P

Since your last visit with the doctor

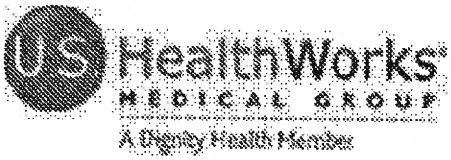
1. Do you feel: ☐ Better ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☑ Burning ☑ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse walk and up
6. Activity or position that makes the pain less lying
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? Aleve
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☐ Modified Work ☑ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 2-4-16



Billing Document

U.S. HealthWorks Documentation and Coding Guidelines utilize the 1995 and 1997 CMS Evaluation and Management Guidelines in determining any given level of E/M service.

Per our coding program the following primary chief complaints utilize the 1995 E/M Coding Guidelines.

Body Part/Organ System	Guideline
Ankle	1995
Back	1995
Blood Borne Pathogen	1995
Elbow	1995
Foot/Toe	1995
Hand/Finger	1995
Head	1995
Hip/Thigh	1995
Knee	1995
Neck	1995
Osteopathic	1995
Shoulder	1995
Wound/Burn	1995
Wrist	1995
Pre-Op Consultation	1995

Per our coding program the following primary chief complaints utilize the 1997 E/M Coding Guidelines.

Body Part/Organ System	Guideline
Abdomen/Groin	1997
Chest-Respiratory	1997
ENT-Respiratory	1997
Eye	1997
Psychiatric	1997
Skin	1997

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

February 4, 2016

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266

RE: PEREZ, CONSUELO
Claim #: 008094-000407-WC-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Alejo Velarde.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee with preoperative examination also. Her condition has not been improving, if anything, it is getting worse. She has had increasing pain and discomfort. She rates her pain level at 6/10 with 10 being worst. She has been scheduled for a right total knee replacement at Los Alamitos Hospital on 02/08/16. Her medical history was reviewed. It is noted that she is allergic to **PENICILLIN**. She takes antihypertensive medication.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 59
Blood Pressure: 114/67
Respirations: 16
Temperature: 98.7

Heart

Her heart has regular rate and rhythm. No murmurs heard.

Lungs

Lungs are clear to auscultation.

Abdomen

Soft.

Examination of the Right Knee

Visual Inspection

There is no effusion noted. There is no obvious gross deformity or malalignment.

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.

Range of Motion

Her right knee shows painful limitation of motion with moderate swelling.

Palpation

The patient is nontender over the lateral joint line or over the medial joint line and the anterior aspect of the knee.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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 2 seconds. The toes are warm and pink with good perfusion distally.

Special Tests

Babinski sign	Negative
Hoffmann sign	Negative
Clonus	Negative

DIAGNOSIS

Osteoarthritis, right knee.

PLAN

RE: **PEREZ, CONSUELO**
February 4, 2016
Page 4

Plan is to proceed with right total knee replacement. The patient is aware of risks and benefits of surgery as well as alternative options and possible complications and she is willing to proceed. It is anticipated she will need skilled nursing facility for rehabilitation in postoperative period.

WORK STATUS

The patient is at presently on temporary total disability.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gtj.BGP
D: 02/05/16
T: 02/06/16
PerezC0204Graham2272

IRVINE CO./WORK COMP ONLY 4559
DOS: 2/04/16 DOI: 3/10/1[illegible] DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT: 5'1.5 WT: 239lbs PULSE: 59 BP: 114/67 RESP: 16 TEMP: 98.7

JAMAR: RIGHT: _____ _____ _____ LEFT: _____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

H&P

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☑ Burning ☑ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse walk and up
6. Activity or position that makes the pain less lay down
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? Pain

   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☑ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

nt Signature Consuelo Perez Date 2-4-16

MEDICAL DOCUMENTATION : DO NOT DETACH

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	01-28-2016
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	IRVINE CO./WORK COMP ONLY
Claim #:	008094-000407-wc-01
Chart #:	EMR/JB

History Of Present Illness:
Preoperative Details: A pre-operative clearance examination is requested by Dr Graham. Reason for Surgery Diagnoses: tear of meniscus . Arthroscopy is the surgical procedure planned. This procedure is elective. Anesthesia anticipated is general.
Pre-Operative Complaints
Complaint: Patient's complaint at this time is as follows: Pain, meniscus tear RIGHT knee

Relevant History NOTES: Last tetanus - unknown.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.

Review Of Systems:
A complete review of systems was performed and was found to be negative unless otherwise noted below.
Cardiovascular: The patient states there is a history of heart disease - HTN, prior history of chest discomfort and diagnostic stress test.
see 1st visit

Relevant Preop. History:
Allergies: The patient denies a history of allergies to medications . The patient states there is no history of abnormal reactions to medications or anesthetics.
Family History: Pertinent Family history is noted: . DM, HTN .
Surgical History: The patients past surgical history is as follows: no issues with anesthesia.

Physical Examination:
Height: 64 inches. Weight: 240 lbs. BMI:41 Pulse: 64/min. BP: 124/66 mmHg. Temperature: 98.2 deg F
Respiration: 16 per min.

Constitutional: The patient appears obese -
Psychiatric: She is alert and oriented to person, place and time . Mood and affect appear appropriate .
Eyes: The eyes are not red or injected .
HEENT: The external ear appears within normal limits . The exam of the middle and inner ears are normal . The nasal airway is patent . The nasal septum is not deviated or perforated . The oral airway is not obstructed .
Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The patient does not display sternal retractions . There is no cyanosis or clubbing noted .

Gastrointestinal: There are no palpable abdominal masses . The abdomen is non-tender on palpation . There is no palpable abdominal guarding . There is no rebound tenderness of the abdomen . A hernia is not identified on examination. There is no evidence of organomegaly on exam . There is no ascites on abdominal exam .
Genitourinary: The external genitalia appear normal. Costovertebral angle tenderness for renal involvement is not noted .
Skin: There are no abnormal skin lesions . The skin turgor is normal . There is no evidence of abnormal bruising or petecchiae on examination .
Lymphatic: There is no palpable lymphadenopathy. There is signs of lymphedema .
Endocrine: The thyroid is non-tender on palpation . The thyroid is not enlarged .
Musculoskeletal: The thoracic spine and rib cage are within normal limits . The range of motion of the spine is within normal limits . The spine and paraspinal muscles are not tender . There is no evidence of muscle weakness .
Cardiovascular: The heart rate is normal . On auscultation, the heart rhythm is abnormal - other difficult to obtain popper EKG will request physcial findings from internist from recent vist. Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . Peripheral pulses are intact.
Neurologic: Sensation to touch is normal . Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits .

Diagnostic Tests:
Radiology

Test Name	Findings
Chest - 2 Views (Standard)	Preliminary interpretation of these x-rays are Normal -

Medical Necessity:
Chest - 2 Views (Standard) preoperative
All radiology studies are sent to Radiologist for review and confirmation.

Laboratory
External Lab Orders:

CBC / Differential: Lab Code - 6399; Collection Date/Time 01-28-2016 10:20; Other -
COMP METABOLIC PANEL / Blood chemistry: Lab Code - 10231; Collection Date/Time 01-28-2016 10:20; Other -
Urinalysis: Lab Code - 5463; Collection Date/Time 01-28-2016 10:20; Other -

Dispensed Medications:

Prescribed Medications:

Medications Completed or Stopped:
Medications to be Continued until Next Visit:

Treatment Plan

Procedures:
An EKG was performed. ms

Pre-Operative Diagnoses: Z01.818 - Pre-operative examination, unspecified .

Other Diagnoses: Tear of right meniscus as current injury, subsequent encounter (S83.206D)
Recommendations: All diagnostics tests ordered were reviewed on 02-02-2016 and recommendations are as follows: I have found no medical contraindication for the anesthetic planned. I recommend additional evaluation PRIOR to surgery

for the following reasons and/or conditions: Review of PCP/Internist records. If no current EKG that is WNL, will request cardiology consult.

Nima . Alipour, D.O.
This has been electronically signed on 02-02-2016

Recv'd Date: 20160206 Bill DCN: 2016037GJ000396

US HealthWorks MEDICAL GROUP

HX2

WC HEALTH HISTORY / HISTORIA MEDICA
Confidential / Confidencial

4:46

To better assess your health condition, please provide the following information (Para evaluar mejor su condición de salud, por favor proporcione la siguiente información)

PLEASE ANSWER ALL QUESTIONS — POR FAVOR, CONTESTE TODAS LAS PREGUNTAS

Yes/Si	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	
		1. Allergies or hives	Alergias o urticaria
		2. Medications	Medicinas
		3. Major illnesses or injuries	Enfermedades/lesiones importantes
		4. Hospitalizations or surgeries	Hospitalizaciones o cirugías
	X	5. Motor vehicle accidents	Accidentes de tránsito
		6. Blood transfusions	Transfusiones de sangre
	X	7. Worked in a hazardous environment	Trabajo en ambientes peligrosos
		8. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo
	X	9. Permanent disabilities	Incapacidad permanente

Yes/Si	No	FAMILY HISTORY / ANTECEDENTES FAMILIARES	
	X	10. Blood diseases in relatives	Familiares con enfermedades de la sangre
	X	11. Cancer or leukemia in relatives	Familiares con cáncer o leucemia
		12. Diabetes in relatives	Familiares con diabetes
	X	13. Heart Disease	Familiares con enfermedades del corazón
		14. High Blood Pressure	Familiares con presión alta
	X	15. Strokes in relatives	Familiares con trombosis / ataques cerebrales
	X	16. Mental illnesses in relatives	Familiares con enfermedades mentales

Yes/Si	No	SOCIAL HISTORY / ANTECEDENTES SOCIALES	
	X	17. Tobacco use. How much? ____ week	Uso de tabaco. ¿Cuanto? ____ semana
	X	18. Alcohol use. How much? ____ week	Uso de alcohol. ¿Cuanto? ____ semana

REVIEW OF SYSTEMS / REVISION DE SISTEMAS

Have you had or do you commonly have; ¿Tiene usted normalmente, o he tenido:

Yes/Si	No	CONSTITUTIONAL	
	X	19. Recent gain or loss of weight	Ganancia o perdida de peso reciente
	X	20. Weakness, fatigue, or appetite loss	Debilidad, fatiga o perdida de apetito
	X	21. Fever	Fiebre

Yes/Si	No	SKIN	
	X	22. Skin diseases or problems	Enfermedades en la piel
	X	23. Discoloration, pigmentation changes	Cambios de color en la piel
	X	24. Cancer/Tumors or cysts	Cáncer, tumores o quistes

Yes/Si	No	HEAD	
	X	25. Frequent or severe headaches	Dolores de cabeza frecuentes o severos

Yes/Si	No	EYES / VISION	
	X	26. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos
	X	27. Blurred, double or decreased vision	Visión borrosa, doble, o disminuida
	X	28. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos
	X	29. Light sensitivity	Sensibilidad a la luz

Yes/Si	No	EARS, NOSE, THROAT, MOUTH	
	X	30. Loss or decreased hearing	Pérdida o disminución de la audición
	X	31. Ear pain, infection, discharge	Dolor, infección o secresión en oídos
	X	32. Nose / Sinus Problems	Problemas en la nariz o en senos nasales
	X	33. Dental/Gum Disease	Enfermedades dentales o de las encías
	X	34. Recurrent throat problems	Problemas de garganta recurrentes
	X	35. Voice Change / Hoarseness	Ronquera o cambios en la voz

Yes/Si	No	CARDIOVASCULAR SYSTEM	
	X	36. Shortness of Breath	Dificultad para respirar
	X	37. Chest Pain or Pressure	Opresión o dolor en el pecho
	X	38. Palpitation/Pounding Heart	Palpitaciones o saltos del corazón
	X	39. High Blood Pressure	Presión sanguínea elevada
	X	40. Swelling Feet/Ankles	Hinchazón de pies o tobillos
	X	41. Varicose Veins	Venas varicosas

RESPIRATORY SYSTEM		Yes/Si	No
42. Chronic/Recurrent Cough/Cold	Resfriado / tos crónica o recurrente		X
43. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho		X
44. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica		X
45. Pneumonia	Pneumonía o pulmonía		X
46. Tuberculosis	Tuberculosis		X
47. Coughing of Blood	Tos con sangre		X

GASTROINTESTINAL TRAC		Yes/Si	No
48. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes		X
49. Nausea or vomiting	Náusea o vómitos		X
50. Vomiting of Blood	Vómitos con sangre		X
51. Abdominal pain	Dolor abdominal		X
52. Liver disease	Enfermedades del hígado		X
53. Change in Bowel Habits	Cambios en hábitos intestinales		X
54. Frequent Constipation/Diarrhea	Constipación o diarea frecuentes		X
55. Blood in stools/Black stools	Heces negras o con sangre		X
56. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto		X

GENITOURINARY TRACT		Yes/Si	No
57. Painful or difficult urination	Difícultad o dolor al orinar		X
58. Blood in urine	Sangre en la orina		X
59. Kidney infection/stones	Infecciones o cálculos del riñón		X
60. Venereal Disease	Enfermedades venéreas		X

MUSCULOSKELETAL		Yes/Si	No
61. Joint pain or disease	Enfermedades o dolor en las articulaciones	Yes	
63. Neck or back injury	Lesiones del cuello o de la espalda		X
64. Foot Problems	Problemas en los pies	Yes	X

NEUROLOGICAL		Yes/S	No
65. Epilepsy, Convulsions	Epilepsia, convusiones, ataques		X
66. Dizziness	Mareos o vértigo		X
67. Muscle weakness or paralysis	Parálisis o debilidad muscular		X
68. Numbness in arms or legs	Adormecimiento de manos o pies		X

PSYCHIATRIC PROBLEMS		Yes/Si	No
69. Depression	Depresion	Yes	X
70. Nervousness	Nerviosismo	Yes	
71. Mood swings	Cambios del humor o del carácter		NO
72. Sleep disturbances	Trastornos del sueño		NO
73. Alcoholism	Alcoholismo		NO
74. Drug abuse treatment/rehabilitation	Rehabilitación por adicción a drogas		NO

ENDOCRINE SYSTEM		Yes/Si	No
75. Increased appetite	Apetito exagerado		NO
76. Increased thirst	Sed exagerada		NO
77. Increased urination	Aumento en la frecuencia o cantidad de orina		NO
78. Diabetes/High Blood Sugar	Diabetes / Azúcar en la sangre		NO
79. Hair loss	Pérdida del cabello		NO

BLOOD DISORDERS		Yes/Si	No
80. Bleeding gums	Sangramiento por las encías		NO
81. Bruising	Moretones o cardenales		NO
82. Spontaneous nose bleeding	Sangramiento espontáneo por la nariz		NO
83. Easy bleeding or hard to stop	Sangramiento fácil o difícil de detener		NO

FOR WOMEN ONLY		Yes/Si	No
84. Pregnant?	Embarazada?		NO
85. Date last menstrual period?	Fecha última menstruación		NO
86. Irregular Menstruation?	¿Menstruación o períodos irregulares?		NO
87. Painful Menstruation	¿Menstruación o períodos dolorosos?		NO

Please write the number of any Yes answers and explain each one of them in the space below.
Por favor escriba el número de las preguntes en las cuáles haya contestado que SÍ y explique sus repuestas en este espacio.

1. Femur fx
2. Blood pressure
3. mi rodilla
4. rodilla, brazo, Seroreo, pendientes
5. Quando me caeron la Sérdea
6. mi rodilla

PROVIDER COMMENTS

SCANNED

I certify that the information above is correct. (Certifico que la información arriba es correcta)

Patient Signature (Firma del Paciente): Consuelo Perez Date (Fecha): 01-28-16

☐ Relevant history was discussed and patient advised to follow up with personal physician

Provider Initials: _____

IF I IRVINE CO./WORK COMP ONLY 164559 CUMENTATION ABOVE.

Name DOS: 1/28/16 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo

ST10: Case # : 32-251644 Ref # : EMR/JB

WC HEALTH HISTORY / HISTORIA MEDICA
Confidential / Confidencial

Date: _____

© US HealthWorks

Recvd Date: 20160206 Bill DCN: 2016037GJ000396

US HealthWorks MEDICAL GROUP

HX2

WC HEALTH HISTORY / HISTORIA MÉDICA
Confidential / Confidencial

To better assess your health condition, please provide the following information (Para evaluar mejor su condición de salud, por favor proporcione la siguiente información)

PLEASE ANSWER ALL QUESTIONS — **POR FAVOR, CONTESTE TODAS LAS PREGUNTAS**

Yes/Si	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS		Yes/Si	No
		1. Allergies or hives	Alérgies o urticaria		
		2. Medications	Medicinas		
		3. Major illnesses or injuries	Enfermedades/lesiones importantes		
		4. Hospitalizations or surgeries	Hospitalizaciones o cirugías		
		5. Motor vehicle accidents	Accidentes de tránsito		
		6. Blood transfusions	Transfusiones de sangre		
		7. Worked in a hazardous environment	Trabajo en ambientes peligrosos		
		8. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo		
		9. Permanent disabilities	Incapacidad permanente		
Yes/Si	No	FAMILY HISTORY / ANTECEDENTES FAMILIARES			
		10. Blood diseases in relatives	Familiares con enfermedades de la sangre		
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		15. Strokes in relatives	Familiares con trombosis / ataques cerebrales		
		16. Mental illnesses in relatives	Familiares con enfermedades mentales		
Yes/Si	No	SOCIAL HISTORY / ANTECEDENTES SOCIALES			
		17. Tobacco use. How much? _____ week	Uso de tabaco. ¿Cuanto? _____ semana		
		18. Alcohol use. How much? _____ week	Uso de alcohol. ¿Cuanto? _____ semana		
		REVIEW OF SYSTEMS / REVISION DE SISTEMAS			
		Have you had or do you commonly have:	**¿Tiene usted normalmente, o ha tenido:**		
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		20. Weakness, fatigue, or appetite loss	Debilidad, fatiga o perdida de apetito		
		21. Fever	Fiebre		
Yes/Si	No	SKIN			
		22. Skin diseases or problems	Enfermedades en la piel		
		23. Discoloration, pigmentation changes	Cambios de color en la piel		
		24. Cancer/Tumors or cysts	Cancer, tumores o quistes		
Yes/Si	No	HEAD			
		25. Frequent or severe headaches	Dolores de cabeza frecuentes o severos		
Yes/Si	No	EYES / VISION			
		26. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos		
		27. Blurred, double or decreased vision	Visión borrosa, doble, o disminuida		
		28. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos		
		29. Light sensitivity	Sensibilidad a la luz		
Yes/Si	No	EARS, NOSE, THROAT, MOUTH			
		30. Loss or decreased hearing	Pérdida o disminución de la audición		
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		34. Recurrent throat problems	Problemas de garganta recurrentes		
		35. Voice Change / Hoarseness	Ronquera o cambios en la voz		
Yes/Si	No	CARDIOVASCULAR SYSTEM			
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		45. Pneumonia	Pneumonía o pulmonía		
		46. Tuberculosis	Tuberculosis		
		47. Coughing of Blood	Tos con sangre		
		GASTROINTESTINAL TRACT		Yes/Si	No
		48. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes		
		49. Nausea or vomiting	Náusea o vómitos		
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		56. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto		
		GENITOURINARY TRACT		Yes/Si	No
		57. Painful or difficult urination	Dificultad o dolor al orinar		
		58. Blood in urine	Sangre en la orina		
		59. Kidney infection/stones	Infecciones o cálculos del riñón		
		60. Venereal Disease	Enfermedades venéreas		
		MUSCULOSKELETAL		Yes/Si	No
		61. Joint pain or disease	Enfermedades o dolor en las artículaciones		
		63. Neck or back injury	Lesiones del cuello o de la espalda		
		64. Foot Problems	Problemas en los pies		
		NEUROLOGICAL		Yes/Si	No
		65. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques		
		66. Dizziness	Mareos o vértigo		
		67. Muscle weakness or paralysis	Parálisis o debilidad muscular		
		68. Numbness in arms or legs	Adormecimiento de manos o pies		
		PSYCHIATRIC PROBLEMS		Yes/Si	No
		69. Depression	Depresión		
		70. Nervousness	Nerviosismo		
		71. Mood swings	Cambios del humor o del carácter		
		72. Sleep disturbances	Trastornos del sueño		
		73. Alcoholism	Alcoholismo		
		74. Drug abuse treatment/rehabilitation	Rehabilitación por adicción a drogas		
		ENDOCRINE SYSTEM		Yes/Si	No
		75. Increased appetite	Apetito exagerado		
		76. Increased thirst	Sed exagerada		
		77. Increased urination	Aumento en la frecuencia o cantidad de orina		
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		79. Hair loss	Pérdida del cabello		
		BLOOD DISORDERS		Yes/S	No
		80. Bleeding gums	Sangramiento por las encías		
		81. Bruising	Moretones o cardenales		
		82. Spontaneous nose bleeding	Sangramiento espontáneo por la nariz		
		83. Easy bleeding or hard to stop	Sangramiento fácil o difícil de detener		
		FOR WOMEN ONLY		Yes/S	No
		84. Pregnant?	Embarazada?		
		85. Date last menstrual period?	Fecha última menstruación		
		86. Irregular Menstruation?	¿Menstruación o periodos irregulares?		
		87. Painful Menstruation	¿Menstruación o periodos dolorosos?		

Please write the number of any Yes answers and explain each one of them in the space below.
Por favor, escriba el número de las preguntas en las cuéles haya contestado que SÍ y expíque sus repuestas en este espacio.

(12) mi Mamá y Sister
(14) mi Mama y Sister's
(61) mi rodilla
(70) por Toda me pongo nerviosa

PROVIDER COMMENTS

I certify that the information above is correct. (Certifico que la información arriba es correcta)

Patient Signature (Firma del Paciente): _____ Date (Fecha): _____

☐ Relevant history was discussed and patient advised to follow up with personal physician

Provider Initials: _____

IRVINE CO./WORK COMP ONLY 164559
DOS: 1/28/16 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

THE DOCUMENTATION ABOVE.

WC HEALTH HISTORY / HISTORIA MEDICA
Confidential / Confidencial

Incident #: _____ Date: _____

ST1012A (11/09)

© US HealthWorks

Recvd Date: 20160126 Bill DCN: 2016027GJ000943

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

January 14, 2016

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company/Work Comp Only

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Alejo Velarde

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for osteochondral defect with progressive osteoarthritis. She was last seen on 12/03/15. Her condition is better now. She wishes to proceed with a total knee replacement. She comes back at this time for followup. Since her last visit, she indicates she is even getting worse again. She describes pain, locking, and giving way of the knee. Her pain level is 6/10 with 10 being worse. This is aggravated by activities and weight-bearing and partially relieved by rest. She continues to takes Norco as needed for pain relief.

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 female appearing her stated age and in no acute distress.

Examination of the Right Knee

Continues be in moderate swelling in the knee. There is pain along the joint lines. Range of motion limited from 0 to 110 degrees. There is no gross instability. Neurovascularly appears to be intact.

DIAGNOSIS

Progressive osteoarthritis, right knee.

PLAN

The patient is scheduled for total knee arthroplasty. She indicates she would require skilled nursing facility for postoperative rehabilitation.

WORK STATUS

Remains modified with limited kneeling and squatting and no climbing and the ability to sit to stand p.r.n. for pain relief. Reevaluation will be preoperative.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:dwe.HBB
D: 01/15/16
T: 01/17/16
PerezC0114Graham22721451

Provider Discharge - Perez, Consuelo - Injury - 03225 1644/032/25 - 12/03/15 14:15

Provider: GRAHAM, STEPHEN, M.D.

Provider of Record:

Diagnosis

	Icd-10	Ref #	Diagnosis Description
1	M17.9	16097	Osteoarthritis of knee, unspecified

Add diagnosis:

Therapy Visit Sub-types

- ☐ Evaluation and treatment
- ☐ Evaluation Only
- ☐ Follow-up treatment
- ☐ Follow-up treatment w/ROM/MMT/PPT
- ☐ Re-evaluation
- ☐ Re-evaluation w/ROM/MMT/PPT
- ☐ Ergonomic evaluation with report (Inclusive of onsite, travel and report completion)
- ☐ FCE w/report (4,5 or 6 hours) ☐ Hours
- ☐ PAT/Post-offer - level 1 (up to 30 min)
- ☐ PAT/Post-offer - level 2 (more than 30 min)
- ☐ Chiro - Manipulation only
- ☐ Other ☐ Mins

Notes

2016-01-13 08:09:26

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: Perez First: Consuelo DOI: 3/15/52 Date of Exam: 1/14/16 Case #: 32251644

Occupation: Laundry Attendent SS# 570-85-1146 Date of Injury: 3/10/13 Claim #: 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCEST. R Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax:

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)

worse pain PRN
work mod

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

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee
R total knee - post op SNF

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
☐ 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.
☐ Off work until (Date) Estimated period of total temporary disability ___ days.
☐ Off the balance of this shift only. Then RTW on (Date) to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) with the restrictions indicated below. Estimated duration of modified duty is ___ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / ( ) Limited standing or walking to ___ hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / ( ) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ___ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other
( ) Must keep ___ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ___ minute stretch break every ___ minutes from ( ) Keyboard / ( )
( ) Other
ut Keford PRN

☐ 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 and correct to the best of my knowledge and that I have not violated Labor Code S 139.3.
Name Stephen Graham M.D. Cal. Lic # Date of Exam 1/14/16
Specialty: Lic G45382 Signature
Executed at: USHW of California-Irvine, 2382 Morse Avenue, Irvine, CA 92614 Tel: 949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
TE: TIME: ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MO ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: TIME: ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

IRVINE CO./WORK COMP ONLY 164559
DOS: 1/14/16 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

STABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 80 BP: 151/75 RESP: 16 TEMP: 98.0

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☑ Worse
2. What does the pain feel like? ☐ Dull ☑ Sharp ☐ Burning ☐ Throbbing ☑ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today (locking pain)

Circle one:

NO PAIN										MOST PAIN
0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse rising from chair, long periods of standing
6. Activity or position that makes the pain less laying down, sitting
7. Have you kept your treatment as indicated? ☑ Yes ☐ No
8. What medications are you currently taking? Norco (only when in pain)

   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☑ Yes ☐ No (pain is getting worse)
    If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature [signature] Date 1/14/16

rev 11-2011

BIL

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

December 3, 2015

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Alejo Velarde.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for an osteochondral defect, which is known to progress with osteoarthritis. She has undergone two arthroscopic procedures and has been treated conservatively. She was last seen on 10/22/15. X-rays showed increased narrowing of the medial compartment. She was provided with Norco for pain relief. She comes back at this time for followup of her knee. Her pain is getting worse. She describes it as sharp, throbbing and pins-and-needles and rates it as 6/10, with 10 being worse. It is aggravated by weightbearing and partially relieved by rest. She has been working modified duties, which is mostly most of her job anyway.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 60
Blood Pressure: 160/79
Respirations: 16
Temperature: 99.0

Examination of the Right Knee

Visual Inspection

She has moderate swelling.

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.

Range of Motion

Knee motion is limited.

	Right	Left	Normal
Flexion	110 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

Tenderness mostly in the medial compartment.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

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U.S. HealthWorks MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation

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

☑ Additional pages attached

4

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 12/03/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCEST R Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax:

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)

worse

1 AV

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

no Δ

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

Long Beach Memorial

S/P total knee needs SNF post op

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

☐ 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.

☐ Off work until (Date) Estimated period of total temporary disability ___ days.

☐ Off the balance of this shift only. Then RTW on (Date) to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) with the restrictions indicated below. Estimated duration of modified duty is ___ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / ( ) Limited standing or walking to ___ hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / (✓) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ___ lbs
(✓) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other
( ) Must keep ___ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ___ minute stretch break every ___ minutes from ( ) Keyboard / ( )
( ) Other sit/stand PRN

☐ Medical status was discussed with employer representative

DISCHARGE STATUS

☐ Return to full duty on (Date) with no limitations or restrictions. Released from care without rateable 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 Stephen Graham M.D. Cal. Lic # Date of Exam 12/03/15

Specialty: Lic G43382 Signature S Graham MD

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: ___ TIME: ___ ☐ Before / After Shift	DATE: ___ TIME: ___ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

December 3, 2015

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Alejo Velarde.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for an osteochondral defect, which is known to progress with osteoarthritis. She has undergone two arthroscopic procedures and has been treated conservatively. She was last seen on 10/22/15. X-rays showed increased narrowing of the medial compartment. She was provided with Norco for pain relief. She comes back at this time for followup of her knee. Her pain is getting worse. She describes it as sharp, throbbing and pins-and-needles and rates it as 6/10, with 10 being worse. It is aggravated by weightbearing and partially relieved by rest. She has been working modified duties, which is mostly most of her job anyway.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse:	60
Blood Pressure:	160/79
Respirations:	16
Temperature:	99.0

Examination of the Right Knee

Visual Inspection

She has moderate swelling.

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.

Range of Motion

Knee motion is limited.

	Right	Left	Normal
Flexion	110 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

Tenderness mostly in the medial compartment.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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 2 seconds. The toes are warm and pink with good perfusion distally.

Special Tests

Babinski sign	Negative
Hoffmann sign	Negative
Clonus	Negative

DIAGNOSIS

Progressive osteoarthritis, right knee.

PLAN

The patient is advised that the only form of treatment I know that would give her significant relief of pain would be total knee replacement. The procedure and recovery was outlined to her, so she is aware of the prolonged recovery and pain involved with going through the operation. She is willing to proceed at this time, as her pain has worsened. Authorization for surgery will be

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requested. In the meantime, she will continue modified duties at work, which limit kneeling and squatting and climbing. Allow her to sit and stand on a p.r.n basis. Reevaluation will be preoperative in preparation for surgery. The patient does live alone and will likely require skilled nursing facility for proper rehabilitation program after surgery.

WORK STATUS

As reported in Plan.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gju.BGP
D: 12/04/15
T: 12/05/15
PerezC1203Graham22721080

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 10/22/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

↑ pain ant med + calf

T AV

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

O-110

xray R knee AP (standing)

↑ narrow 3V

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

Pt will consider TKA

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 Rx norco 5/325
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
(✓) No climbing limit

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 10/22/15
Specialty: Lic G43382 Signature _____
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
TE: _____ TIME: _____ ☐ Before / After Shift
LEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

October 22, 2015

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-WC-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

We communicated with the assistance of an interpreter, Alejo Velarde.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for an osteochondral defect, which has been treated arthroscopically two times. She is noted to have osteoarthritis of the knee. She has been placed on nabumetone and last seen on 09/10/15. She comes back at this time for a followup. I have been asked to evaluate her for possible permanent and stationary rating. However, the patient comes back at this time indicating her condition has changed and it is getting worse. She has had increasing pain in the front of the knee and extends down into the calf area. She requires Norco for pain relief; nabumetone has been ineffective in relieving her symptoms. Her pain level is 5/10, with 10 being worst. It is aggravated by walking and partially relieved by rest. She has been working on modified duties, but has not been able to increase her activities.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 65
Blood Pressure: 154/78
Respirations: 16
Temperature: 98.2

Examination of the Right Knee

Visual Inspection

There is some mild swelling in the knee. There is no sign of infection.

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.

Range of Motion

Her range of motion is noted to be from 0-110 degrees. There is no instability.

Palpation

She has pain along the anteromedial and medial joint line.

Special Tests

McMurray test is painful. Gait is mildly antalgic.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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 2 seconds. The toes are warm and pink with good perfusion distally.

Special Tests

Babinski sign	Negative
Hoffmann sign	Negative
Clonus	Negative

DIAGNOSTIC TESTING

X-rays were repeated today, and there does appear to be increasing narrowing of the medial joint space slightly greater than 50% at this time.

DIAGNOSIS

Progressive osteoarthritis, right knee.

PLAN

The patient's condition does not appear to be permanent and stationary. She has had an increase in symptoms and is strongly considering knee replacement as a treatment of choice. She would like to give it a little bit more time before she makes a complete decision to do so. Norco 5/325 will be renewed for p.r.n pain relief. She will continue on modified duties at work with limited standing, kneeling or squatting, limited climbing and allow her to sit and stand on an as-needed basis. Reevaluation will be in six weeks. If her condition continues to worsen, it is my opinion, she will probably require total knee replacement at that time.

Recvd Date: 20151105 Bin: DCN: 2015309GJ000862

WORK STATUS

As reported in Plan.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gju.BSG
D: 10/23/15
T: 10/24/15
PerezC1022Graham22720650

Recvd Date: 20151105 Brit DCN: 2015309GJ000862

IRVINE CO./WORK COMP ONLY 164559

DOS:10/22/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 65 BP: 154/78 RESP: 16 TEMP: 98.2

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY:_____ DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☑ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☑ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see back page for description of pain levels

Circle one:	NO PAIN										MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse Walk up
6. Activity or position that makes the pain less rest
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? for pain
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐Physical Therapy ☐Acupuncture ☐Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☐ No
    If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☐ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☐ No

Please explain Some the pain and boot again

Patient Signature Consuelo Perez Date 10/22/15

rev 11-2011

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

September 10, 2015

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for an osteochondral defect, which developed into progressive osteoarthritis for the medial compartment of her right knee. She has undergone two arthroscopic procedures, most recently on 05/03/15. Postoperatively, she has done reasonably well. She indicates that as long as she takes medications, she does not have any significant pain, but she has hard time going up and down steps and tries to avoid them even when on the medications. When her pain is better, it is at level 5/10, but again she has good relief from the nabumetone, which she takes twice a day. She continues to work modified duties.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 68
Blood Pressure: 152/81
Respirations: 18
Temperature: 98.2

Examination of the Right Knee

Visual Inspection

There is moderate effusion of the knee. She has minimal limp when walking.

Skin

There is no sign of infection.

Range of Motion

Knee motion is restricted.

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

There is tenderness on the medial and anteromedial joint line. There is no gross instability.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Progressive osteoarthritis, right knee.

PLAN

Plan would be to renew the nabumetone, which she will take twice a day as long as this reduces her pain symptoms, it will be helpful. The only other option at this time might be more surgery, which would include knee replacement. It does not appear to be that severe at the present time. Her condition is maximal improvement as of yet.

WORK STATUS

She will continue modified duties at work, which limit kneeling, squatting and limit climbing.

FOLLOW-UP APPOINTMENT

She will return in four to six weeks for followup.

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 Orange County, California, on 12-3-15.

Physician Signature S Graham MD CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gsa.CNO
D: 09/11/15
T: 09/12/15
PerezC0910Graham22720222

U.S. HealthWorks MEDICAL GROUP

(A)

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

☑ Additional pages attached

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 9/10/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

↑ steps meds help

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

mod eff 0-120 + Mel

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

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 Rx naproxen BID _____
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

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

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
(✓) No climbing limit

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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.

(1)

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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 9/10/15
Specialty: _____ Lic G43382 Signature _____
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 9/10/15 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES/GALLAGHER BASSETT Tel.: (213) 612-5400 Fax: _____

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

☐ improved as expected ☒ improved, but slower than expected ☐ work status pending PR2
☐ worsened ☐ reached plateau and no further improvement is expected ☐ not improved significantly
☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R
733.92 CHONDROMALACIA R

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 _____

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 9/10/15 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / ( ) Limited standing or walking to ____ hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / (X) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
( ) No climbing

( ) Sit down job.
( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
( ) Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
(X) Other LIMITED CLIMBING

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 9/10/15

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:30 PM Checkout Time 3:22 PM Next Visit Date 10/22/15 Time 1:45 PM

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

August 13, 2015

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post repeat arthroscopy, meniscectomy, chondroplasty and débridement of the right knee on 05/03/15. Initial surgery was on 06/17/13. She is noted to have significant chondral defect, which was debrided. She returns at this time for followup. She indicates her condition seems to be getting worse. She states her pain is sharp at level 6/10. She has been out of medications for the past two weeks. Medications were very helpful when she is taking them. She was taking nabumetone for anti-inflammatory effect and Norco once in while for pain relief.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 61
Blood Pressure: 138/71
Respiration: 16
Temperature: 98.3

Examination of the Right Knee

Visual Inspection

There is mild swelling in the right knee.

Skin

There is no sign of infection.

Range of Motion

Knee motion is restricted.

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

There is tenderness along the anterior and medial joint line in the area of the medial femoral condyle and some medial joint line pain also.

Special Tests

There is no instability.

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Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Progressive osteoarthritis right knee due to osteochondral defect.

PLAN/PROCEDURE

The patient was given steroid injection in the knee using 1 cc of dexamethasone and 4 cc of lidocaine. A prescription for Nabumetone and Norco will be renewed.

WORK STATUS

She will continue working modified duties, which limit kneeling and squatting and stair climbing.

FOLLOW-UP APPOINTMENT

Reevaluation will be in four weeks.

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 Orange County, California, on 12-3-15.

Physician Signature S Graham MD CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gsa.BGP
D: 08/14/15
T: 08/15/15
PerezC0813Graham21212

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 8/13/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./WORK COMP ONLY Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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

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

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

SUBJECTIVE COMPLAINTS (Document and describe significant complaints)

out meds 2 wks 4 pain

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

mod swell 0-120 + MF C

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

TREATMENT

urgent 1cc dex 4cc lido

☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____
☑ Meds / Supplies Dispensed Naprosyn, norco
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

WRITTEN RX REQUIRED

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
(✓) ~~No~~ climbing limit

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

Medical status was discussed with employer representative _____

CHARGE 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.

IARY TREATING PHYSICIAN

lare 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.

s Stephen Graham M.D. Cal. Lic # _____ Date of Exam 8/13/15

ialty: Lic G43382 Signature _____

rted at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 4 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

ION ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

_____ TIME: _____ ☐ Before / After Shift

LEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

DATE: _____ TIME: _____ ☐ Before / After Shift

PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

June 25, 2015

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 008094-000407-wc-01

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post arthroscopy meniscectomy, chondroplasty and debridement of the right knee on 05/03/15. Postoperatively, she has made some progress. She was last seen by me on 05/28/15 and her condition seemed to be improving. She was advised to continue to exercise and increase daily activities. She returns at this time and again, there have been some good days and some bad days. Her pain is described as sharp at level 4/10. It seems to be aggravated by pivoting with weight on the leg. She does use medications for pain relief. She has been working modified duties.

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

D:\PrintImageBundler\Temp\658317\Original\280429DA-724D-4552-ACE0-08F3F5AF6B67-24611-IF.PDF

General Appearance

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

Vital Signs

Pulse: 59
Blood Pressure: 149/96
Respirations: 15
Temperature: 96.8

Examination of the Right Knee

Visual Inspection

Gait is mildly antalgic.

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.

Range of Motion

Knee motion is restricted.

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

Her knee shows mild swelling with pain over the anterior medial joint line.

Special Tests

There is no instability.

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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 2 seconds. The toes are warm and pink with good perfusion distally.

Special Tests

Babinski sign	Negative
Hoffmann sign	Negative
Clonus	Negative

DIAGNOSIS

Chondral defect right knee, status post arthroscopy.

PLAN

Medications will be renewed. The patient will continue home exercise program. She will likely be left with some residuals, which in the future I anticipate to progress to the need for knee arthroplasty.

WORK STATUS

Work status at this time is modified with limited kneeling or squatting, limited climbing.

FOLLOW-UP APPOINTMENT

Reevaluation will be in four to six weeks.

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 Orange County, California, on 12-3-15.

Physician Signature S Graham MD CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gsa.CNO
D: 06/26/15
T: 06/27/15
PerezC0625Graham20794

Recvd Date: 20150713 Bill DCN: 2015194GJ000071

U.S. HealthWorks MEDICAL GROUP

(6)

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

☒ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 6/25/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 008094-000407-wc-01

Employer: IRVINE CO./CORP. Contact: CORPORATE RECRU Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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

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

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

SUBJECTIVE COMPLAINTS (Document and describe significant complaints)

worse ↑↓ out med

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

pain

DIAGNOSES (Include ICD-9 code, if possible) DJD R Knee

renew meds

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 _____

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
(✓) No climbing limit

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 6/25/15

Specialty: _____ Signature S Graham

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: 7/13 TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Provider

DAILY THERAPY TREATMENT NOTE

Treatment Visit #: 14
Authorized Visit #: 18 of 6
Auth Exp Date: _____
Next MD Appt: _____

Diagnosis: (R) knee OA, chondromalacia

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
(R) knee mildly stiff & achy mostly p activity
working at work

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretator. Mins: ____ Interpreter _____

Treatment goals: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP Issued (see handout)
25 ☒ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ 97535 Self Care/Home Management Training ☐ ADLs ☐ Posture and positioning ☐ Joint Protection _____
15 ☒ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping _____
☒ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____
_____
☐ _____ Other: _____
10 ☒ 97140 Manual Therapy STM/MFR/ Mob/Man Traction/Scar massage Grade. I II III IV V (R) knee
☐ ☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ ☐ 97124 Massage/ Ice Massage: _____
☐ ☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____
☐ ☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non selec _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ ☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min). Current: _____ (mA)
☐ In clinic ☐ Extended wear. _____ hours _____
☐ ☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ ☐ 97039 Laser/Light: Probe: _____ J/cm² _____
☐ ☐ 97034 Contrast Baths: Cycles: _____ Temp warm: _____ °F/ _____ min. Temp cool: _____ °F: _____ min Body Part _____
☐ ☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed _____ % @ _____ w/ cm² _____ MHz

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ ☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low-Med-High: _____
10 ☒ 97014 E-Stimulation: (R) knee to ↓ (P) & Thumb
☐ IFC ☐ EMS ☐ Premod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☒ TENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ___ Hz/bps
☐ ☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static ___ lbs/mmHg
☐ Intermit Hold ___ lbs / mmHg _____ sec / min Relax ___ lbs / mmHg _____ sec / min Time / Cycles _____
☐ ☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidtherapy _____
☐ ☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ ☐ 99070 Supplies Dispensed
for home program:

☒ Skin checked and clear following treatment
Response to Treatment: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability
Assessment: _____

☒ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist or Patient Transportation
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 6/03/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Steve Honda, PTA
License Number AT62
Provider Signature, License Number, and Date

1 Eval & Treat 2 Eval only 3 F/U 4 F/U w/ Prog Note/PAT 5. RE only 6. RE & T-

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: KEEP IN CHART DX:

CLINICIAN'S INITIALS:																	
EXERCISE:	Setting:	Date:	3/20	3/24	3/27	3/31	4/1	4/7	4/9	4/14	4/17	4/21	4/24	4/28	5/1	5/5	5/8
FA Bike		Wt.	12	10	10	12	10	10	12	12	12	12	12	12	12	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20	20	20	20	20	20	20
Lunges,		Wt.					10	10	10	10	10	15	15	15	15	15	15
Toe Raises		Reps	15	15	15	15	15	20	20	20	20	20	20	20	20	20	20
Step ups,		Wt.							15	15	15	15	15	15	15	15	15
alternate		Reps															
Side steps		Wt.															
		Reps															
NMR Tilt board		Wt.	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30 x 2	30 x 2	30 x 2	30x 2	30x 2	30x 2	30x 2
		Reps	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2	20 x 2	20 x 2	20 x 2	20 x 2	20x 2	20x 2	20x 2	20x 2
		Wt.															
		Reps															
TE UBE		Wt.	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Chest Stretch		Reps															
Pulley, Hold		Wt.	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
		Reps															
		Wt.															
		Reps															
		Wt.															
		Reps															
		Wt.															
		Reps															

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US HealthWorks MEDICAL GROUP
A Dignity Health Member

Bill.

Treatment Visit #: 17
Approved Visit #: 17 of 18

DAILY THERAPY TREATMENT NOTE

Auth Exp Date: _____

Diagnosis: R knee OA, chondromalacia

Next MD Appt: _____

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
R knee feeling stronger & stable. Very painful → 7/10

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☑ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Mins ____ Interpreter _____

Treatment goals: ☐ ↓Inflammation /Edema ☑ ↓Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☑ ↑ Coordination ☑ ↑ Functional Ability

Time Dx **Therapeutic Procedures (Time based):** ☑ See flowsheet ☐ Written HEP issued (see handout)

25 ☑ 97530 Functional Activities ☑ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____
15 ☑ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture-Taping _____
10 ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established ☐ Reviewed ☐ Progressed Home Ex Program _____
_____
☐ _____ Other: _____
10 ☑ 97140 Manual Therapy STM/MFR/JMob/Man Traction/Scar massage: Grade: I II III IV V R knee
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ 97124 Massage/ Ice Massage _____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check _____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care ☐ 97597 Selective ☐ 97602 Non-select _____

Time Dx **Constant Attendance (Time based):** ☐ See flowsheet
☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min) Current _____ (mA)
☐ In clinic ☐ Extended wear: ____ hours _____
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ 97039 Laser/Light Probe: ____ J/ cm² _____
☐ 97034 Contrast Baths: Cycles: _____ Temp warm: ____ °F/____ min. Temp cool ____ °F: _____ min Body Part: _____
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/ Pulsed _____ % @ _____ w / cm² _____ MHz _____

Time Dx **Supervised (Untimed- Service Based):** ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High _____
10 ☑ 97014 E-Stimulation: R knee IFC for pain
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ Unidirectional ☐ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/pps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static ____ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg ____ sec / min Time / Cycles ____
☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ 99070 Supplies: Dispensed for home program

☑ Skin checked and clear following treatment
Response to Treatment: ☐ ↓Inflammation /Edema ☑ ↓Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☑ ↑ Coordination ☑ ↑ Functional Ability
Assessment: _____
_____ Dina PT

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist or Second Transfer of Tie

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

164551
IRVINE CO./CORP.
DOS: 5/28/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

BOVE

_____ License Number [illegible]225
Provider Signature, License Number and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

KEEP IN CHART

THERAPIST:

START DATE: DX:

CLINICIAN'S INITIALS:																	
EXERCISE:	Settings	Dates	3/20	3/24	3/27	3/31	4/3	4/7	4/10	4/14	4/17	4/21	4/24	4/28	5/1	5/5	5/8
Bike		Wt.	10	10	10	10	10	10	10	12	12	12	12	12	12	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20	20	20	20	20	20	20
[illegible]		Wt.					10	10	10	10	10	15	15	15	15	15	15
[illegible]		Reps	15	15	15	15	15	20	20	20	20	20	20	20	20	20	20
Step [illegible]		Wt.							15	15	15	15	15	15	15	15	15
[illegible]		Reps															
Side steps		Wt.															
		Reps															
EMR Tricep [illegible]		Wt.	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2
		Reps	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2
		Wt.															
		Reps															
TE [illegible]		Wt.	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
[illegible]		Reps															
[illegible]		Wt.	15	16	15	15	15	16	16	15	16	15	15	15	15	16	15
		Reps															
		Wt.															
		Reps															
		Wt.															
		Reps															
		Wt.															
		Reps															

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A Dignity Health Member

DAILY THERAPY T[illegible] BIL

Treatment Visit #: 16
Authorized Visit #: 16 of 18
Auth Exp Date: _____
Next MD Appt: _____

Diagnosis: (R) OA, chondromalacia
Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
(R) Knee (R) [illegible] Inflam'd 2° to [illegible] new med. More for to extension at bending also

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/RCM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation, Mins.____ Interpreter _____

Treatment goals: ☐ ↓Inflammation /Edema ☒ ↓Pain ☐ ↓Muscle Spasm ☒ ↑Strength ☒ ↑ROM ☐ ↑Coordination ☒ ↑Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
☐ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____
15 ☒ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping _____
10 ☒ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____
☐ _____ Other: _____
10 ☒ 97140 Manual Therapy: STM/MFR/JT Mob/Man Traction/Scar massage: Grade: I II III IV V (R) Knee
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ 97124 Massage/ Ice Massage: _____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non selective _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ 97033 Iontophoresis (_____ml of Dexamethasone 4 mg/ml) Dose:_____(mA/min), Current_____mA)
☐ In clinic ☐ Extended wear: _____hours _____
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ 97039 Laser/Light Probe: _____J/cm² _____
☐ 97034 Contrast Baths: Cycles: _____Temp warm:_____°F/_____min Temp cool._____°F/_____min Body Part:_____
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/ Pulsed _____% @_____w/cm² _____MHz

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High _____
10 ☒ 97014 E-Stimulation: (R) Knee to JP
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☒ ENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq____Hz/bps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel ☐ Trac ☐ Static ____ lbs/mmHg
☐ Intermit Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles _____
☐ 97018 Paraffin Bath: _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ 99070 Supplies: Dispensed for home program:

NS Skin checked and clear following treatment
Response to Treatment ☐ ↓Inflammation /Edema ☒ ↓Pain ☐ ↓Muscle Spasm ☒ ↑Strength ☒ ↑ROM ☐ ↑Coordination ☒ ↑Functional Ability
Assessment: Able to tol. [illegible] & progress [illegible]
Sig. lifts = significant [illegible]

Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer of Care
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy - see attached summary

IRVINE CO./CORP. 164551
DOS: 5/27/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JP

Steve Honda, PTA License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: [redacted] IN CHART Rx:

CLINICIAN'S INITIALS:															
EXERCISE:	Set/Hrs	Date:	3/20	3/24	3/27	3/31	4/2	4/7	4/9	4/14	4/16	4/21	4/23	4/28	5/5
FA Bike		Wt.	12	10	10	10	10	10	12	12	12	12	12	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20	20	20	20	20
Lunges,		Wt.					10	10	10	10	10	15	15	15	15
Toe touch		Reps	15	15	15	15	15	20	20	20	20	20	20	20	20
Step ups		Wt.							15	15	15	15	15	15	15
down		Reps													
Side steps		Wt.													
		Reps													
NMR Tramp - Stn		Wt.	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30 2	30 2	30 2	30x 2	30x 2	30x 2
Hit		Reps	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2	20 2	20 2	20 2	20 2	20x 2	20x 2	20x 2
		Wt.													
		Reps													
TE HIS Stretch		Wt.	2	2	2	2	2	2	2	2	2	2	2	2	2
Quad Stretch		Reps													
Hamstring		Wt.	15	15	15	15	15	15	15	15	15	15	15	15	15
		Reps													
		Wt.													
		Reps													
		Wt.													
		Reps													
		Wt.													
		Reps													

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

DAILY THERAPY TREATM... NOTE

Treatment Visit #: 15
Authorized Visit #: 15 of 16
Auth Exp Date: _____
Next MD Appt: _____

Diagnosis: (R) OA of knee, chondromalacia

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report

(R) knee pain mildly elevated x some T'd for 15 extended w/ heating

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation. Mins:____ Interpreter:_____

Treatment goals: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
25 ☒97530 Functional Activities ☒Therapeutic Activities ☐Job simulation ☐ Body Mechanics _____
☐97535 Self Care/Home Management Training ☐ADL's ☐Posture and positioning ☐Joint Protection _____
15 ☒97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping _____
15 ☒97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program: _____
☐ _____Other: _____
10 ☒97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage: Grade: I II III IV V (R) knee, patellar mobs
☐97116 Gait Training ☐Cane ☐Crutches ☐Walker ☐Stairs ☐Uneven surfaces _____
☐97124 Massage/ Ice Massage: _____
☐97760 Orthotic management/fit/training ☐97762 Orthotic check: _____
☐97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐97597 Selective ☐97602 Non select _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐97033 Iontophoresis (_____ml of Dexamethasone 4 mg/ml) Dose:_____(mA/min), Current:_____(mA)
☐In clinic ☐Extended wear: _____hours _____
☐97032 Manual Electric Stimulation ☐Probe ☐US/E-stim Combo (Parameters below) _____
☐97039 Laser/Light Probe: _____J/ cm² _____
☐97034 Contrast Baths: Cycles: _____Temp warm:____°F/_____ min. Temp cool:_____°F/_____min Body Part:_____
☐97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed _____% @_____w / cm² _____ Mhz

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐97016 Vasopneumatic Compression /Edema Control. Pressure: Low Med High : _____
10 ☒97014 E-Stimulation: (R) knee to ↓ pain ☐IFC ☐EMS ☐Pre-mod ☐Micro ☐H-Wave ☐HV ☐LV ☒TENS ☐Modulated ☐Continuous ☐Burst ☐Freq___Hz/pps
☐97012 Mechanical Traction ☐Cervical ☐Lumbar ☐Carpal Tunnel C-Trac ☐Static: ___ lbs/mmHg
☐Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles: _____
☐97018 Paraffin Bath _____ ☐97022 Whirlpool/Fluidotherapy _____
☐97026 Infrared _____ ☐97010 Hot/Cold Pack _____
☐99070 Supplies: Dispensed for home program:

☒ Skin checked and clear following treatment
Response to Treatment: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability
Assessment: Able to stand & turn & sit throughout exercises & tx

☒ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer of file
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy - see attached summary

IRVINE CO./CORP. 164551
DOS: 5/21/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case #: 32-254644 Ref #: FMR/LB

Steve Honcia, PTA
License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: NEED IN CHART DX:

CLINICIAN'S INITIALS:														
EXERCISE:	Settings:	Date:	3/20	3/24	3/27	3/31	4/2	4/7	4/9	4/14	4/16	4/21	4/23	4/28	4/30
FA Bike		Wt.	10	10	10	10	10	10	10	12	12	12	12	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20	20	20	20	20
Lunges,		Wt.					10	10	10	10	10	15	15	15	15
Toe touch		Reps	15	15	15	15	15	20	20	20	20	20	20	20	20
Step ups		Wt.							15	15	15	15	15	15	15
down		Reps													
Side steps		Wt.													
		Reps													
NMR Trunk twist		Wt.	30# 2	30# 2	30# 2	30# 2	30# 2	30# 2	30# 2	30# 2	30 #2	30 #2	30 #2	30# 2	30# 2
Medicine		Reps	20# 2	20# 2	20# 2	20# 2	20# 2	20# 2	20# 2	20 #2	20 #2	20 #2	20 #2	20# 2	20# 2
		Wt.													
		Reps													
PE HDS Stretch		Wt.	2	2	2	2	2	2	2	2	2	2	2	2	2
Clock Stretch		Reps													
Ball toss, Wall		Wt.	15	15	15	15	15	15	15	15	15	15	15	15	15
		Reps													
		Wt.													
		Reps													
		Wt.													
		Reps													
		Wt.													
		Reps													

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

Treatment Visit #: 14
Authorized Visit #: 14 of 18
Auth Exp Date: _____
Next MD Appt: _____

DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) Knee OA, chondromalacia

Subjective: ☒ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report

(R) knee has felt @ F/U not bearing well but
good @ knee symptoms upon returning to work.

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation: Mins _____ Interpreter: _____

Treatment goals: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
25 ☒ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ ☐ 97535 Self Care/Home Management Training ☐ ADLs ☐ Posture and positioning ☐ Joint Protection _____
15 ☒ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping _____
10 ☒ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____
☐ ☐ ☐ _____ Other: _____
10 ☒ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage: Grade: I II III IV (R) knee/patellar mobs
☐ ☐ ☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ ☐ ☐ 97124 Massage/ Ice Massage: _____
☐ ☐ ☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____
☐ ☐ ☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ ☐ ☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min), Current: _____ (mA)
☐ In clinic ☐ Extended wear: _____ hours _____
☐ ☐ ☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ ☐ ☐ 97039 Laser/Light Probe: _____ J/ cm² _____
☐ ☐ ☐ 97034 Contrast Baths: Cycles: _____ Temp warm: _____ °F/ _____ min. Temp cool. _____ °F/ _____ min Body Part: _____
☐ ☐ ☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed _____ % @ _____ W/ cm² _____ MHz _____

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ ☐ ☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High _____
10 ☒ 97014 E-Stimulation (R) knee to IQ @ Therex
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ Hi-Wave ☐ HV ☐ LV ☒ TENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/bps
☐ ☐ ☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ____ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles: _____
☐ ☐ ☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ ☐ ☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ ☐ ☐ 99070 Supplies: Dispensed
for home program:

☒ Skin checked and clear following treatment

Response to Treatment: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Assessment: Able to tolerate > 1/2 squat. Responds well to (R) knee therapy

☒ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on File

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 5/20/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Steve Hoxie, PTA
License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: KEEP IN CHART DX:

CLINICIAN'S INITIALS:														
EXERCISE:	Settings	Dates	3/20	3/24	3/27	3/31	4/2	4/7	4/9	4/14	4/16	4/21	4/23	4/28
A Bike		Wt.	12	10	10	10	10	10	12	12	12	12	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20	20	20	20
Lunges		Wt.					10	10	10	10	10	15	15	15
Toe touch		Reps	15	15	15	15	15	20	20	20	20	20	20	20
Step ups		Wt.							15	15	15	15	15	15
down		Reps												
Side steps		Wt.												
		Reps												
NMR Trunk Stab		Wt.	30x 2	30x 2	30x 2	30x 2	30/ 2	30x 2	30x 2	30/ 2	30 2	30 2	30 2	30/ 2
Work		Reps	20y 2	20/ 2	20x 2	20x 2	20/ 2	20/ 2	20/ 2	20 2	20 2	20 2	20 2	20/ 2
		Wt.												
		Reps												
TE HIS Stretch		Wt.	2	2	2	2	2	2	2	2	2	2	2	2
Clam Shell		Reps												
Bridge Ball		Wt.	15	15	15	15	15	15	15	15	15	15	15	15
		Reps												
		Wt.												
		Reps												
		Wt.												
C		Reps												
		Wt.												
		Reps												

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

DAILY

BIL

Treatment Visit #: 12
Authorized Visit #: 13 of 18
Auth Exp Date: _____
Next MD Appt: _____

Diagnosis: (R) knee OA chondromalacia

Subjective: ☐ Improved ☐ Same ☑ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
(R) knee stiffness/ache & fatigued 2° returning to work Hx stroke

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Mins ____ Interpreter _____

Treatment goals: ☐ ↓Inflammation /Edema ☒ Pain ☐ ↓ Muscle Spasm ☒ Strength ☒ ROM ☐ ↑ Coordination ☒ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
25 ☒ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____
15 ☒ 97112 Neuromuscular re-education Balance/Coordination/Propric/Kinesthetic sense/Posture/Taping _____
10 ☒ 97110 Therapeutic Exercise for Strength /ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____
_____
☐ _____ Other: _____

10 ☒ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage: Grade: I II III IV (R) knee patellar mobs
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ 97124 Massage/ Ice Massage: _____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check. _____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care ☐ 97597 Selective ☐ 97602 Non select _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min), Current _____ (mA)
☐ In clinic ☐ Extended wear: _____ hours _____
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ 97039 Laser/Light Probe: _____ J/ cm² _____
☐ 97034 Contrast Baths: Cycles: _____ Temp warm _____ °F/_____ min. Temp cool: _____ °F/_____ min Body Part: _____
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocor) Cont/ Pulsed _____ % @ _____ w / cm² _____ MHz _____

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High: _____
10 ☒ 97014 E-Stimulation: (R) knee to VQ & Thera-Band _____
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☒ TENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/pps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel ☐ Trac ☐ Static ____ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles _____
☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ 99070 Supplies: Dispensed
for home program:

☒ Skin checked and clear following treatment
Response to Treatment: ☐ ↓Inflammation /Edema ☒ Pain ☐ ↓Muscle Spasm ☒ Strength ☒ ROM ☐ ↑ Coordination ☒ Functional Ability
Assessment: Pt able to walk 3 hrs, pt still unable to use effort 2° knee stiffness & pain, will continue

☒ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 5/15/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
tl Case # : 32-251644 Ref # : EMR/JB

Steve Honde, PTA
License Number AT6225
Provider Signature, License Number, and Date

1 Eval & Treat 2 Eval only 3 F/U 4 Flow Prog Note/FAX 5 RE new 6 RE 4 Treat

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: KEEP IN CHART DX:

CLINICIAN'S INITIALS:													
EXERCISE:	Settings:	Date:	3/20	3/24	3/27	3/31	4/3	4/7	4/10	4/14	4/17	4/21	4/24
FA Bike		Wt.	12	10	10	10	10	10	10	12	12	12	12
Squats		Reps	15	15	18	20	20	20	20	20	20	22	20
Lunges		Wt.					10	10	10	10	10	15	15
Toe Reach		Reps	15	15	15	15	15	20	20	20	20	20	20
Step ups down		Wt.							15	15	15	15	15
		Reps											
Side Steps		Wt.											
		Reps											
NMR Trunk Stab		Wt.	30x 2	30x 2	35x 2	30x 2	30x 2	35x 2	30x 2	30x 2	30 x2	30 x2	30 x2
		Reps	24x 2	22x 2	24x 2	20x 2	20x 2	24x 2	24x 2	30 x2	30 x2	22 x2	22 x2
		Wt.											
		Reps											
TE HS Stretch		Wt.	2	2	2	2	2	2	2	2	2	2	2
Quad Stretch		Reps											
Bridges + Hold		Wt.	15	16	15	15	15	15	15	15	15	15	15
		Reps											
		Wt.											
		Reps											
		Wt.											
		Reps											
		Wt.											
		Reps											

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

April 30, 2015

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is status post arthroscopy, chondroplasty and debridement of the right knee on 03/03/15 for osteochondral defect in the medial femoral condyle. Postoperatively, she returned on 03/12/15 and her sutures were removed and was she referred for physical therapy. She has been through physical therapy and was last seen on 04/02/15. Her condition seemed to be improving. She had some swelling and some quadriceps atrophy. Norco was prescribed, therapy was continued. She returns at this time for followup. She still has some soreness over the inner aspect of the knee. It is aggravated by walking and partially relieved by rest. She rates as 4/10, with 10 being at worst. At times, it feels pins-and-needles, and other times it feels sharp. She is using pain medications sporadically, but not on a regular basis. She plans to return to modified duties at work on 05/11/15, if possible.

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, female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 59
Blood Pressure: 170/86, repeated 150/90
Respiration: 16
Temperature: 98.6

Examination of the Right Knee

Visual Inspection

There is mild swelling in the knee. There is no sign of infection.

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.

Range of Motion

Range of motion is limited from 0 to 120 degrees.

Palpation

There is pain along the medial and anteromedial joint line with mild quadriceps atrophy.

Special Tests

There is no instability.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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 2 seconds. The toes are warm and pink with good perfusion distally.

Special Tests

Babinski sign	Negative
Hoffmann sign	Negative
Clonus	Negative

DIAGNOSIS

Osteochondral defect medial femoral chondral right knee, status post arthroscopy.

PLAN

Plan will be to recommend more therapy. She has quadriceps atrophy which could be built up with more therapy two times a week for three more weeks, this will be in preparation. We are returning her to work.

WORK STATUS

At the present time, she is TTD. I would anticipate return to modified duties at work as of 05/11/15 with restrictions of no kneeling or squatting and limit stair climbing.

FOLLOW-UP APPOINTMENT

Reevaluation in three to four weeks for followup.

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 Orange County, California, on 12-3-15.

Physician Signature S Graham MD CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gju.BSJ
D: 04/30/15
T: 05/01/15
PerezC0430Graham22720234

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US HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

Treatment Visit #: 12
Authorized Visit #: 12 of 12
Auth Exp Date: _____
Next MD Appt: _____

DAILY THERAPY TREATMENT NOTE

Diagnosis: R knee OA, chondromalacia

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
R knee has not improved since starting PT. Pt feels ready to return to work at full duties per MD visit.

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation: Mins ____ Interpreter _____

Treatment goals: ☐ ↓Inflammation /Edema ☐ ↓Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☐ ↑ROM ☐ ↑ Coordination ☐ ↑Functional Ability

Time Dx Therapeutic Procedures (Time based): ☐ See flowsheet ☐ Written HEP issued (see handout)
25 ☐ 97530 Functional Activities ☐ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____
15 ☐ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping _____
To ☐ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____
☐ _____ Other: _____
10 ☐ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage: Grade: I II III IV V R knee, patellar mobs
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ 97124 Massage/ Ice Massage: _____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check _____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ 97033 Iontophoresis (____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min), Current: _____ (mA)
☐ In clinic ☐ Extended wear: _____ hours
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ 97039 Laser/Light Probe: _____ J/ cm² _____
☐ 97034 Contrast Baths: Cycles: _____ Temp warm: ____ °F/ ____ min. Temp cool: ____ °F/ ____ min Body Part: _____
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/ Pulsed _____ % @ _____ w / cm² _____ MHz

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control Pressure: Low Med High : _____
10 ☐ 97014 E-Stimulation: R knee to VMO @ P flex ek
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☐ TENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/bps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ____ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles: _____
☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ 99070 Supplies Dispensed for home program.

☐ Skin checked and clear following treatment
Response to Treatment: ☐ ↓Inflammation /Edema ☐ ↓Pain ☐ ↓Muscle Spasm ☐ ↑Strength ☐ ↑ROM ☐ ↑Coordination ☐ ↑Functional Ability
Assessment: Able to 1/2 squat, lunge, step up, +15 @ P for functional improvement

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 4/29/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Def # : EMD / IB

Steve Honda, PTA License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMB/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: FIELD IN CHART DX:

CLINICIAN'S INITIALS:												
EXERCISE:	Settings	Dates:	3/20	3/24	3/27	3/31	4/3	4/7	4/10	4/14	4/17	4/21
A Bike		Wt.	12	10	10	10	10	10	10	12	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20	20
Incops		Wt.					10	10	10	10	10	15
Toe Riser		Reps	15	15	15	15	15	20	20	20	20	20
Step ups		Wt.							15	15	15	15
down		Reps										
Side Steps		Wt.										
		Reps										
B Trap Shrug		Wt.	30x2	30x2	30x2	30x2	30x2	30x2	30x2	30x2	30x2	30x2
more		Reps	20x2	20x2	20x2	20x2	20x2	20x2	20x2	20x2	20x2	20x2
		Wt.										
		Reps										
E HS stretch		Wt.	2	2	2	2	2	2	2	2	2	2
Quad stretch		Reps										
Bridges + Add.		Wt.	15	15	15	15	15	15	15	15	15	15
		Reps										
		Wt.										
		Reps										
C		Wt.										
		Reps										
		Wt.										
		Reps										

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

DAILY THERAPY TREATMENT NOTE

Diagnosis. R CA knee, chondromalacia

Auth Exp Date: ____

Next MD Appt: ____

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report

R knee pain with squatting, going up and down stairs, kneeling, sitting for long periods of time

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary

☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 95199 Interpretation Mins: ____ Preparation

Treatment goals: ☐ ↓Inflammation /Edema ☑ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☐ ↑ Coordination ☑ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☐ See flowsheet ☐ Written HEP issued (see handout)

25 ☑ 97530 Functional Activities ☑ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics ____

☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection ____

15 ☑ 97112 Neuromuscular re-education (Balance/Coordination/Proprioception/Kinesthetic sense/Posture/Taping ____

10 ☑ 97110 Therapeutic Exercise for (Strength / ROM / Flexibility) ☐ Established / Reviewed / Progressed Home Ex Program ____

☐ ____ Other ____

10 ☑ 97140 Manual Therapy (STM/MFR/ Mobil/Man Traction/Scar massage Grade I II III IV) R knee, patellar mobs

☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces ____

☐ 97124 Massage/ Ice Massage: ____

☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check ____

☐ 97113 Aquatic Therapy w/ ther ex ☐ Sum/Wound Care: ☐ 97597 Selective ☐ 97602 Non select ____

Time Dx Constant Attendance (Time based): ☐ See flowsheet

☐ 97033 Iontophoresis (____ ml of Dexamethasone 4 mg/ml) Dose: ____ (mA/min), Current ____ (mA)

☐ In clinic ☐ Extended wear ____ hours ____

☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) ____

☐ 97039 Laser/Light: Probe. ____ J/ cm² ____

☐ 97034 Contrast Baths Cycles: ____ Temp warm: ____ °F; ____ min Temp cool: ____ °F; ____ min Body Part ____

☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed ____ % @ ____ w/ cm² ____ MHz ____

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet

☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High ____

10 ☑ 97014 E-Stimulation: R knee for pain & ther

☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☑ TENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/bps

☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static ____ lbs/mmHg

☐ Intermit: Hold ____ lbs / mmHg ____ sec / min. Relax ____ lbs / mmHg ____ sec / min Time / Cycles ____

☐ 97018 Paraffin Bath ____ ☐ 97022 Whirlpool/ Hydrotherapy ____

☐ 97026 Infrared ____ ☐ 97010 Hot/Cold Pack ____

☐ 99070 Supplies: Dispensed for home program:

☑ Skin checked and clear following treatment

Response to Treatment: ☐ ↓Inflammation /Edema ☑ Pain ☐ ↓Muscle Spasm ☐ ↑ Strength ☑ ↑ ROM ☐ ↑ Coordination ☑ ↑ Functional Ability

Assessment: Able to perform 1/4 squats x 20 steps up/down & did start/dc & balance today

☑ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer of Care

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy - see attached summary

IRVINE CO./CORP. 164551

DOS: 4/27/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Steve Honda, PTA License Number AT6225

Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: KEEP IN CHART DX:

CLINICIAN'S INITIALS:											
EXERCISE:	Settings	Date:	3/20	3/24	3/27	3/31	4/1	4/7	4/24	4/29	4/27
Bike		Wt.	12	10	10	10	10	10	18	12	12
Squats		Reps	15	15	15	20	20	20	20	20	20
Lunges		Wt.					10	10	10	10	10
Toe Raises		Reps	15	15	15	15	15	20	20	20	20
Step ups down		Wt.							15	15	15
		Reps									
Side Steps		Wt.									
		Reps									
MR Trays Sto S		Wt.	30x 2	30x 2	30x 2	30 x 2	30x 2	35x 2	35x 2	30 x2x2	30
Mental		Reps	20x 2	20x 2	20x 2	20x 2	22x 2	22x 2	20x 2	20 x2x2	20
		Wt.									
		Reps									
E- HS Stretch		Wt.	2	2	2	2	2	2	2	2	2
Quad Stretch		Reps									
Bridges + Add.		Wt.	15	15	15	15	15	15	15	15	15
		Reps									
		Wt.									
		Reps									
		Wt.									
		Reps									
		Wt.									
		Reps									

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

DAILY THERAPY TREATMENT NOTE

Treatment Visit #: 10
Authorized Visit #: 10 of 12
Auth Exp Date ___
Next MD Appt. ___

Diagnosis: (R) knee OA, chondromalacia
Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
(R) knee pain 5/10 & intermittent, feeling like it wants to lock & pt. instructed exercises

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report ☐ D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Mins ___ Interpreter ___

Treatment goals: ☐ ↓ Inflammation /Edema ☑ ↓ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☐ ↑ Coordination ☑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
25 ☑ 97530 Functional Activities ☑ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics ___
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection ___
15 ☑ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping ___
10 ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program: ___
☐ ___ Other ___
10 ☑ 97140 Manual Therapy STM/MFR/JT Mob/Mar Traction/Scar massage. Grade I II III IV (R) knee, patellar mob
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces ___
☐ 97124 Massage/ Ice Massage ___
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check ___
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care ☐ 97597 Selective ☐ 97602 Non-select ___

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ 97033 Iontophoresis ___ ml of Dexamethasone 4 mg/ml Dose ___ (mA/min) Current ___ (mA)
☐ In clinic ☐ Extended wear ___ hours ___
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ IFC/E-stim Combo (Parameters below) ___
☐ 97039 Laser/Light Probe: ___ ___ J/cm² ___
☐ 97034 Contrast Baths: Cycles: ___ Temp warm: ___ °F: ___ min Temp cool: ___ °F: ___ min Body Part: ___
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocor): Cont./ Pulsed ___ % @ ___ w/cm² ___ ___ Mhz ___

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control, Pressure: Low Med High ___
10 ☑ 97014 E-Stimulation: (R) knee to ↓ P & ↑ mvmt ___
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ Ly ☑ TENS ☑ Modulated ☐ Continuous ☐ Burst ☐ Freq ___ Hz/pps ___
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Cervical Lumbar C-Trac ☐ Static: ___ lbs/mmHg
☐ Intermit Hold ___ lbs/mmHg ___ sec/min Relax ___ lbs/mmHg ___ sec/min Time/Cycles ___
☐ 97018 Paraffin Bath ___ ☐ 97022 Whirlpool/Fluidotherapy ___
☐ 97026 Infrared ___ ☐ 97010 Hot/Cold Pack ___
☐ 99070 Supplies Dispensed for home program

☑ Skin checked and clear following treatment
Response to Treatment: ☐ ↓ Inflammation /Edema ☑ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☑ ↑ ROM ☐ ↑ Coordination ☑ Functional Ability
Assessment: able to perform exercises & trans at 5 limitations but remains weak to squat & lunge

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist Record Transferred to File
Plan: ☐ Progress therapeutic treatment program. ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 4/24/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo

Steve Horse, PTA License Number AT6225
Provider Signature License Number and Date

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IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

KEEP IN CHART

THERAPIST:

START DATE:

DX:

CLINICIAN'S INITIALS:			[illegible]	[illegible]	SH	[illegible]	SH	SH	SH	SH
EXERCISE:	Settings	Dates	3/20	3/26	3/27	3/31	4/16	4/17	4/22	4/24
A- Bike		Wt.	15	10	10	10	10	10	12	12
Squats		Reps	15	15	18	22	20	20	20	20
Lunges		Wt.					10	10	10	10
Toe Risers		Reps	15	15	15	15	15	20	20	20
Step ups / downs		Wt.							15	15
		Reps								
Side Steps		Wt.								
		Reps								
[illegible] Tramp [illegible] / [illegible]		Wt.	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2
		Reps	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2
		Wt.								
		Reps								
E- HS stretch		Wt.	2	2	2	2	2	2	2	2
Quad stretch		Reps								
Bridges c̄ hold		Wt.	15	15	15	15	15	15	15	15
		Reps								
		Wt.								
		Reps								
		Wt.								
		Reps								
		Wt.								
		Reps								

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US HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

DAILY THERAPY TREATMENT NOTE

Treatment Visit # 9
Authorized Visit #: 9 of 12
Auth Exp Date: ___
Next MD Appt: ___

Diagnosis: (R) knee OA, chondromalacia

Subjective: ☒ Improved ☐ Same ☐ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
(R) knee less inflammed & pain, walking & ITBS less pain today

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation: Mins: ___ Interpreter ___

Treatment goals: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
20 ☒ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics ___
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection ___
15 ☒ 97112 Neuromuscular re-education: Balance/Coordination/Gait/Proprio/Kinesthetic sense/Posture/Taping ___
15 ☒ 97110 Therapeutic Exercise for Strength /ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program ___
___
☐ ___ Other: ___
10 ☒ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage: Grade: I II III IV V: (R) knee (ant & post fibers)
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces ___
☐ 97124 Massage/ Ice Massage: ___
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: ___
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select ___

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ 97033 Iontophoresis (___ ml of Dexamethasone 4 mg/ml) Dose: ___ (mA/min), Current: ___ (mA)
☐ In clinic ☐ Extended wear: ___ hours ___
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) ___
☐ 97039 Laser/Light Probe: ___ J/ cm² ___
☐ 97034 Contrast Baths: Cycles: ___ Temp warm: ___ °F/ ___ min. Temp cool: ___ °F/ ___ min Body Part: ___
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed ___ % @ ___ w / cm² ___ MHz ___

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High : ___
10 ☒ 97014 E-Stimulation: (R) knee to WB & pain ___
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☐ ENS: ☐ Modulated ☐ Continuous ☐ Surg. ☐ Freq ___ Hz/pps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel ☐ Trac ☐ Static: ___ lbs/mmHg
☐ Intermit Hold ___ lbs / mmHg ___ sec / min Relax ___ lbs / mmHg ___ sec / min Time / Cycles: ___
☐ 97018 Paraffin Bath ___ ☐ 97022 Whirlpool/Fluidotherapy ___
☐ 97026 Infrared ___ ☐ 97010 Hot/Cold Pack ___
☐ 99070 Supplies: Dispensed for home program:

☒ Skin checked and clear following treatment Pain down to WB & Pain & T Spine Less

Response to Treatment: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Assessment: Able to perform SLR on 8" step & TKE with limitation on ROM (R)

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary Start Supervised

Steve Hence, PTA
License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551
DOS: 4/22/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMD / IP

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

START DATE: [redacted] [redacted] IN CHART THERAPIST: [redacted]

DX: [redacted]

CLINICIAN'S INITIALS:										
EXERCISE:	Settings	Dates	3/20	3/24	3/27	3/31	4/6	4/8	4/13
A Bike		Wt.	10	10	10	10	10	10	10
Squats		Reps	15	15	15	20	20	20	20
Lunges		Wt.					10	10	10
Toe Risers		Reps	15	15	15	15	15	20	20
Step ups		Wt.							15
down		Reps							
Side Steps		Wt.							
		Reps							
Incline Tread Mill		Wt.	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2
		Reps	2y 2	2y 2	2y 2	2y 2	2y 2	2y 2	2y 2
		Wt.							
		Reps							
E HS Stretch		Wt.	2	2	2	2	2	2	2
Quad Stretch		Reps							
Bridges & Abd.		Wt.	15	15	15	15	15	15	15
		Reps							
		Wt.							
		Reps							
		Wt.							
		Reps							
		Wt.							
		Reps							

CLINICIAN: [redacted] CLINICIAN: [redacted] CLINICIAN: [redacted]

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US HealthWorks
A Dignity Health Member

DAILY THERAPY TREATMENT NOTE

Treatment Visit #: ____
Authorized Visits #: 12
Auth Exp Date: ____
Next MD Appt: ____

Diagnosis: L / R / B Knee OA, Chondromalacia

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
R knee pain, worse with standing, 6/10 today

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation: Mins:____ Interpreter:____

Treatment goals: ☐ ↓ Inflammation /Edema ☑ ↓ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☐ ↑ Coordination ☑ ↑ Functional Ability

Time Units **Therapeutic Procedures (Time based):** ☑ See flowsheet ☐ Written HEP issued (see handout)

25 ☑ 97530 Functional Activities ☑ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics ____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection ____
15 ☑ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping ____
to ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program ____
☐ ____ Other: ____
10 ☑ 97140 Manual Therapy STM/MFR/IT Mob/Man Traction/Scar massage: Grade: I II III IV V: R knee, ant groin soft tissue
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces ____
☐ 97124 Massage/ Ice Massage: ____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: ____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select ____

Time Units **Constant Attendance (Time based):** ☐ See flowsheet
☐ 97033 Iontophoresis (____ml of Dexamethasone 4 mg/ml) Dose:____(mA/min), Current:____(mA)
☐ In clinic ☐ Extended wear: ____hours ____
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) ____
☐ 97039 Laser/Light Probe: ____J/ cm² ____
☐ 97034 Contrast Baths: Cycles:____ Temp warm:____°F/____min Temp cool:____°F/____min Body Part:____
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed ____% @____w / cm² ____MHz

Time Units **Supervised (Untimed- Service Based):** ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High : ____
10 ☑ 97014 E-Stimulation: R knee ↓ P ↑ therex
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☐ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ___Hz/bps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ___ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg ____ sec / min Relax ____ lbs / mmHg ____ sec / min Time / Cycles: ____
☐ 97018 Paraffin Bath ____ ☐ 97022 Whirlpool/Fluidotherapy ____
☐ 97026 Infrared ____ ☐ 97010 Hot/Cold Pack ____
☐ 99070 Supplies: Dispensed for home program:

☐ Skin checked and clear following treatment

Response to Treatment: ☐ ↓ Inflammation /Edema ☐ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☐ ↑ ROM ☐ ↑ Coordination ☐ ↑ Functional Ability

Assessment: Able to do 1/4 squat x 20 c WB shift on tray
5 limitations on pl of tx.

☑ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 4/17/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo

Steve Honde, PTA
License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE:

KEEP IN CHART

DX:

CLINICIAN'S INITIALS:								
EXERCISE:	Sutulings	Date:	3/20	3/24	3/27	3/31	4/6	4/7
Bike		Wt.	10	10	10	10	10	10
Squats		Reps	15	15	15	20	20	20
Lunges		Wt.					10	10
Toe Risers		Reps	15	15	15	15	15	20
Step ups		Wt.						
down		Reps						
Side Steps		Wt.						
		Reps						
Wall Tramp Stars		Wt.	30x 2	30x 2	30x 2	30x 2	30x 2	30x 2
		Reps	20x 2	20x 2	20x 2	20x 2	20x 2	20x 2
		Wt.						
		Reps						
HS Stretch		Wt.	2	2	2	2	2	2
Quad Stretch		Reps						
Bridges & Hold.		Wt.	15	16	15	15	15	15
		Reps						
		Wt.						
		Reps						
		Wt.						
		Reps						
		Wt.						
		Reps						

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ST 4106 (Rev. 4/08)

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U.S HealthWorks
A Dignity Health Member

BIL

DAILY THERAPY TREATMENT NOTE

Authorized Visits #: 12

Auth Exp Date: _____

Next MD Appt: _____

Diagnosis: (R) (L) Knee, bilateral

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report

Post-operative C/O pain at both knees / bilateral knee injections 5 days ago 2-3 days ago

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary

☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation. Mins: ____ Interpreter _____

Treatment goals: ☐ ↓ Inflammation /Edema ☑ ↓ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☑ ↑ Coordination ☑ ↑ Functional Ability

Time Units Therapeutic Procedures (Time based): ☑ See flowsheet ☐ Written HEP issued (see handout)

25 ☑ 97530 Functional Activities ☑ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____

☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____

15 ☑ 97112 Neuromuscular re-education: Balance/Coordination/Propro/Kinesthetic sense/Posture/Taping _____

10 ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____

☐ _____ Other: _____

10 ☑ 97140 Manual Therapy STM/MFR/ Mob/Man Traction/Scar massage: Grade: I II III IV V (R) Knee including post side

☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____

☐ 97124 Massage/ Ice Massage: _____

☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____

☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select _____

Time Units Constant Attendance (Time based): ☐ See flowsheet

☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min). Current: _____ mA)

☐ In clinic ☐ Extended wear: _____ hours _____

☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____

☐ 97039 Laser/Light Probe: _____ J/ cm² _____

☐ 97034 Contrast Baths: Cycles: _____ Temp warm: _____ °F/_____ min. Temp cool: _____ °F/_____ min Body Part: _____

☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hyorocort) Cont./ Pulsed _____ % @ _____ w / cm² _____ MHz _____

Time Units Supervised (Untimed- Service Based): ☐ See flowsheet

☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High : _____

10 ☑ 97014 E-Stimulation: (R) Knee to SLR x there x _____

☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☑ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/bps

☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ____ lbs/mmHg

☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles: _____

☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____

☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____

☐ 99070 Supplies. Dispensed for home program:

☑ Skin checked and clear following treatment

Response to Treatment: ☐ ↓ Inflammation /Edema ☑ ↓ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☐ ↑ ROM ☑ ↑ Coordination ☑ ↑ Functional Ability

Assessment: Able to perform 1/4 squats & short lunges 5 limited by pain & L balance

☑ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551

DOS: 4/16/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Steve Honda, PTA
License Number AT622

Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

START DATE: KEEP IN CHART THERAPIST:

DX:

CLINICIAN'S INITIALS:								
EXERCISE:	Settings	Dates	3/20	3/24	3/27	3/31	4/1	
4 Bike		Wt.	10	10	10	10	10	
Squats		Reps	15	15	18	20	20	
lunges		Wt.					10	
Toe Risers		Reps	15	15	15	15	15	
Step ups		Wt.						
downs		Reps						
Side Steps		Wt.						
		Reps						
3 Trap Sq's		Wt.	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2	
rows		Reps	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2	
		Wt.						
		Reps						
E HS stretch		Wt.	2	2	2	2	2	
Quad stretch		Reps						
Bridges & Add.		Wt.	15	15	15	15	15	
		Reps						
		Wt.						
		Reps						
		Wt.						
		Reps						
		Wt.						
		Reps						

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97 4100 (Rev. 4/04)

Page 79

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

April 2, 2015

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company/Corp

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is status post arthroscopy, chondroplasty and debridement of the right knee on 03/03/15. Postoperatively she had her sutures removed and was referred to physical therapy. She was last seen on 03/12/15. She comes back at this time indicating therapy is helpful and she does seem to be improving. She still remains sore and she points to the medial aspect of the knee joint. Her pain level is described as 5/10 with 10 being worst. It is aggravated by walking and partially relieved by rest and use of Norco.

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, female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 57
Blood Pressure: 136/78
Respiration: 15
Temperature: 97.8

Examination of the Right Knee

Visual Inspection

There is moderate swelling in the knee. There is no sign of infection.

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.

Range of Motion

Range of motion is limited from 0 to 120 degrees.

Palpation

There is pain along the anteromedial joint line and in the area of the medial femoral condyle.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Chondral defect, right knee, status post arthroscopy.

PLAN

Plan will be to continue therapy two times a week for at least three more weeks. Norco will be renewed for pain relief.

She will return in three to four weeks for followup.

WORK STATUS

She remains on temporary total disability.

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 Orange County, California, on 12-3-15.

Physician Signature S Graham MD CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:dty.CUG
D: 04/03/15
T: 04/04/15
PerezC0402Graham22729956

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U.S HealthWorks MEDICAL GROUP
A Dignity Health Member

Treatment Visit #: 6
Authorized Visit #: 6 of 6
Auth Exp Date: ____

DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) Knee OA, Chondromalacia
Subjective: ☐ Improved ☒ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
Next MD Appt: ____
(R) knee pain 2-10 during activities, stiffness, tightness, popping, locking, swelling, weakness
Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Min: Interpreter: ____

Treatment goals: ☐ ↓ Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
25 ☒ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics ____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protector ____
15 ☒ 97112 Neuromuscular re-education: Balance/Coordination/Proprioception/Kinesthetic sense/Posture/Taping ____
10 ☒ 97110 Therapeutic Exercise for: Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program ____
☐ ____ Other: ____
10 ☒ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage Grade I II III IV V: (R) Knee
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces ____
☐ 97124 Massage/ Ice Massage: ____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: ____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care ☐ 97597 Selective ☐ 97602 Non-select ____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ 97033 Iontophoresis (____ml of Dexamethasone 4 mg/ml Dose ____(mA/min). Current ____(mA)
☐ In clinic ☐ Extended wear: ____ hours ____
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) ____
☐ 97039 Laser/Light Probe ____ J/cm² ____
☐ 97034 Contrast Baths: Cycles: ____ Temp warm: ____ °F: ____ min Temp cool ____ °F: ____ min Body Part: ____
8 ☒ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocor) Cont (Pulsed) 50 % @ .8 W/cm² 1 MH (R) Knee

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High: ____
10 ☒ 97014 E-Stimulation. (R) Knee to tolerance
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☒ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ____ Hz/pps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel ☐ Thoracic ☐ Static ____ lbs/mmHg
☐ Intermit Hold ____ lbs / mmHg ____ sec / min Relax ____ lbs / mmHg ____ sec / min Time / Cycles ____
☐ 97018 Paraffin Bath ____ ☐ 97022 Whirlpool/Fluidotherapy ____
☐ 97026 Infrared ____ ☐ 97010 Hot/Cold Pack ____
☐ 99070 Supplies: Dispensed for home program:

☒ Skin checked and clear following treatment
Response to Treatment: ☐ ↓ Inflammation /Edema ☒ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability
Assessment: Able to perform lly squats & trans w/ c/o pain & ↑d knee (R), but still walks a slight limp throughout ROM

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer of file
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 4/01/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251444 Doc #:

Steve Honda, PTA
License Number AT6
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

START DATE: _____ SIGNED IN CHART THERAPIST: _____

DX: _____

CLINICIAN'S INITIALS:					
EXERCISE:	Settings:	Date:	3/20	3/24	3/27
4 Bike		Wt.	12	10	10
Squats		Reps	15	15	15
Lunges		Wt.			
Toe Raises		Reps	15	15	15
Step ups		Wt.			
down		Reps			
Side Steps		Wt.			
		Reps			
Mini Tramp Sq's		Wt.	30# x 2	30# x 2	30# x 2
more		Reps	20 x 2	20 x 2	20 x 2
		Wt.			
		Reps			
E- HS Stretch		Wt.	2	2	2
Quad Stretch		Reps			
Bridges & Hold.		Wt.	15	15	15
		Reps			
		Wt.			
		Reps			
		Wt.			
		Reps			
		Wt.			
		Reps			

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US HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

Treatment Visit #: 5
Authorized Visit #: 5 of 6
Auth Exp Date: _____
Next MD Appt: _____

DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) LA [illegible]

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
A: 7 Sports (PT) E Bike

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Mins ____ Interpreter _____

Treatment goals: ☐ ↓ Inflammation /Edema ☐ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☐ ↑ ROM ☐ ↑ Coordination ☐ ↑ Functional Ability

Time Dx **Therapeutic Procedures (Time based):** ☐ See flowsheet ☐ Written HEP issued (see handout)
25 ☑ 97530 Functional Activities ☐ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics for Sports Upper
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection: _____
15 ☑ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping trap
15 ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program: _____
Sports not [illegible]
☐ _____ Other: _____
10 ☑ 97140 Manual Therapy STM/MFR/JT Mob/Man Traction/Scar massage. Grade: I II III IV (R) grs
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ 97124 Massage/ Ice Massage: _____
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care ☐ 97597 Selective ☐ 97602 Non select _____

Time Dx **Constant Attendance (Time based):** ☐ See flowsheet
☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min) Current: _____ (mA)
☐ In clinic ☐ Extended wear: _____ hours _____
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ 97039 Laser/Light Probe: _____ J/ cm² _____
☐ 97034 Contrast Baths: Cycles: _____ Temp warm: _____ °F/ _____ min Temp cool: _____ °F/ _____ min Body Part: _____
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/ Pulsed _____ % @ _____ w / cm² _____ MHz

Time Dx **Supervised (Untimed- Service Based):** ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High : _____
15 ☑ 97014 E-Stimulation. (R) hr
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☐ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ___ Hz/pps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static ___ lbs/mmHg
☐ Intermit: Hold ___ lbs / mmHg _____ sec / min Relax ___ lbs / mmHg _____ sec / min Time / Cycles _____
☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ 99070 Supplies: Dispensed for home program

☐ Skin checked and clear following treatment

Response to Treatment: ☐ ↓ Inflammation /Edema ☐ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☐ ↑ ROM ☐ ↑ Coordination ☐ ↑ Functional Ability

Assessment: A: G2 (PT) E Bike

☑ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer of file

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 3/31/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Therapist Signature, PT

Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: FILED IN CHART DX:

CLINICIAN'S INITIALS:						
EXERCISE:	Settings	Dates	3/20	3/24	3/27	3/31
Bike		Wt.	10	10	10	10
Squats		Reps	15	15	18	20
Lunges		Wt.				
Toe Risers		Reps	15	15	15	15
Step ups down		Wt.				
		Reps				
Side Steps		Wt.				
		Reps				
EMR Tramp Step Moves		Wt.	30x 2	30x 2	30x 2	30x 2
		Reps	20y 2	20y 2	20y 2	20y 2
		Wt.				
		Reps				
HS Stretch		Wt.	2	2	2	2
Quad Stretch		Reps				
Bridges & Hold.		Wt.	15	16	15	15
		Reps				
		Wt.				
		Reps				
		Wt.				
		Reps				
		Wt.				
		Reps				

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US HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

Treatment Visit #: 4
Authorized Visit #: 4 of 6
Auth Exp Date: _____
Next MD Appt: _____

DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) knee OA, chondromalacia

Subjective: ☐ Improved ☒ Same ☐ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report
(R) knee pain, inflamed & mild sore days to touch at beginning.

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 interpretation: Mins ____ Interpreter _____

Treatment goals: ☐ ↓Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Time Dx Therapeutic Procedures (Time based): ☒ See flowsheet ☐ Written HEP issued (see handout)
25 ☒ 97530 Functional Activities ☒ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics _____
☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____
15 ☒ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping _____
10 ☒ 97110 Therapeutic Exercise for: Strength / ROM / Flexibility ☒ Established / Reviewed / Progressed Home Ex Program _____
☐ _____ Other: _____
60 ☒ 97140 Manual Therapy: STM/MFR/Jt Mob/Man Traction/Scar massage. Grade: I II III IV V (R) knee, patellar mobs
☐ ☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ ☐ 97124 Massage/ Ice Massage: _____
☐ ☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____
☐ ☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care ☐ 97597 Selective ☐ 97602 Non select _____

Time Dx Constant Attendance (Time based): ☐ See flowsheet
☐ ☐ 97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose: _____ (mA/min), Curren: _____ (mA)
☐ In clinic ☐ Extended wear: _____ hours
☐ ☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ ☐ 97039 Laser/Light Probe: _____ J/ cm² _____
☐ 97034 Contrast Baths Cycles: ____ Temp warm: ____ °F/ ____ min Temp cool: ____ °F/ ____ min Body Part: _____
8 ☒ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/Pulsed 50 % @ .70 w / cm² 1 MH (R) knee

Time Dx Supervised (Untimed- Service Based): ☐ See flowsheet
☐ ☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High _____
10 ☒ 97014 E-Stimulation (R) knee to d/c PT therapy
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ I-V ☐ V ☒ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ___ Hz/pps
☐ ☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ___ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles _____
☐ ☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ ☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ ☐ 99070 Supplies: Dispensed for home program

☒ Skin checked and clear following treatment
Response to Treatment: ☐ ↓Inflammation /Edema ☒ ↓ Pain ☐ ↓ Muscle Spasm ☒ ↑ Strength ☒ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability
Assessment: More TO perform H/E secondary to Temp shifts & limitations but continued to make progress. Ready for discharge next visit.

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 3/27/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo

Steve Honda, PTA License Number AT6225
Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: KEEP IN CHART DX:

CLINICIAN'S INITIALS:								
EXERCISE:	Setting:	Date:	3/20	3/24	3/27	3/31	4/1
Bike		Wt.	10	10	10	10	10
Squats		Reps	15	15	15	20	20
Lunges		Wt.					
Toe Risers		Reps	15	15	15	15	15
Step ups		Wt.					
down		Reps					
Side Steps		Wt.					
		Reps					
NR Tramp Stp S		Wt.	30# x 2	30# x 2	30# x 2	30# x 2	30# x 2
Marsh		Reps	20# x 2	20# x 2	20# x 2	20# x 2	20# x 2
		Wt.					
		Reps					
HS Stretch		Wt.	2	2	2	2	2
Quad Stretch		Reps					
Bridges + Add.		Wt.	15	15	15	15	15
		Reps					
		Wt.					
		Reps					
		Wt.					
		Reps					
		Wt.					
		Reps					

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US HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

Treatment Visit #: 3

Authorized Visit #: 3 of 6

Auth Exp Date: _____

Next MD Appt: _____

DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) knee OA, Chondromalacia

Subjective: ☐ Improved ☑ Same ☐ Worsened Pain level 0 1 2 3 4 5 6 7 8 9 10 ☐ See attached report

(R) med knee remains mod sore & it's caused deficits in kneeling

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary

☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Mins _____ Interpreter _____

Treatment goals: ☐ ↓ Inflammation /Edema ☑ ↓ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☑ ↑ ROM ☐ ↑ Coordination ☑ ↑ Functional Ability

Time	Dx	Therapeutic Procedures (Time based): ☑ See flowsheet ☐ Written HEP issued (see handout)
20	☑	97530 Functional Activities ☑ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics Toe raises, Bike, Squats, marching
	☐	97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection
15	☑	97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Pacing Tramp.
10	☑	97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program Stretches, bridges, Atrom
	☐	Other:
10	☑	97140 Manual Therapy STM/MFR/JT Mob/Man Traction/Scar massage: Grade: I II III IV V (R) knee
	☐	97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces
	☐	97124 Massage/ Ice Massage:
	☐	97760 Orthotic management/fit/training ☐ 97762 Orthotic check:
	☐	97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select

Time	Dx	Constant Attendance (Time based): ☐ See flowsheet
	☐	97033 Iontophoresis (_____ ml of Dexamethasone 4 mg/ml) Dose._____(mA/min), Current_____(mA) ☐ In clinic ☐ Extended wear: _____ hours
	☐	97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below)
	☐	97039 Laser/Light Probe: _____ J/ cm²
	☐	97034 Contrast Baths: Cycles: Temp warm: _____ °F/ _____ min. Temp cool: _____ °F/ _____ min. Body Part:
5	☑	97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/Pulsed 50 % @ .50 w / cm² 1 MHz (R) knee

Time	Dx	Supervised (Untimed- Service Based): ☐ See flowsheet
	☐	97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High :
10	☑	97014 E-Stimulation: (R) knee to V(P) for ea ☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☑ ENS ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq ___ Hz/bps
	☐	97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ___ lbs/mmHg ☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles: _____
	☐	97018 Paraffin Bath: _____ ☐ 97022 Whirlpool/Fluidotherapy _____
	☐	97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
	☐	99070 Supplies: Dispensed for home program:

☑ Skin checked and clear following treatment

Response to Treatment: ☐ ↓ Inflammation /Edema ☐ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☐ ↑ ROM ☐ ↑ Coordination ☒ ↑ Functional Ability

Assessment: Able to perform 1/4 squats & achieve full knee ext & limitations on ↑ ROM (R)

☐ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer of file

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy - see attached summary

IRVINE CO./CORP. 164551

DOS: 3/26/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251[illegible]

Steve Honde, PTA License Number AT5225

Provider Signature, License Number, and Date

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

THERAPIST:

START DATE: KEEP IN CHART Dx:

CLINICIAN'S INITIALS:				
EXERCISE:	Settings	Date:	3/20	3/24
A Bike		Wt.	10	10
Squats		Reps	15	15
Lunges		Wt.		
Toe Risers		Reps	15	15
Step ups		Wt.		
down		Reps		
Side Steps		Wt.		
		Reps		
Hip Trap Step		Wt.	3 x 2	3 x 2
over		Reps	20 x 2	20 x 2
		Wt.		
		Reps		
E HS Stretch		Wt.	2	2
Quad Stretch		Reps		
Bridges + Add.		Wt.	15	16
		Reps		
		Wt.		
		Reps		
		Wt.		
		Reps		
		Wt.		
		Reps		
		Wt.		
		Reps		

CLINICIAN: CLINICIAN: CLINICIAN: CLINICIAN: CLINICIAN: CLINICIAN:

ST 4105 (Rev. 4/03)

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U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

BIL

Treatment Visit #: 2

Authorized Visit #: 2 of 8

DAILY THERAPY TREATMENT NOTE

Auth Exp Date: _____

Diagnosis: C.A. strain/sprain

Next MD Appt: _____

Subjective: ☑ Improved ☐ Same ☐ Worsened Pain level: 0 1 (2) 3 4 5 6 7 8 9 10 ☐ See attached report

J. P. in isb

Objective: ☐ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation: Mins:____ Interpreter _____

Treatment goals: ☐ ↓Inflammation /Edema ☑ ↓Pain ☐ ↓ Muscle Spasm ☐ ↑Strength ☐ ↑ ROM ☐ ↕Coordination ☐ ↑ Functional Ability

Time Dx **Therapeutic Procedures (Time based):** ☐ See flowsheet ☐ Written HEP issued (see handout)

8 8 ☐ 97530 Functional Activities ☐ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics Bike, Sports, lumbar
☐ ☐ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection _____
16 ☐ ☐ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping trunk rotation
20 ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program _____
Bruges, hot pk
☐ ☐ ☐ _____ Other: _____
10 ☐ ☑ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage: Grade: I II III IV V: ② knee quads pelvis
☐ ☐ ☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces _____
☐ ☐ ☐ 97124 Massage/ Ice Massage: _____
☐ ☐ ☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check: _____
☐ ☐ ☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select _____

Time Dx **Constant Attendance (Time based):** ☐ See flowsheet

☐ ☐ ☐ 97033 Iontophoresis (_____ml of Dexamethasone 4 mg/ml) Dose:_____(mA/min), Current:_____(mA)
☐ In clinic ☐ Extended wear: _____hours _____
☐ ☐ ☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below) _____
☐ ☐ ☐ 97039 Laser/Light Probe: _____J/ cm² _____
☐ ☐ ☐ 97034 Contrast Baths: Cycles:_____ Temp warm:_____°F/_____min Temp cool:_____°F/_____min Body Part:_____
☐ ☐ ☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont./ Pulsed _____% @_____w / cm² _____ MHz_____

Time Dx **Supervised (Untimed- Service Based):** ☐ See flowsheet

☐ ☐ ☐ 97016 Vasopneumatic Compression /Edema Control: Pressure: Low Med High : _____
10 ☐ ☑ 97014 E-Stimulation: _____
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☐ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Frec____Hz/bps
☐ ☐ ☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ___ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles. _____
☐ ☐ ☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ ☐ ☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ ☐ ☐ 99070 Supplies: Dispensed for home program:

☑ Skin checked and clear following treatment

Response to Treatment: ☐ ↓Inflammation /Edema ☐ ↓Pain ☐ ↓Muscle Spasm ☐ ↑Strength ☑ ↑ROM ☐ ↕Coordination ☐ ↑Functional Ability

Assessment: Knee to 1/2 squat, good tol to tmg

☑ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file

Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 3/20/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Bonnie Katayama P.T.
Lic 8714

Provider Signature, License Number, and Date

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IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

HealthWorks MEDICAL GROUP

KEEP IN CHART

START DATE: _____ THERAPIST: _____ DX: _____

CLINICIAN'S INITIALS:			JR
EXERCISE:	Setting:	Date:	3/20
A Bike		Wt.	12
Squats		Reps	15
Lunges Toe Risers		Wt.	
		Reps	15
Step ups downs		Wt.	
		Reps	
Side Steps		Wt.	
		Reps	
UNE Tramp Step Rocker		Wt.	30# 2
		Reps	20Y 2
		Wt.	
		Reps	
E HS Stretch Quad Stretch		Wt.	2
		Reps	
Bridges + Add.		Wt.	15
		Reps	
		Wt.	
		Reps	
		Wt.	
		Reps	
		Wt.	
		Reps	

CLINICIAN: JR CLINICIAN: _____ CLINICIAN: _____

CLINICIAN: _____ CLINICIAN: _____ CLINICIAN: _____

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A Dignity Health Member

DAILY THERAPY TREATMENT NOTE

Treatment Visit #: 1
Authorized Visits #: _____
Auth Exp Date: _____
Next MD Appt: _____

Diagnosis: L (R) B knee Osteoarthritis 715.16 chondromalacia 733.92

Subjective: ☐ Improved ☐ Same ☐ Worsened Pain level: 0 1 2 3 4 5 6 7 8 9 10 ☑ See attached report
Pain 5-6/10

Objective: ☑ PT Eval 97001 ☐ OT Eval 97003 ☐ PT Re-Eval 97002 ☐ OT Re-Eval 97004 ☐ Progress Report / D/C Summary
☐ RTW PAT 97750 ☐ MMT/ROM ☐ Orthotic/Splint (See attached report) ☐ 99199 Interpretation Mins ____ Interpreter ____

Treatment goals: ☑ ↓ Inflammation /Edema ☐ ↓ Pain ☐ ↓ Muscle Spasm ☑ ↑ Strength ☐ ↑ ROM ☐ ↑ Coordination ☐ ↑ Functional Ability

Time Units **Therapeutic Procedures (Time based):** ☐ See flowsheet ☐ Written HEP issued (see handout)
20 ☑ 97530 Functional Activities ☐ Therapeutic Activities ☐ Job simulation ☐ Body Mechanics Sports Bike
20 ☑ 97535 Self Care/Home Management Training ☐ ADL's ☐ Posture and positioning ☐ Joint Protection Ergonomics, stairs, pain
☐ 97112 Neuromuscular re-education: Balance/Coordination/Proprio/Kinesthetic sense/Posture/Taping
15 ☑ 97110 Therapeutic Exercise for Strength / ROM / Flexibility ☐ Established / Reviewed / Progressed Home Ex Program
Bridge + hip, knee, HS stretch
☐ Other:
10 ☑ 97140 Manual Therapy STM/MFR/Jt Mob/Man Traction/Scar massage Grade: I II III IV V: patella mob
☐ 97116 Gait Training ☐ Cane ☐ Crutches ☐ Walker ☐ Stairs ☐ Uneven surfaces
☐ 97124 Massage/ Ice Massage:
☐ 97760 Orthotic management/fit/training ☐ 97762 Orthotic check:
☐ 97113 Aquatic Therapy w/ ther ex ☐ Burn/Wound Care: ☐ 97597 Selective ☐ 97602 Non select

Time Units **Constant Attendance (Time based):** ☐ See flowsheet
☐ 97033 Iontophoresis (_____ml of Dexamethasone 4 mg/ml) Dose:_____(mA/min), Current._____(mA)
☐ In clinic ☐ Extended wear: _____hours
☐ 97032 Manual Electric Stimulation ☐ Probe ☐ US/E-stim Combo (Parameters below)
☐ 97039 Laser/Light Probe: _____J/ cm²
☐ 97034 Contrast Baths: Cycles: _____Temp warm:_____°F/_____ min. Temp cool:_____°F:_____min Body Part
☐ 97035 Ultrasound/Phonophoresis (w/ 10% Hydrocort) Cont/ Pulsed _____% @_____W/cm² _____MHz

Time Units **Supervised (Untimed- Service Based):** ☐ See flowsheet
☐ 97016 Vasopneumatic Compression /Edema Control Pressure: Low Med High :
10 ☑ 97014 E-Stimulation: (C) Unattended
☐ IFC ☐ EMS ☐ Pre-mod ☐ Micro ☐ H-Wave ☐ HV ☐ LV ☐ TENS: ☐ Modulated ☐ Continuous ☐ Burst ☐ Freq___Hz/bps
☐ 97012 Mechanical Traction ☐ Cervical ☐ Lumbar ☐ Carpal Tunnel C-Trac ☐ Static: ___ lbs/mmHg
☐ Intermit: Hold ____ lbs / mmHg _____ sec / min Relax ____ lbs / mmHg _____ sec / min Time / Cycles _____
☐ 97018 Paraffin Bath _____ ☐ 97022 Whirlpool/Fluidotherapy _____
☐ 97026 Infrared _____ ☐ 97010 Hot/Cold Pack _____
☐ 99070 Supplies: Dispensed for home program:

HCPCS: A4556
NPPS18UTC
REUSABLE 2" ROUND WHITE F
ABRIC CARBON ELECTRODE

☑ Skin checked and clear following treatment
Response to Treatment: ☐ ↓ Inflammation /Edema ☐ ↓ Pain ☐ ↓ Muscle Spasm ☐ ↑ Strength ☐ ↑ ROM ☐ ↑ Coordination ☐ ↑ Functional Ability
Assessment: Knee to Sport, ↓ Inflammation Goal

☑ Treatment Plan Reviewed by Supervising Therapist ☐ Therapist of Record Transfer on file
Plan: ☐ Progress therapeutic treatment program ☐ D/C from therapy – see attached summary

IRVINE CO./CORP. 164551
DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : FMR/

Ronnie Kalayama P.T.
Lic #[illegible]
Provider Signature, License Number, and Date

1 Eval & Treat 2 Eval only 3 F.. 4 F.. w PAT 5 RE only 6 RE & Treat

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A Dignity Health Member

Date of Surgery: 3/31/15 Next MD Visit: _____ Referred by: _____

Diagnosis: R/L wrist tc chondromalacia 733.92

ICD: 715.16

Mechanism of Injury: ☑ Work Related ☐ Sports ☐ MVA ☐ Sudden ☐ Gradual ☐ Repetitive ☐ Contusion ☐ Crushing
☐ Slip and Fall ☐ Bending/Stooping ☐ Squatting/Kneeling ☐ Sitting ☐ Twisting ☐ Lifting ☑ Climbing ☐ Running ☐ Jumping
☐ Reaching- Overhead/ Forward/ Behind/ Across the body ☐ Operating Hand Tools / Machinery/ Keyboard ☐ Throwing ☐ Overhead work

Details: Pain in surgery & knee wrist standing repetitively.

Past Medical History: ☐ Reviewed past medical history filed in chart dated: _____ PMH is ☐ Contributory ☐ Non-contributory

Previous treatment for this injury before today ☐ No If Yes: ☐ PT ☐ OT ☐ Chiropractor ☐ Acupuncture ☐ PCP ☐ ER visit

Other: hand C, HTN DM CAC DVT

Diagnostic Tests: ☐ None ☐ X-ray ☑ MRI ☐ CT Scan ☐ NC/EMG ☐ Other:

Past Relevant Surgical History: ☐ None List _____

Allergies: ☐ NKDA ☐ Latex ☐ Adhesive/Tape ☐ Bees ☐ Other _____

Current Medications: ☐None ☐NSAID ☐Pain ☐ M Relaxer ☐Steroid ☐Insulin Others: Lisinopril HTN meds

Subjective: ☐ Fatigue ☐ Fever ☐ Paresthesias ☐Weakness ☐ Dizziness ☐ Headaches ☐ Bowel/Bladder Changes

Pt to D on WB

D/D wrist surgery. No locking.

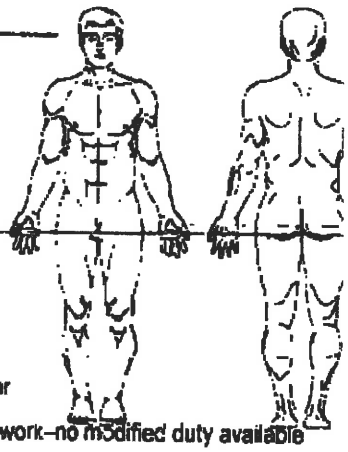
Pain Level: Current 6 /10 Worst: 6 /10 Best: 5 /10

Quality: ☐ Faint ☐ Sharp ☐ Dull ☐ Tingling ☐ Burning ☐ Ache ☐ Throbbing ☐ Stabbing

Severity: ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe Freq: ☐ Occasional ☐ Intermittent ☐ Constant

↑ by: WB

↓ by: NWB



Impaired motion: ☐Bend/Stoop ☐Squat ☐Kneel ☐Climb ☐Lift ☐Push ☐Pull

Reaching: ☐Overhead ☐Forward ☐Behind back ☐Across body ☐ADLs ☐IADLS

Fine Motor: ☐Pick ☐Pinch Handling: ☐Hold ☐Grasp ☐Turn

Position tolerances: ☐ Sit _____ min/hr ☐ Stand _____ min/hr ☐ Walk _____ min/hr ☐Drive _____ min/hr

Occupational History: Working: ☐ Modified duty ☐Full duty ☐ Off work – Medically necessary ☐Off work–no modified duty available

Job title Senior Coordinator Worked for co for 6 mos/yrs Avg hrs/week 40 ☐No longer works for co.

Job functions at time of injury:

☐Sit _____ mins / hrs	☐Lift floor to waist	max _____ lbs avg _____ lbs	☐Repetitive Keyboard / Mouse use	_____ mins / hrs	
☑Stand _____ mins / hrs	☐Lift waist to shoulder	max _____ lbs avg _____ lbs	☐Phone use _____ cal s/hr _____ mins/cal	Headset Y N	
☐Kneel _____ mins / hrs	☑1 hand Carry _____ ft	max _____ lbs avg _____ lbs	☐Drive _____ mins / hrs		
☐Squat _____ mins / hrs	☐2 hand Carry _____ ft	max _____ lbs avg _____ lbs	☐Patient transfers		
☐Walk _____ mins / hrs	☐Push sled/cart/dolly _____ ft	Difficulty _____	☐ _____		
☐Crawl _____ mins / hrs	☐Pull sled/cart/dolly _____ ft	Difficulty _____	☐ _____		

Climb ☐Stairs ☐Ladder ☐Ramps ☐Handtool use Tool *Uniform attendant freq/duration _____

Social/Leisure Activities: T.V. family

IRVINE CO./CORP. 164551
DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo

Bonnie Katayama P.T.
Inc 4714
Provider Signature/Stamp

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Involved Side: ☐ Left ☑ Right ☐ Bilateral

Posture: Standing: ☐ Good ☑ Fair ☐ Poor Sitting: ☑ Good ☐ Fair ☐ Poor
☐ Decreased weigh: bearing on L/R in standing ☐ Recurvatum ☐ Pes Planus ☐ Pes Cavus
☐ Genu Varus ☐ Genu Valgum ☐ Knee Position: _____
☐ Other _____

Gait: ☐ Normal ☐ FWB ☑ PWB ☐ WBAT ☐ Antalgic ☐ Mid-stance ☐ Uneven stride ☐ ER/OT ☐ Foot Drop ☐ Circumduction ☐ Hip Hike
Device ☑ None ☐ Crutches: ☐ One R / L ☐ Bilateral ☐ Straight Cane ☐ Quad Cane Walker: ☐ Standard ☐ Front Wheeled
Brace/Orthotic _____ Other _____

Functional Mobility: Impaired: ☐ Sit to Stand ☐ Heel walk ☐ Toe walk ☑ Double squat ☑ Single leg squat R / L
Balance: ☐ Good ☑ Fair ☐ Poor Single leg ☐ R _____ sec ☐ L _____ sec

Neurovascular: ☐ Normal LE DTR Patellar (L4) R____ L____ Achilles (S1) R____ L____

Sensation: ☐ Normal ☐ Not tested ☐ Abnormal ☐ L1-L3-ant thigh ☐ L4-medial leg/foot ☐ L5-lateral leg/dorsal foot ☐ S1-lateral plantar foot
Inspection: ☐ Erythema ☐ Ecchymosis ☐ Scars ☑ Swelling/Masses ☐ Deformities
Palpation: ☐ Normal Comments: _____
Tenderness of: ☑ Medial joint line ☐ Lateral joint line ☑ Patella: ligament ☐ Fibular head ☐ _____
Altered mobility or crepitation of: ☐ Tibiofemoral jt ☐ Patellofemoral jt ☐ Proximal Tib/fib jt ☐ _____
Soft tissue restriction/atrophy of: ☑ Quads ☐ VMO ☐ Hamstrings ☐ Popliteus ☐ ITB/TFL ☐ Gastroc

		AROM		PROM		STRENGTH	
KNEE	Degrees	LEFT ☐ Normal except	RIGHT ☐ Normal except	LEFT ☐ Normal except	RIGHT ☐ Normal except	LEFT ☐ Normal except	RIGHT ☐ Normal except
FLEXION	135°	130	110		115		
EXTENSION	0°	0	20		15		
ANKLE							
DORSIFLEXION	20°	10	10				
PLANTARFLEXION	50°	50	50				
HIP							

PATELLA								
Patellar Alignment: MED ROTATION	+ -	(+) -	Patellar Alignment: TILT	+ -	+ -	PATELLAR APPREHENSION	+ -	+ -
Patellar Alignment LAT ROTATION	+ -	+ -	Patellar Alignment GLIDE	+ -	(+) -	PATELLAR GRIND	+ (-)	+ (-)

Special Tests	LEFT	RIGHT	Special Tests	LEFT	RIGHT	Special Tests	LEFT	RIGHT
KNEE VARUS STRESS	+ -	+ -	KNEE VALGUS STRESS	+ -	(+) -	THESSALY	+ -	+ -
ANTERIOR DRAWER / LACHMAN	+ -	+ -	POSTERIOR DRAWER	+ -	+ -	PIVOT SHIFT	+ -	+ -
MCMURRAY'S	+ -	+ -	OBER	+ -	+ -		+ -	+ -
CIRCUMFERENCE (cm)						**Muscle Length Test**		
____ cm ↑ TIBIAL TUBEROSITY			KNEE JOINT LINE			QUADRICEPS		
____ cm ↓ TIBIAL TUBEROSITY			SUPRAPATELLAR			HAMSTRING		

Motion Analysis/ Additional Findings:

IRVINE CO./CORP. 164551
DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

DVE.

Provider Signature/Stamp

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U.S. HealthWorks MEDICAL GROUP

EVALUATION / RE-

REHABILITATION

IRVINE CO./CORP. 164551

DOS: 3/19/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

Name: _____

SUBJECTIVE: _____

ASSESSMENT: 1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

GOALS

STG	LTG		TIME FRAME
☐	☑	Increase strength (R) UE to 5/5	2-4 wks
☐	☐	Increase AROM (R) UE	1-4
☐	☑	Restore prior function, including pain & fully	4
☐	☐	Independent with strengthening home exercise program for continued carryover of functional gains made during skilled therapy.	1-4
☐	☐	Pt able to lift ____ # floor to knuckle and ____ # knuckle to shoulder to _____	
☐	☐	Joint ROM	<3
☐	☐	4 YMD Resistance	1-3
☐	☐		

Frequency: 3 Estimated Length of Treatment: 4

Therapy assessment, goals and treatment plan have been discussed with patient and patient is in agreement. ☑ Yes ☐ No

☑ Strengthening	☑ Postural education/exercise	☐ Heat
☑ Stretching	☑ Body mechanics/Joint protection training	☑ Ice
☑ Stabilization	☑ Joint mobilizations	☐ Traction
☑ A/AA/PROM	☑ Soft tissue mobilization	☑ US/Phono
☑ Neuromuscular re-ed	☑ Home exercise program	☐ Iontophoresis
☐ Gait training	☐ Tape/brace support	☑ E-Stim
☐ Aquatics	☐ Symptom management	☐ SEMG Biofeedback
☐ ADL training	☐ Work conditioning	☐ Whirlpool
☐ Paraffin	☐ Splinting/Orthotic training	☐ TENS issue & instruction
☐ Post Injury PAT	☐ Balance/Proprioceptive training	☐ VASO-Compression
		☑ Patient Education
☐ Recommend Discharge	☐ Follow up with Physician	☑ Continue with therapy
☑ Reusable Electrodes dispensed	☐ Iontoophoresis Electrodes dispensed	

☐ Other/Supplies Dispensed: _____

Today's Treatment:

Time: E.M. Ice Dist

Time:		Time:	
____	☐ Patient education regarding nature of their injury.	____	☐ _____
____	☐ Home exercises as per handouts/log.	____	☐ _____
____	☐ _____	____	☐ _____
____	☐ _____	____	☐ _____

Bonnie Kanyuna PT

Lic 8714

☐ Treatment Plan Discussed/Reviewed with PTA

Signature. _____ Lic #: _____

CA4104 (REV 8/09)

Received Date: 20150327 Filed Date: 20150327 Image ID: 2015086GJ000180 DCN: 2015086GJ000180

U.S. HealthWorks MEDICAL GROUP

5

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

X *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 3/12/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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: post op

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)

Post op scope c/o pain swell cont R med BID

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

mod swell ecchy sup med 0-90 N.V OK

DIAGNOSES (Include ICD-9 code, if possible) Chondromalacia > R knee
DJD

TREATMENT DIC suture

☐ Office Visit / Injury Treatment ☑ Start / ☐ Continue ☑ Therapy: 2 times / week for 3 weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

POST OP VISIT

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions.

☑ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 3/12/15
Specialty: Lic G43382 Signature S Graham
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

3-4 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

IRVINE CO./CORP. 164551
DOS: 3/12/15 DOI: 3/10/1[illegible] DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

VITALS: HT:_____ WT:_____ PULSE: 67 BP: 128/77 RESP: 16 TEMP: 98.6

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see back page for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse walk
6. Activity or position that makes the pain less rest
7. Have you kept your treatment as indicated? ☑ Yes ☐ No
8. What medications are you currently taking? For pain
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☐ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐Physical Therapy ☐Acupuncture ☐Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☑ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 3-12-15

Received Date: 20150327 Bill DCN: 2015086GJ000180

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

March 12, 2015

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post arthroscopy, chondroplasty and debridement of the right knee on 03/03/15. Postoperatively, she is doing well. She has some pain. She is using pain medications as needed. She is walking with assistance of crutches. She describes her pain level as 5/10 with 10 being worst.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 57
Blood Pressure: 128/73
Respiration: 16
Temperature: 98.6

Examination of the Right Knee

Visual Inspection

Knee shows moderate swelling.

Skin

There is no sign of infection. There is some ecchymosis around the superomedial incision.

Range of Motion

	Right	Left	Normal
Flexion	90 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

The patient is nontender over the lateral joint line or over the medial joint line and the anterior aspect of the knee.

Special Tests

McMurray sign is negative. Cruciate function of the knee is intact with a negative posterior drawer sign and a negative Lachman maneuver.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Received Date: 20150327 Bill DCN: 2015086GJ000180

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Chondromalacia and osteoarthritis right knee, status post arthroscopy.

PLAN

The intraoperative pictures were reviewed with the patient. Her sutures will be removed today. She will start therapy two times a week for the next three weeks.

WORK STATUS

She remains on temporary total disability.

FOLLOW-UP APPOINTMENT

She will return in three to four weeks for followup evaluation.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gju.BGP
D: 03/13/15
T: 03/14/15
PerezC0312Graham22729725

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Patient: Perez, Consuela **Carrier:** GALLAGHER BASSETT - ORANGE, CA **Injury State:** CA

Patient #: 7173601 **Claim #:** 008094000407WC01

Note Details

03/06/2015 11:46 AM **csmith**

X1687
Ref#1221596
Vendor: BEAVANS MEDICAL INC
Items Requested: UNIT AND SUPPLIES
Date of Service: PENDING
3Rd Attempt / Carrier Communication
Comments: Sent below email to adj.
F/up date 3/10/15

From: Christy Smith
Sent: Friday, March 06, 2015 11:46 AM
To: 'CBANUELOS@CCMS-TPA.COM'
Subject: IMPORTANT!!!!! FW: 2nd AUTHORIZATION REQUEST----Claim #: 2013419849
Importance: High
Please advise if authorized or denied
Christy Smith
Electrotherapy Department
One Call Care Management
From: Christy Smith
Sent: Tuesday, March 03, 2015 11:59 AM
To: 'CBANUELOS@CCMS-TPA.COM'
Subject: FW: 2nd AUTHORIZATION REQUEST----Claim #: 2013419849
Please advise if authorized or denied
Christy Smith
Electrotherapy Department
One Call Care Management
From: Christy Smith
Sent: Friday, February 27, 2015 4:43 PM
To: 'CBANUELOS@CCMS-TPA.COM'
Subject: AUTHORIZATION REQUEST----Claim #: 2013419849
Authorization Request
Date:February 27, 2015
Attention: CHRISTINA BANUELOS
Claimant: Perez, Consuela
OCCM ID: 7173601
Claim Number: 2013419849
Date of Injury: 3/10/13
Employer: IRVINE COMPANY
Prescribing Physician: GRAHAM, STEPHEN L
MSC is seeking authorization to provide your claimant with the following products and/or services. Please respond via e-mail to this notification stating "Authorized" or sign and fax this notification to the fax number listed

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below. Note that additional state taxes may apply as required by state law. Any applicable taxes will be added to the final invoice based on the taxability of the specific products under the laws of the delivery state. If authorizing services via e-mail, your electronic signature will be used as proof of authorization. In the event these products or services require Utilization Review, please provide the necessary UR information for submitting approval. If the equipment listed below is not authorized, please respond with "Denied."

Services / Products

Qty	Description	HCPCS Code	Rental/ Purchase	Price / Each (if pre-dispensed)	Service Date
2	WIRE, LEAD ONE-TOUCH	A4557	P	11.65	PENDING
10	ELECTRODES 2X4 RECTANGLE	A4556	P	36.80	PENDING
1	UNIT, PAINCARE ONE-TOUCH	E0730	P	384.09	PENDING

Purchases of custom or hygienic items are non-returnable. With the exception of defective merchandise, items authorized for return may be subject to a restocking fee. Should you have any questions, please contact your service representative at the number referenced in this request.

Thank you!

Christy Smith
Patient Care Coordinator
One Call Care Management
EQUIPMENT + DEVICES
P: 800-848-1989 ext. 1687
F: 866-211-9788
www.onecallcm.com
841 Prudential Drive, Suite 900 | Jacksonville, FL 32207

"We are always working to be better than the day before. Click here to tell us how we can be better tomorrow."

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May. 6. 2015 3:07PM 3/2015 7:58:01 PM PAGE 2/003 Fax No. 5417 P. 62/63

PLACENTIA LINDA HOSPITAL
1301 Rose Drive Placentia, CA 92870 714-524-4846

DATE OF SURGERY: 03/03/2015

PREOPERATIVE DIAGNOSES: Osteochondral defect and osteoarthritis, right knee.

POSTOPERATIVE DIAGNOSES: Osteochondral defect and osteoarthritis, right knee plus chondromalacia patella.

PROCEDURES: Arthroscopy, chondroplasty and debridement, right knee followed by injection of Marcaine and Duramorph.

SURGEON: Stephen Graham, M.D.

ANESTHESIA: General.

ANESTHESIOLOGIST: Brett Florie, M.D.

ESTIMATED BLOOD LOSS: Tourniquet.

TOURNIQUET PRESSURE: 300 mmHg for 13 minutes.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and induced under general anesthesia. She was given antibiotics intravenously. A tourniquet was applied to the proximal aspect of the right leg. The right leg was prepped and draped sterilely. Leg was exsanguinated with Esmarch bandage and tourniquet inflated to 300 mmHg of pressure. Arthroscopic portals were established over the anteromedial and anterolateral joint line and third one made in the medial suprapatellar area. Fluid was instilled using the arthroscopic pump. Inspection of the joint showed grade III chondromalacia of the patella and II-III the anterior femoral trochlea. The medial compartment showed the osteochondral defect previously noted. It had filled in with fibrous cartilage; however, there was some looseness and some detachment around the periphery, mostly on the lateral aspect of the defect. The defect was smoothed down using a combination of the meniscus shaver and the Arthrocare at low setting to further smooth off the area and to remove the detached peripheral edges. I still left the defect there, but it less irregular. The medial meniscus appeared to be intact. There were some grade II chondromalacia of medial tibial plateau. Anterior cruciate ligament was intact. Lateral compartment showed some rim tearing of the lateral meniscus and grade II-III chondromalacia of lateral tibial plateau. The condylar surface otherwise appeared to be good. After the medial femoral condyle was smoothed off, the Arthrocare was placed in the patellofemoral area and the undersurface of the patella was smoothed down using the Arthrocare at low setting. No

PLACENTIA LINDA HOSPITAL
1301 Rose Drive Placentia, CA 92870 714-524-4846

further pathology was identified. The scope was then removed. The stab wounds were closed with 4-0 nylon sutures, 15 mL of 0.25% Marcaine with epinephrine and 4 mg of Duramorph was then injected for an analgesic effect. Sterile dressings were then applied using Xeroform, 4 x 4's, ABD and an Ace bandage applied loosely. The tourniquet was released with good return of circulation. The patient was awakened. She tolerated the procedure well and was sent to the recovery room in satisfactory condition.

STEPHEN P GRAHAM, MD
Orthopedic Surgery

SPG / in
D: 03/03/2015 15:20 PST
T: 03/03/2015 19:35 PST
Job #: 14858916

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Placentia - Linda Hospital
1301 Rose Drive
Placentia, CA 92870

Name: PEREZ, CONSUELO
MRN: 000386717
ACCT: 009554643

STEPHEN P. GRAHAM, MD
ADM: 03/03/2015

Operative Report

DATE OF SURGERY: 03/03/2015

PREOPERATIVE DIAGNOSES: Osteochondral defect and osteoarthritis, right knee.

POSTOPERATIVE DIAGNOSES: Osteochondral defect and osteoarthritis, right knee plus chondromalacia patella.

PROCEDURES: Arthroscopy, chondroplasty and debridement, right knee followed by injection of Marcaine and Duramorph.

SURGEON: Stephen Graham, M.D.

ANESTHESIA: General.

ANESTHESIOLOGIST: Brett Florie, M.D.

ESTIMATED BLOOD LOSS: Tourniquet.

TOURNIQUET PRESSURE: 300 mmHg for 13 minutes.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and induced under general anesthesia. She was given antibiotics intravenously. A tourniquet was applied to the proximal aspect of the right leg. The right leg was prepped and draped sterilely. Leg was exsanguinated with Esmarch bandage and tourniquet inflated to 300 mmHg of pressure. Arthroscopic portals were established over the anteromedial and anterolateral joint line and third one made in the medial suprapatellar area. Fluid was instilled using the arthroscopic pump. Inspection of the joint showed grade III chondromalacia of the patella and II-III the anterior femoral trochlea. The medial compartment showed the osteochondral defect previously noted. It had filled in with fibrous cartilage; however, there was some looseness and some detachment around the periphery, mostly on the lateral aspect of the defect. The defect was smoothed down using a combination of the meniscus shaver and the Arthrocare at low setting to further smooth off the area and to remove the detached peripheral edges. I still left the defect there, but it was less irregular. The medial meniscus appeared to be intact. There were some grade II chondromalacia of medial tibial plateau. Anterior cruciate ligament was intact. Lateral compartment showed some rim tearing of the lateral meniscus and grade II-III chondromalacia of lateral tibial plateau. The condylar surface otherwise appeared to be good. After the medial femoral condyle was smoothed off, the Arthrocare was placed in the patellofemoral area and the undersurface of the patella was smoothed down using the Arthrocare at low setting. No further pathology was identified. The scope was then removed. The stab wounds were closed with 4-0 nylon sutures, 15 mL of 0.25% Marcaine with epinephrine and 4 mg of Duramorph was then injected for an analgesic

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Name: PEREZ, CONSUELO
MRN: 000386717
ACCT: 009554643

STEPHEN P. GRAHAM, MD
ADM: 03/03/2015

Operative Report

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effect. Sterile dressings were then applied using Xeroform, 4 x 4's, ABD and an Ace bandage applied loosely. The tourniquet was released with good return of circulation. The patient was awakened. She tolerated the procedure well and was sent to the recovery room in satisfactory condition.

STEPHEN P GRAHAM, MD
Orthopedic Surgery

Dictated by: STEPHEN P. GRAHAM, MD

TR:SPG/IN
DD:03/03/2015 15:20 PST
DT:03/03/2015 19:35 PST
Dictation ID: 14858916/Confirmation #: 6933084

Printed: 04/10/2015 by: JazzminePerkal COPY...COPY...COPY...COPY...COPY...COPY

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Patient: Perez, Consuela **Carrier:** GALLAGHER BASSETT - ORANGE, CA **Injury State:** CA

Patient #: 7173601 **Claim #:** 008094000407WC01

Note Details

03/03/2015 11:59 AM **csmith**

X1687
Ref#1221596
Vendor: BEAVANS MEDICAL INC
Items Requested: UNIT AND SUPPLIES
Date of Service: PENDING
2nd Attempt / Carrier Communication
Comments: Sent below email to adj.
F/up date 3/6/15

From: Christy Smith
Sent: Tuesday, March 03, 2015 11:59 AM
To: 'CBANUELOS@CCMS-TPA.COM'
Subject: FW: 2nd AUTHORIZATION REQUEST----Claim #: 2013419849
Please advise if authorized or denied
Christy Smith
Electrotherapy Department
One Call Care Management
From: Christy Smith
Sent: Friday, February 27, 2015 4:43 PM
To: 'CBANUELOS@CCMS-TPA.COM'
Subject: AUTHORIZATION REQUEST----Claim #: 2013419849
Authorization Request
Date:February 27, 2015
Attention: CHRISTINA BANUELOS
Claimant: Perez, Consuela
OCCM ID: 7173601
Claim Number: 2013419849
Date of Injury: 3/10/13
Employer: IRVINE COMPANY
Prescribing Physician: GRAHAM, STEPHEN L
MSC is seeking authorization to provide your claimant with the following products and/or services. Please respond via e-mail to this notification stating "Authorized" or sign and fax this notification to the fax number listed below. Note that additional state taxes may apply as required by state law. Any applicable taxes will be added to the final invoice based on the taxability of the specific products under the laws of the delivery state. If authorizing services via e-mail, your electronic signature will be used as proof of authorization. In the event these products or services require Utilization Review, please provide the necessary UR information for submitting approval. If the equipment listed below is not authorized, please respond with "Denied."
Services / Products

Qty	Description	HCPCS Code	Rental/Purchase Price / Each
	Service Date		

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(if pre-dispensed)

2	WIRE, LEAD ONE-TOUCH	A4557	P	11.65	PENDING
10	ELECTRODES 2X4 RECTANGLE	A4556	P	36.80	PENDING
1	UNIT, PAINCARE ONE-TOUCH	E0730	P	384.09	PENDING

Purchases of custom or hygienic items are non-returnable. With the exception of defective merchandise, items authorized for return may be subject to a restocking fee. Should you have any questions, please contact your service representative at the number referenced in this request.

Thank you!

Christy Smith
Patient Care Coordinator
One Call Care Management
EQUIPMENT + DEVICES
P: 800-848-1989 ext. 1687
F: 866-211-9788
www.onecallcm.com
841 Prudential Drive, Suite 900 | Jacksonville, FL 32207

"We are always working to be better than the day before. Click here to tell us how we can be better tomorrow."

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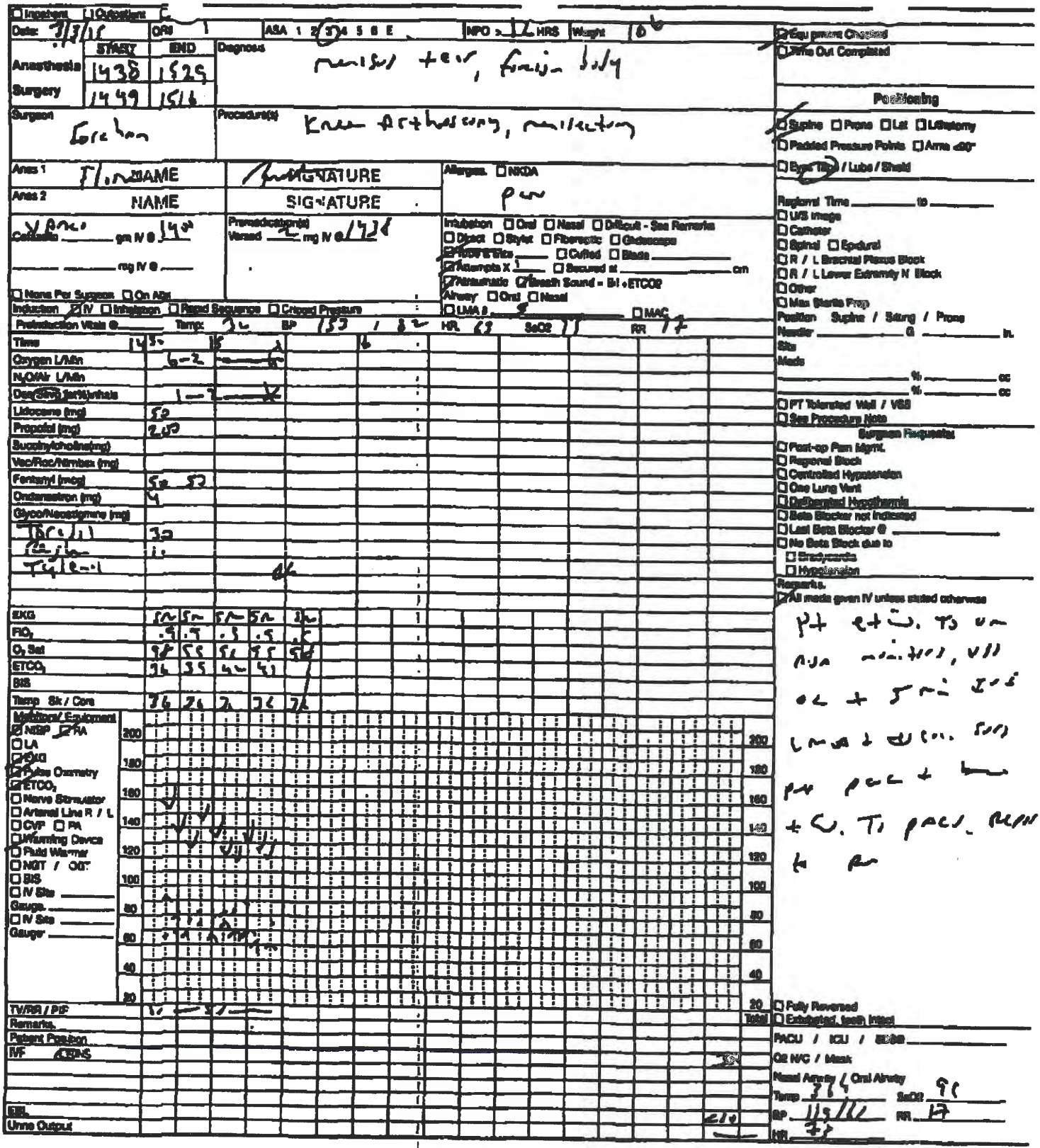

Anesthesia Record
Pre and Post Evaluation
Page 2 of 2

ACCT: 9554843 DOB: 03/15/1952 F 62
PEREZ, CONSUELO 03/03/2015
GRAHAM STEPHEN P MR.000386717
PLACENTIA LINDA HOSPITAL

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Placentia-Linda HOSPITAL

PLAAR

DATE

TIME

Proposed Procedure. Knee Arthroscopy

Current Medications: ☐ See M.A.R. Ø Diovan, Prilosec

Allergies. ☐NKDA ☐Latex ☑PCN ☐SULFA

NPO ☑>8 Hrs ☐ Other

Medical History: ☐No Pertinent Medical History	Comments	Review of Systems ☐Negative
Cardiovascular ☐Normal ☐CAD ☐Arrhythmia ☐CHF ☑HTN	QC.1.	CV.
Pulmonary ☐Normal ☐COPD ☐Asthma ☐OSA ☐Resp Failure	QhJ	Pulmonary.
Hepato /Gastrointestinal ☐Normal ☑Obesity ☐Cirrhosis ☐GERD ☐Hepatitis		GI
Renal / Endocrine ☐Normal ☐Diabetes Mellitus ☐Thyroid Disease ☐Renal Failure ☐Hepatitis		
Neuro / Musculoskeletal ☐Normal ☑Arthritis / DJD ☐Seizure ☐CVA / TIA ☐Psychiatric Disorder		CNS

Previous Anesthesia / Surgery.

Ø Cyst c GA

Previous Problems ☐PONV ☐Difficult Intubation ☐Awareness

Family Anesthetic History
☑None
☐Malignant Hyperthermia
☐Cholinesterase Deficiency

Reviewed: ☑H&P, ☐Consultations ☐Cardiology ☐Pulmonary

Recommendations

Type of Anesthesia: ☑General ☐MAC ☐Spinal ☐Epidural ☐Other:

Invasive Monitoring ☐Arterial Line ☐CVP Cath ☐PA Cath ☐Other

ASA Class ☐I ☐II ☑III ☐IV ☐V ☐VI ☐E ☐NHR

Informed Consent for Anesthesia I have explained anesthesia options, alternatives, risks (including possible sore throat and dental injury sustained with general anesthesia) Also the possibility of headaches, backache, infection and nerve damage from regional anesthesia/block. Anesthesia benefits have been explained and all questions have been answered. The patient/family understands the risk and plans

Anesthesiologist's Signature:

Physical Examination:

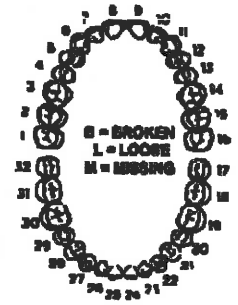
Height 160 Weight 101 BMI 40

T: 97 P: 100 R: 20

BP. 140 / 80 SPO2. 95

Mental Status ☑Alert ☑Oriented x 4

Airway: MP1 MP2 MP3 MP4



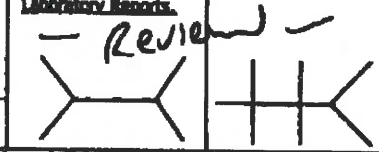
☑Poor Dentition ☑Multiple Teeth Missing

Heart RRR

Lungs Clear

Laboratory Reports.

Reviewed



☐PT/PTT ☐ECG SK ☐CXR. NPO ☐Other

Pregnancy Test. ☐Neg ☐Pos ☐N/A

Post Anesthesia Evaluation: ☐ pt actively participated in post operative evaluation

Date 2/3/15 Time 1550 Pain Scale /10 T. 96 BP 142/71 P 76 R: 16 SAO2: 97

Mental Status ☐Alert ☐Oriented X ☐Unchanged from Preanesthesia

Cardiovascular Function ☑Adequate ☐Other

Respiratory Function ☑Adequate ☐ Other

Anesthesia Complications ☑None ☐Yes

Nausea and Vomiting ☐Mild Hydration ☐Adequate

Comments.

Anesthesiologist's Signature

430-1168 02/14

Anesthesia Record
Page 1 of 2

ACCT: 9554643 DOB: 03/16/1952 F 62
PEREZ, CONSUELO 03/03/2015
GRAHAM STEPHEN P MR 000386717
PLACENTIA LINDA HOSPITAL

CONSUELO PEREZ

PT Initial Evaluation

1919 Sherry Ln Apt 37
Santa Ana , CA 92705
(714) 865-1227
DOB: 3/15/1952
Frequency: N/A

Physician: Ky Tran
Agency: Network Providers for Home Health, Inc.
Phone: (562)904-9040
Fax: (562)904-9045
Nurse: N/A
Medicare Week: Sunday - Saturday

Visit Date: 3/2/2016
Time In: 1:00 PM
Time Out: 1:45 PM
Units: (3) - 38-52 minutes
Therapist: Efren Ablis, Jr., PT w/ Marquin Rehab Services
G-Code: G0151

Vitals

Heart Rate (HR):	Blood Pressure (BP):	Respirations (R):	O² Saturation (O²Sat):	Temperature:
at rest: NT	at rest: NT	at rest: NT	at rest: NT	NT
after exer/amb: NT	after exer/amb: NT	after exer/amb: NT	after exer/amb: NT	

Past Medical History: s/p Right knee replacement

Past Therapy History: Patient has received Therapy Services in a Rehab Center.

Surgical Procedures: , Right knee replacement

Hospitalization Dates:

Therapy Diagnosis: R26.2 - Difficulty in Walking Not Elsewhere Classified

Nursing Diagnosis: N/A

Weight Bearing Status: FWB

Prior Level of Function: I (No Assist)
Additional Information: Patient is independent in all aspects of functional mobility

Subjective: This is a case of a 63 y/o Hispanic female who was referred to Home Health Therapy after recent hospitalization secondary to Right Knee Replacement.

Living Arrangements:

Home Setting: House

Entrance - 1 step to the front door **Railing Upon Entry -** No Railing

Additional Information: Patient lives with family members in a single level house with single steps in different parts of the house.

Equipment Owned: Standard Walker

Sensory/Current Status:

Temperature NT | **Skin** N | **Edema** N | **Vision** N | **Sensation** N |
Communication N | **Hearing** N | **Posture** AB | **Endurance** AB

Behavior/Mental Status: Alert, Oriented, Cooperative

Gait Assessment:

Level Surface - 50 ft. with Standard Walker requiring MI level of assist.

Gait Quality/Deviations/Postures: slow, unsteady, decreased foot clearance
Curbs/Stairs:

Transfers/Functional Independence:

Transfers - **Sit↔Stand:** MI, **Bed↔Wheelchair:** NT, **Toilet:** MI, **Tub:** NT, **Auto:** NT

Bed Mobility - **Roll/Turn:** I, **Sit/Supine:** I, **Scoot/Bridge:** I

Additional Information:

Balance:

Sitting - **Static:** G, **Dynamic:** G

Standing - **Static:** G-, **Dynamic:** G-

Standardized Tests:

Tinetti Assessment

Current - Balance: 13 out of 16 **Gait:** 9 out of 12 **Total:** 22 out of 28

Additional Assessment:

Muscle Strength/Functional ROM Evaluation:

Upper Extremities (UE): BUE's WFL ROM with 4-/5 muscle strength
Lower Extremities (LE): BLE's WFL ROM with 4-/5 muscle strength

Pain:

Intensity: No Pain
Aggravating Factors:
Location(s):
Relieving Factors:

Instructions: Safety Measures, Breathing Exercises, Joint Protections, Energy Conservation, HEP, Fall Prevention/Recovery, Proper Use of Equipment
Additional Information: Patient is only being seen for Physical Therapy Evaluation. No follow up visit indicated at this time. Patient is being referred to Outpatient Therapy.

Medication: There were **no changes** in medication.

Objective: (Additional Information) Patient scored 22/28 on the Tinetti Test putting the patient at great chance of falling.

Problem Areas/Functional Limitations:

Impaired Functional Endurance, Impaired Functional Mobility, Dysfunctional Posture, Impaired Functional Strength, Dysfunctional Gait, Impaired Balance, Impaired Transfers, Fall Risk -

Goals:

Rehab Potential/Progress Towards Goals:

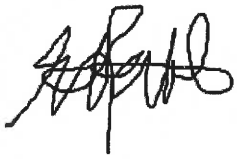
Treatment as Tolerated (Basic POC): Evaluation

Homebound Status: N/A

Homebound Additional Information:

Digitally Signed, which is approved by the Home Health Care Governing Bodies and Federal Guidelines.

Verbal order with MD was received on the physical therapy plan of care



3/2/16

Digital Signature by Therapist (Efren Ablis, Jr., PT) **Date**

Patient(Consuelo Perez) **Date**

Physician Signature **Date**

CONSUELO PEREZ

Tinetti Balance Test

1919 Sherry Ln Apt 37
Santa Ana , CA 92705
(714) 865-1227
DOB: 3/15/1952
Frequency: N/A

Physician: Ky Tran
Agency: Network Providers for Home Health, Inc.
Phone: (562)904-9040
Fax: (562)904-9045
Nurse: N/A
Medicare Week: Sunday - Saturday

Visit Date: 3/2/2016
Therapist: Efren Ablis, Jr., PT w/ Marquin Rehab Services

Balance

1. Sitting Balance -	1 - Steady, Safe
2. Rises From Chair -	1 - Able (uses arms)
3. Attempt To Rise -	2 - Able (1 attempt)
4. Immediate Standing Balance (5 sec.) -	1 - Steady (but uses walker or other support)
5. Standing Balance -	2 - Narrow Stance (w/out support)
6. Nudged -	2 - Steady
7. Eyes Closed -	1 - Steady
8. Turning 360 Degrees -	1 - Continuous
360 Steadiness -	1 - Steady
9. Sitting Down -	1 - Uses Arms (not a smooth motion)

Balance Score: **13 out of 16**

Gait

10. Initiation of Gait -	1 - No hesitancy
11. Step Length and Height	
Right Swing Foot -	1 - Passes left stance foot
	1 - Completely clears floor
Left Swing Foot -	1 - Passes right stance foot
	1 - Completely clears floor
12. Step Symmetry -	1 - Right and left step equal
13. Step Continuity -	1 - Steps appear continuous
14. Path -	1 - Mild to moderate deviation or uses walking aid
15. Trunk -	1 - No sway but flexion of knees or back or spreads arms out while walking
16. Walking Stance -	0 - Heels apart

Gait Score: **9 out of 12**

Total Score:	22 out of 28
Fall Risk Interpretation:	25-28 = Low Fall Risk 19-24 = Moderate Fall Risk 0-18 = High Fall Risk

(created to accompany PT Evaluation)

U.S. HealthWorks MEDICAL GROUP (6)

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

☒ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 2/26/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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: PR eff

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)

PR eff

All - PCN
navarane
T - ō
Et - ō
M - ↓ HTN
pmg - knee
DM - ō

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

HRR no ♄ clear A - ō

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

TREATMENT prop

☑ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____
☐ Meds / Supplies Dispensed _____
☐ 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.
☑ Off work until (Date) 3-3-15 Estimated period of total temporary disability _____ days. WRITTEN RX REQUIRED
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

D PR 6/10 2-26-15 # 6

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 2/26/15
Specialty: _____ Signature _____
Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103** Fax: 949 863-9104

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

Document Date: 20150416 Bill DCN: 20155106GJ005225

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

February 26, 2015

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company/Corporation

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for preoperative evaluation and she is scheduled for arthroscopic surgery of her right knee at the Placentia-Linda Hospital of 03/03/15. Her condition has not improved. She continues have painful swelling of her right knee. Her medical history is once again reviewed. She does have a history of hypertension and is on medication. She otherwise appeared to be medically stable. Previous surgeries include appendectomy, oophorectomy and cesarean section. **SHE IS ALLERGIC TO PENICILLIN AND TO NOVOCAIN.**

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

Recvd Date: 20150416 Bill DOS: 20150106GJ005225

General Appearance

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

Vital Signs

Pulse: 64
Blood Pressure: 130/82
Respiration: 16
Temperature: 98.5

Heart

Her heart has a regular rate and rhythm. No murmurs heard.

Lungs

Lungs are clear to auscultation.

Abdomen

Abdomen is soft.

Examination of the Right Knee

Right knee shows mild to moderate fullness. Range of motion 0 to 120 degrees. Neurovascular is grossly intact.

DIAGNOSES

Osteochondral defect and osteoarthritis, right knee.

PLAN

Plan will be to proceed with arthroscopy possible meniscectomy, chondroplasty and debridement and the patient is aware of the risks and benefits of surgery as well as alternatives, options and possible complications. She will continue on modified duties up until the time of surgery, which limit kneeling or squatting. She will be TTD in immediate postoperative period.

WORK STATUS

As above.

RE: **PEREZ, CONSUELO**
February 26, 2015
Page 3

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:gju.BGP
D: 02/27/15
T: 02/28/15
PerezC0226Graham22720779

IRVINE CO./CORP. 104551

DOS: 2/26/15 DOI: 3/10/ DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 64 BP: 130/82 RESP: 16 TEMP: 98.5

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First: Maria E. Last: Velarde

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☑ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see back page for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse Standing prolonged period of time
6. Activity or position that makes the pain less Walking
7. Have you kept your treatment as indicated? ☑ Yes ☐ No
8. What medications are you currently taking? Pain medication Norco
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain PENECILINE
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☑ Yes ☐ No

Please explain.

Gall bladder Surgery

Patient Signature Consuelo Perez Date 02/26/2015

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ACCESSION: EN654677P
->

REPRINT

97508376 AREA/ROUTE/STOP: MAIL000
USHW-IRVINE
2362 MORSE AVE
IRVINE, CA 92614-6234

PEREZ,CONSUELO 62 F ALIPOUR,NIMA

1 7658739 EN654677P E44593 02252015 1239 02262015 02262015 9:51PM

PACIFIC TIME
FASTING: U

FINAL

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Date of Birth: 03/15/1952
Patient Phone: 714-865-1227

BASIC METABOLIC PANEL EN

GLUCOSE	85	mg/dL	65-99
		Fasting reference interval	
UREA NITROGEN (BUN)	19	mg/dL	7-25
CREATININE	0.73	mg/dL	0.50-0.99
For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.			
eGFR NON-AFR. AMERICAN	88	mL/min/1.73m2> OR = 60	
eGFR AFRICAN AMERICAN	102	mL/min/1.73m2> OR = 60	
BUN/CREATININE RATIO	NOT APPLICABLE	(calc)	6-22
SODIUM	142	mmol/L	135-146
POTASSIUM	4.4	mmol/L	3.5-5.3
CHLORIDE	103	mmol/L	98-110
CARBON DIOXIDE	21	mmol/L	19-30
CALCIUM	9.3	mg/dL	8.6-10.4

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URINALYSIS, COMPLETE EN

COLOR	YELLOW	YELLOW
APPEARANCE	CLEAR	CLEAR
SPECIFIC GRAVITY	1.011	1.001-1.035
PH	6.5	5.0-8.0
GLUCOSE	NEGATIVE	NEGATIVE
BILIRUBIN	NEGATIVE	NEGATIVE
KETONES	NEGATIVE	NEGATIVE
OCCULT BLOOD	NEGATIVE	NEGATIVE
PROTEIN	NEGATIVE	NEGATIVE
NITRITE	NEGATIVE	NEGATIVE
LEUKOCYTE ESTERASE	NEGATIVE	NEGATIVE

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WBC	NONE SEEN	/HPF	< OR = 5
RBC	NONE SEEN	/HPF	< OR = 3
SQUAMOUS EPITHELIAL CELLS	0-5	/HPF	< OR = 5
BACTERIA	NONE SEEN	/HPF	NONE SEEN
HYALINE CAST	NONE SEEN	/LPF	NONE SEEN

CBC (INCLUDES DIFF/PLT) EN

WHITE BLOOD CELL COUNT	6.8	Thousand/uL	3.8-10.8
RED BLOOD CELL COUNT	4.47	Million/uL	3.80-5.10

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CONTINUED REPORT

REPRINT

97508376 AREA/ROUTE/STOP: MAIL000
USHW-IRVINE
2362 MORSE AVE
IRVINE, CA 92614-6234

PEREZ,CONSUELO 62 F ALIPOUR,NIMA

2 7658739 EN654677P E44593 02252015 1239 02262015 02262015 9:51PM

PACIFIC TIME

FASTING: U

FINAL

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Date of Birth: 03/15/1952
Patient Phone: 714-865-1227

CBC (INCLUDES DIFF/PLT) (CONTINUED)

HEMOGLOBIN	13.8	g/dL	11.7-15.5
HEMATOCRIT	39.7	%	35.0-45.0
MCV	88.9	fL	80.0-100.0
MCH	30.9	pg	27.0-33.0
MCHC	34.7	g/dL	32.0-36.0
RDW	13.6	%	11.0-15.0
PLATELET COUNT	191	Thousand/uL	140-400
MPV	10.8	fL	7.5-11.5
ABSOLUTE NEUTROPHILS	3550	cells/uL	1500-7800
ABSOLUTE LYMPHOCYTES	2230	cells/uL	850-3900
ABSOLUTE MONOCYTES	728	cells/uL	200-950
ABSOLUTE EOSINOPHILS	272	cells/uL	15-500
ABSOLUTE BASOPHILS	20	cells/uL	0-200
NEUTROPHILS	52.2	%	
LYMPHOCYTES	32.8	%	
MONOCYTES	10.7	%	
EOSINOPHILS	4.0	%	
BASOPHILS	0.3	%	

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HCG, TOTAL, QL NEGATIVE EN

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Reference Range
Non-Pregnant: Negative
Pregnant: Positive

>> END OF REPORT - PEREZ,CONSUELO EN654677P <<

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Encounter Addendum Notes Reason :No Revisions/AS400 interface only
Modified By: Duong Kim 2015.06.01 15:26:55

Reason :No Revisions/AS400 interface only
Modified By: Vela, Will 2015.06.04 17:20:48

Reason :No Revisions/AS400 interface only
Modified By: Duong Kim 2015.11.18 08:56:36

MEDICAL DOCUMENTATION : DO NOT DETACH

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	02-25-2015
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	IRVINE CO./WORK COMP ONLY
Claim #:	008094-000407-wc-01
Chart #:	EMR/JB

History Of Present Illness:
Preoperative Details: A pre-operative clearance examination is requested by Dr. Graham. Reason for Surgery Diagnoses: s/p meniscus arthroscopy - pain persists . Arthroscopy R knee is the surgical procedure planned. This procedure is elective. Anesthesia anticipated is general.
Pre-Operative Complaints
Complaint: Patient's complaint at this time is as follows: Right knee Psain - Medial R knee. Patient describes the symptom(s) as dull. She says it is moderately severe. The frequency is constant. The symptoms are exacerbated by amnulation and prolonged weight bearing. The symptoms are lessened by rest, meds, ICE.

Relevant History NOTES: Last tetanus - unknown.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.

Review Of Systems:
A complete review of systems was performed and was found to be negative unless otherwise noted below.
see 1st visit

Relevant Preop. History:
Allergies: The patient denies a history of allergies to medications . The patient states there is no history of abnormal reactions to medications or anesthetics.
Family History: Pertinent Family history is noted . DM, HTN .
Surgical History: The patients past surgical history is as follows: Prior knee arthroscopy - No issues with anesthesia .

Physical Examination:
Pulse: 60/min. BP: 179/85 mmHg. Temperature: 98.7 deg F Respiration: 18 per min.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: She is alert and oriented to person, place and time . Mood and affect appear appropriate .
Eyes: The eyes are not red or injected .
HEENT: The external ear appears within normal limits . The exam of the middle and inner ears are normal . The nasal airway is patent . The nasal septum is not deviated or perforated . The oral airway is not obstructed .
Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The patient does not display sternal retractions . There is no cyanosis or clubbing noted .
Gastrointestinal: There are no palpable abdominal masses . The abdomen is non-tender on palpation . There is no palpable abdominal guarding . There is no rebound tenderness of the abdomen . A hernia is not identified on examination. There is no evidence of organomegaly on exam . There is no ascites on abdominal exam .
Genitourinary: The external genitalia appear normal. Costovertebral angle tenderness for renal involvement is not noted .
Skin: There are no abnormal skin lesions . The skin turgor is normal . There is no evidence of abnormal bruising or petecchiae on examination .
Lymphatic: There is no palpable lymphadenopathy. There is signs of lymphedema .
Endocrine: The thyroid is non-tender on palpation . The thyroid is not enlarged .
Musculoskeletal: The thoracic spine and rib cage are within normal limits . The range of motion of the spine is within normal limits . The spine and paraspinal muscles are not tender . There is no evidence of muscle weakness .
Cardiovascular: The heart rate is normal . Heart rhythm is not irregular. Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . Peripheral pulses are intact.
Neurologic: Sensation to touch is normal . Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits .

Diagnostic Tests:
Radiology

Test Name	Findings
Chest - 2 Views (Standard)	Pending-

Test Name	Findings
Chest - 2 Views (Standard)	Preliminary interpretation of these x-rays are Normal -

Medical Necessity:
Chest - 2 Views (Standard) preoperative
Chest - 2 Views (Standard) preoperative
All radiology studies are sent to Radiologist for review and confirmation.

External Lab Orders:

Dispensed Medications:

Prescribed Medications:

Medications Completed or Stopped:
Medications to be Continued until Next Visit:

Treatment Plan

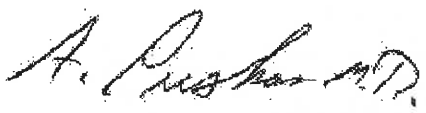
Procedures:
An EKG was performed.

Pre-Operative Diagnoses: v72.84 - pre-operative examination unspecified .

Document Date: Temp\2015\11\25\Originals\2015329GJ004064-0001

Other Diagnoses: Medial Meniscus Tear (836.0)

Recommendations: All diagnostics tests ordered were reviewed on 02-27-2015 and recommendations are as follows: I have found no medical contraindications for the surgical procedures planned. I have found no medical contraindication for the anesthetic planned.



Albert . Puskas, M.D.
This has been electronically signed on 11-18-2015

Recvd Date: 20151125 Brch DCN: 20155329GJ004064

U.S HealthWorks MEDICAL GROUP

HX2

FEB 25 AM 11:34

WC HEALTH HISTORY / HISTORIA MÉDICA

Confidential / Confidencial

To better assess your health condition, please provide the following information (Para evaluar mejor su condición de salud, por favor proporcione la siguiente información)

PLEASE ANSWER ALL QUESTIONS — **POR FAVOR, CONTESTE TODAS LAS PREGUNTAS**

Yes/Sí	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	
	/	1. Allergies or hives	Alérgias o urticaria
	/	2. Medications	Medicinas
	/	3. Major illnesses or injuries	Enfermedades/lesiones importantes
	/	4. Hospitalizations or surgeries	Hospitalizaciones o cirugías
	/	5. Motor vehicle accidents	Accidentes de tránsito
	/	6. Blood transfusions	Transfusiones de sangre
	/	7. Worked in a hazardous environment	Trabajo en ambientes peligrosos
	/	8. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo
	/	9. Permanent disabilities	Incapacidad permanente
Yes/Sí	No	**FAMILY HISTORY / ANTECEDENTES FAMILIARES**	
	/	10. Blood diseases in relatives	Familiares con enfermedades de la sangre
	/	11. Cancer or leukemia in relatives	Familiares con cáncer o leucemia
	/	12. Diabetes in relatives	Familiares con diabetes
	/	13. Heart Disease	Familiares con enfermedades del corazón
/		14. High Blood Pressure	Familiares con presión alta
	/	15. Strokes in relatives	Familiares con trombosis / ataques cerebrales
	/	16. Mental illnesses in relatives	Familiares con enfermedades mentales
Yes/Sí	No	**SOCIAL HISTORY / ANTECEDENTES SOCIALES**	
	/	17. Tobacco use. How much? ____ week	Uso de tabaco. ¿Cuanto? ____ semana
	/	18. Alcohol use. How much? ____ week	Uso de alcohol. ¿Cuanto? ____ semana

REVIEW OF SYSTEMS / REVISION DE SISTEMAS

Have you had or do you commonly have: ¿Tiene usted normalmente o ha tenido:

Yes/Sí	No	CONSTITUTIONAL	
	/	19. Recent gain or loss of weight	Ganancia o perdida de peso reciente
	/	20. Weakness, fatigue, or appetite loss	Debilidad, fatiga o perdida de apetito
	/	21. Fever	Fiebre
Yes/Sí	No	**SKIN**	
	/	22. Skin diseases or problems	Enfermedades en la piel
	/	23. Discoloration, pigmentation changes	Cambios de color en la piel
	/	24. Cancer/Tumors or cysts	Cáncer, tumores o quistes
Yes/Sí	No	**HEAD**	
		25. Frequent or severe headaches	Dolores de cabeza frecuentes o severos
Yes/Sí	No	**EYES / VISION**	
	/	26. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos
	/	27. Blurred, double or decreased vision	Visión borrosa, doble, o disminuida
	/	28. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos
	/	29. Light sensitivity	Sensibilidad a la luz
Yes/Sí	No	**EARS, NOSE, THROAT, MOUTH**	
	/	30. Loss or decreased hearing	Pérdida o disminución de la audición
	/	31. Ear pain, infection, discharge	Dolor, infección o secresión en oidos
	/	32. Nose / Sinus Problems	Problemas en la nariz o en senos nasales
	/	33. Dental/Gum Disease	Enfermedades dentales o de las encias
	/	34. Recurrent throat problems	Problemas de garganta recurrentes
	/	35. Voice Change / hoarseness	Ronquera o cambios en la voz
Yes/Sí	No	**CARDIOVASCULAR SYSTEM**	
	/	36. Shortness of Breath	Dificultad para respirar
	/	37. Chest Pain or Pressure	Opresión o dolor en el pecho
	/	38. Palpitation/Pounding Heart	Palpitaciones o saltos del corazón
/		39. High Blood Pressure	Presión sanguinea elevada
	/	40. Swelling Feet/Ankles	Hinchazón de pies o tobillos
	/	41. Varicose Veins	Venas varicosas

Yes/Sí	No	RESPIRATORY SYSTEM	
	/	42. Chronic/Recurrent Cough/Cold	Resfriado / tos crónica o recurrente
	/	43. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho
	/	44. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica
	/	45. Pneumonia	Pneumonía o pulmonía
	/	46. Tuberculosis	Tuberculosis
	/	47. Coughing of Blood	Tos con sangre
Yes/Sí	No	**GASTROINTESTINAL TRACT**	
	/	48. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes
	/	49. Nausea or vomiting	Náusea o vómitos
	/	50. Vomiting of Blood	Vómitos con sangre
	/	51. Abdominal pain	Dolor abdominal
	/	52. Liver disease	Enfermedades del higado
	/	53. Change in Bowel Habits	Cambios en hábitos intestinales
	/	54. Frequent Constipation/Diarrhea	Constipación o diarea frecuentes
	/	55. Blood in stools/Black stools	Heces negras o con sangre
	/	56. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto
Yes/Sí	No	**GENITOURINARY TRACT**	
	/	57. Painful or difficult urination	Dificultad o dolor al orinar
	/	58. Blood in urine	Sangre en la orina
	/	59. Kidney infection/stones	Infecciones o cálculos del riñón
	/	60. Venereal Disease	Enfermedades venéreas
Yes/Sí	No	**MUSCULOSKELETAL**	
	/	61. Joint pain or disease	Enfermedades o dolor en las articulaciones
	/	63. Neck or back injury	Lesiones del cuello o de la espalda
	/	64. Foot Problems	Problemas en los pies
Yes/Sí	No	**NEUROLOGICAL**	
	/	65. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques
	/	66. Dizziness	Mareos o vértigo
	/	67. Muscle weakness or paralysis	Parálisis o debilidad muscular
	/	68. Numbness in arms or legs	Adormecimiento de manos o pies
Yes/Sí	No	**PSYCHIATRIC PROBLEMS**	
	/	69. Depression	Depresión
	/	70. Nervousness	Nerviosismo
	/	71. Mood swings	Cambios del humor o del carácter
	/	72. Sleep disturbances	Trastornos del sueño
	/	73. Alcoholism	Alcoholismo
	/	74. Drug abuse treatment/rehabilitation	Rehabilitación por adicción a drogas
Yes/Sí	No	**ENDOCRINE SYSTEM**	
	/	75. Increased appetite	Apetito exagerado
	/	76. Increased thirst	Sed exagerada
	/	77. Increased urination	Aumento en la frecuencia o cantidad de orina
	/	78. Diabetes/High Blood Sugar	Diabetes / Azúcar en la sangre
	/	79. Hair loss	Pérdida del cabello
Yes/Sí	No	**BLOOD DISORDERS**	
	/	80. Bleeding gums	Sangramiento por las encias
	/	81. Bruising	Moretones o cardenales
	/	82. Spontaneous nose bleeding	Sangramiento espontáneo por la nariz
	/	83. Easy bleeding or hard to stop	Sangramiento facil o difícil de detener
Yes/Sí	No	**FOR WOMEN ONLY**	
	/	84. Pregnant?	Embarazada?
	/	85. Date last menstrual period?	Fecha última menstruación
	/	86. Irregular Menstruation?	¿Menstruación o períodos irregulares?
	/	87. Painful Menstruation	¿Menstruación o periodos dolorosos?

Please write the number of any Yes answers and explain each one of them in the space below.
Por favor, escriba el número de las preguntas en las cuáles haya contestado que SÍ y explique sus repuestas en este espacio.

CB laparoscopy 1 mo ago.

Scheduled for meniscus surgery.

PROVIDER COMMENTS

To see PMD for improved BP control 1 month prior to seeing ortho/hand

I certify that the information above is correct. (Certifico que la información arriba es correcta)

Patient Signature (Firma del Paciente): Consuelo Perez **Date** (Fecha): 2-25-15

☐ Relevant history was discussed and patient advised to follow up with personal physician

Provider initials:

DO NOT WRITE AND DO NOT COVER ANY OF THE DOCUMENTATION ABOVE.

IRVINE CO./CORP. 164551

DOS: 2/25/15 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

WC HEALTH HISTORY / HISTORIA MEDICA
Confidential / Confidencial

den #: Date:

© US HealthWorks

Received Date: 20150709 Originals\2015GJ00667-20150098GJ000667

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 2/19/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

GB surg OK cleared to do knee knee same ant meds

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

WD

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

arthroscopy chondroplasty + debride R knee

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 _____
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☑ Return to work as of (Date) 2-19-15 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 2/19/15
Specialty: _____ Signature S Graham MD
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

IRVINE CO./CORP. 164551

DOS: 2/19/15 DOI: 3/10/13 DB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 62 BP: 140/78 RESP: 16 TEMP: 98.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY:_____ DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see back page for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0 No Pain	1	2 Mild symptoms	3	4	5 Moderate symptoms	6	7	8 Severe	9	10 Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse When sitting for to long
6. Activity or position that makes the pain less Moved
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking?_____
   a. Do you need refills? ☑ Yes ☐ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 2-19-15

rev 11-2011

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

February 19, 2015

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is being followed for an osteochondral defect, which is leading to progressive osteoarthritis. She was last seen by me in 01/08/15, her condition was getting worse and we have obtained authorization to repeat the arthroscopic chondroplasty; however, she was going through a cholecystectomy and we put everything on hold. She comes back at this time for followup. She has successfully had the gallbladder removed. Her surgeon has cleared her to proceed with orthopedic surgical intervention if necessary. Her knee has not improved. She describes her pain as throbbing at level 5/10, it is aggravated by walking and prolonged standing and partially relieved by rest. She has returned to modified duties at work as of this week.

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, female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 62
Blood Pressure: 140/78
Respiration: 16
Temperature: 98.8

Examination of the Right Knee

Right knee shows moderate fullness. There is no sign of infection. Range of motion is limited from 0-120 degrees. There is no instability. There is tenderness along the medial joint line and painful McMurray test.

DIAGNOSES

Osteochondral defect and osteoarthritis, right knee.

PLAN

Plan will be to proceed with plans for arthroscopy, debridement chondroplasty, and possible meniscectomy of the right knee. The patient will continue working modified duties in the meantime up until the time of surgery, which is to limit kneeling and squatting.

RE: **PEREZ, CONSUELO**
February 19, 2015
Page 3

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:dty.KP
D: 02/20/15
T: 02/21/15
PerezC0219Graham22720725

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
M 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016

Operative Report

SURGEON: Stephen P. Graham, M.D.
ASSISTANT: Michelle Shin, PA, student
ANESTHESIOLOGIST: Dr. Zhang.

DATE OF SURGERY: 2/8/2016

PREOPERATIVE DIAGNOSIS: Progressive osteoarthritis, right knee.

POSTOPERATIVE DIAGNOSIS: Progressive osteoarthritis, right knee.

PROCEDURE PERFORMED: Right total knee arthroplasty.

ANESTHESIA: Spinal with sedation.

FINDINGS: osteochondral defect med femoral condyle and OA medial and patellofemoral

ESTIMATED BLOOD LOSS: Tourniquet.

TOURNIQUET PRESSURE: 300 mm for 81 minutes.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and induced under spinal anesthetic. She was positioned supine. A Foley catheter was inserted. She was given a test dose of Ancef and had no problems and a full-dose Ancef was given intravenously for an antibiotic effect. A tourniquet was applied to the proximal aspect of the right leg. The right leg was then prepped and draped sterilely. The leg was exsanguinated with an Esmarch bandage and the tourniquet inflated to 300 mm of pressure. An anterior incision made over the knee joint, carried down through subcutaneous tissue and medial capsule incision was made into the knee joint. There was noted be significant deformity in the medial femoral condyle and osteophytes on the periphery of the patella. Portions of the menisci were removed as well as the fat pad. The patella was flipped over. The knee was hyperflexed. Further menisci was removed laterally as well as the ACL and tissue from the intercondylar area. A drill was used to make a hole in the intracondylar area and intramedullary guide was then inserted, referencing off the posterior condyles. It measured at slightly greater than a size 4. It was elected to go with a size 4. The anterior femoral cut was made off this guide. The distal cutting guide was then attached to this at a plus 0 position and distal cut was made at a 5-degree valgus angle. The size 4 cutting guide was then applied to the cut surfaces and the posterior condylar, posterior bevel, anterior and anterior bevel cuts were then made. The finishing guide was impacted into place and the intercondylar area was then reamed out. Bony debris was removed. Remnants of the PCL were then removed and the tibia was able to be translated anteriorly using a posterior retractor. The external tibial cutting guide was attached. The guide was referenced off the lateral

COPIED Date: COPIED

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
M 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016

Operative Report

tibial plateau at a 9-mm level. This was pinned into place and the tibial cut was then made. The tibial surface was smoothed and measured size 3. The size 3 trial was placed on the cut surface and the centering hole was punched down with the impactor. A size 3 trial was then placed on the tibial surface. The size 4 trial at femoral surface and then a reduction was performed with 9-mm and 11-mm spacers. The 11-mm spacer allowed for more stability and still allowed for complete extension. The position of tibial tray was then marked on the front of the tibia. The patellar surface was then prepared. It was elected to use an inset biconvex patellar button 23 mm. A guide was placed directly over the patella centering off the median raphe. It was drilled down to a depth of 10.5 mm. The trial button was inserted and reduction was performed and the patella tracked nicely within the trial component. The trial components were removed except for the tibial tray, which was left in place until the keel cut could be made. This was then removed. The bone was then debrided with the irrigator aspirator. At the same time methyl methacrylate was then mixed on the back table. The methacrylate was then applied to the cut surface of the tibia and the tibial component, which was impacted into place. Excess cement was removed. Cement was then applied to the cut surface of the femur and the femoral component, which was impacted into place. Excess cement was removed. Cement was then applied to the inside part of the patella and patellar button compressed into place. Knee was brought out into full extension to compress the components together after the cement hardened. Protruding areas of cement on the rim were then removed using an osteotome. Once again, the trial was performed with an 11-mm spacer, which appeared to be the appropriate size. The final spacer was then inserted without difficulty and final reduction was performed. Full extension was obtained as well as flexion easily to 110 degrees without any instability. The tourniquet was released. Minor bleeding points were cauterized. There was no major bleeding encountered. It was elected not to insert a drain. The joint was thoroughly irrigated with irrigator aspirator and then closed. The capsule was reapproximated with interrupted sutures of #1 Vicryl using a figure-of-eight from the distal two-thirds and simple sutures to the proximal one-third, subcutaneous tissue was closed with interrupted sutures of 2-0 Vicryl and skin was closed with skin staples. Sterile dressings were applied using Xeroform, 4 x 4s, ABD, Sof-Rol and bias-cut stockinette. The patient was awakened. She tolerated the procedure well, was sent to the recovery room in satisfactory condition. It is planned that she will have a femoral nerve block in recovery room. It was also noted that she was given tranexamic acid before tourniquet went up for control of bleeding.

As an addendum, the components used are Smith-Nephew Genesis II posterior stabilized knee, size 4 femoral component cemented, size 3 tibial tray cemented, 11-mm spacer and 23 mm inset biconvex patellar button.

COPIED Date: COPIED

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos, CA 90720

Name: PEREZ, CONSUELO
MR#: 001019121
ACCT: 011725348

STEPHEN P. GRAHAM, MD
ADM: 02/08/2016

Operative Report

STEPHEN P. GRAHAM, MD

cc: Michelle Shin

T: PG/IN
DD:02/08/2016 10:09 PST
DT:02/08/2016 10:57 PST
Dictation ID: 17821409/Confirmation #: 8506871

COPIED
Date: ____
COPIED

Work Type: Operative Report Work Type Code: OPT
T001 Page: 3
Authenticated and Edited by STEPHEN GRAHAM, M.D. On 2/08/16 2:22:36 PM Central Time

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· MEDICAL GROUP

032 25 Case Number : 32-251644 Visit Date : 2/08/16 Time : 10:15

Patient **Perez, Consuelo**
Employer IRVINE CO./WORK COMP ONLY
Injury Date 3/10/13 Time 5:00 PM

Age 63 Sex F DOB 3/15/52
Occupation Laundry Attendent
Med Ref# EMR/JB

Employer 164559
IRVINE CO./WORK COMP ONLY
550 NEWPORT CENTER DR.
NEWPORT BEACH CA 92660
Phone: (949) 720-4055
Fax: (949) 720-3455

Payor C 014748
CHUBB SERVICES/GALLAGHER BASSETT
P.O. BOX 660403
DALLAS TX 75266
Phone: (213) 612-5400
Fax: (000)

Check-In _____ Chart Drop _____ Provider _____ Check-Out _____

Printed On: 2/26/16 18:14

M.D. SIGNATURE _____

Document Made Date: 20150127 Original Filename: 2015027GJ002581-001.pdf DCN: 2015027GJ002581

S. HealthWorks
MEDICAL GROUP

6

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)
X *Additional pages attached*

Last Name Perez First Consuelo DOB 3/15/52 Date of Exam: 1/08/15 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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

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

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

SUBJECTIVE COMPLAINTS (Document and describe significant complaints)

Worse choke neptush

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

same Pain Cspine

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

surgery OK c surgeon

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 _____

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. WRITTEN RX REQUIRED

Off work until (Date) _____ Estimated period of total temporary disability _____ days.

Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from ( ) Keyboard / ( ) _____
( ) Other limit stair climb

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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 1/08/15

Specialty: _____ Signature S Graham MD

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 will call

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

Recvd Date: 20150127 Bill DCN: 2015027GJ002581

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

January 8, 2015

Chubb Services/Gallagher Bassett
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

A Spanish interpreter, Maria Velarde, was used in the face-to-face time with this patient during the course of the history and physical examination.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is being followed for an osteochondral defect of medial femoral condyle, which is resulted in progressive osteoarthritis. Arthroscopic surgery has been recommended. It has been slowly authorized, but ultimately she has not been authorized for care. The patient's condition continues to be worse. She has persistent pain, which is aggravated by activity and partially relieved by rest. She is willing to proceed with arthroscopic surgery; however, she is having cholecystectomy done next week and would like to perform as soon as possible after the proposed operation.

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 female appearing her stated age and in no apparent distress.

Vital Signs

Pulse: 52
Blood Pressure: 117/97
Respiration: 15
Temperature: 98.8

Examination of the Right Knee

Visual Inspection

Knee shows moderate swelling.

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.

Range of Motion

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

There is pain and tenderness on the medial joint line.

Special Tests

There is no gross instability. McMurray test is painful. Her gait is mildly antalgic.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSES

Osteochondral defect and osteoarthritis of the right knee.

PLAN

Plan will be to proceed with arthroscopic surgery for further chondroplasty and debridement. We have requested the patient to call her general surgeon to see how soon after her cholecystectomy he feels like it would be safe to proceed with arthroscopic surgery. In the meantime, she will continue with modified duties at work, which is limited kneeling or squatting and limited stair climbing.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.EEM
D: 01/09/15
T: 01/11/15
PerezC0108Graham22720302

NE CO./CORP. 164551

1/08/15 DOI: 3/10/13 DOB: 3/15/52

ent: Perez, Consuelo

: 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

OFFICE USE

ALS: HT:_____ WT:_____ PULSE: 62 BP: 171/97 RESP: 15 TEMP: 98.8

AR: RIGHT:_____ LEFT:_____ SETTING #:_____

REPRETER NAME: First: Maria Last: Valadez

E OF SURGERY:_____ DAYS SINCE SURGERY:_____

ce your last visit with the doctor

Do you feel: ☐ Better ☐ Same ☒ Worse

What does the pain feel like? ☐ Dull ☐ Sharp ☒ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain

Rate the intensity of your pain today Please see back page for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

How often do you feel the pain? ☐ Rare ☐ Occasional ☒ Intermittent ☐ Constant

Activity or position that makes the pain worse Standing.

Activity or position that makes the pain less_____

Have you kept your treatment as indicated? ☐ Yes ☒ No

What medications are you currently taking?_____

a. Do you need refills? ☐ Yes ☐ No

Do you have any allergies? ☒ Yes ☐ No

If yes, please explain Penicillin -

Are you receiving therapy? ☐ Yes ☒ No

What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic

Have you experienced any new symptoms? ☐ Yes ☒ No

If yes, are these symptoms related with your injury? ☐ Yes ☐ No

Are you currently ☐ Off Work ☒ Modified Work ☐ Full Duty

Have there been any changes in your medical history? ☐ Yes ☐ No

ase explain.

ient Signature Consuelo Perez Date 1/8/15

Document Created: 20150114 Filed in Originals\2B511GJ000777-2015014GJ000777

U.S. HealthWorks
MEDICAL GROUP

5

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

☒ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 11/20/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

worse PRN some await with surg work rest

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

no Δ

DIAGNOSES (Include ICD-9 code, if possible) DJD R Knee

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 _____
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days. WRITTEN RX REQUIRED
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from ( ) Keyboard / ( ) _____
(✓) Other limit stair climb

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 11/20/14
Specialty: Lic G43382 Signature _____
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 4-6 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

November 20, 2014

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit and it remains unchanged other than the exceptions otherwise noted.

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is being followed for an osteochondral defect in medial femoral condyle of the right knee. Recent x-rays have also demonstrated a medial compartment osteoarthritis, which is progressing. She was last seen on 10/09/14. Her condition seems to be getting worse. She had marked pain and discomfort. As a result of that, she might benefit from repeat arthroscopy and chondroplasty and débridement, authorization was requested. She comes back at this time for followup. Her surgery has not been authorized as of yet. Her condition remains about the same. Her pain level is described as throbbing and numbness and tingling, at a level of 5/10 with 10 being worst. She continues to take Norco on a p.r.n. basis for pain. She also continued to work modified duties.

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.

Recvd Date: 20150114 Bill DCN: 2015014GJ000777

OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 55
Blood Pressure: 153/101
Respirations: 16
Temperature: 97.8

Examination of the Right Knee

The knee remains about the same. There is mild swelling. There is tenderness along the medial joint line. Range of motion is 0 to 120 degrees without gross instability. There is mild antalgic limp.

DIAGNOSIS

Osteochondral defect and osteoarthritis of the right knee.

PLAN

We will need to await the authorization for surgical intervention, which will include arthroscopy, chondroplasty and débridement.

WORK STATUS

Remains modified with limited kneeling or squatting and limited stair climbing.

FOLLOW-UP APPOINTMENT

Reevaluation in four to six weeks or sooner if authorization for surgery has been approved.

RE: **PEREZ, CONSUELO**
November 20, 2014
Page 3

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.KKC
D: 11/20/14
T: 11/22/14
PerezC1120Graham22729311

IRVINE CO./CORP. 164551
DOS:11/20/14 DOI: 3/10/1[illegible] DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 55 BP: 153/101 RESP: 16 TEMP: 97.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First _____ Last _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☑ Throbbing ☐ Pins and Needles ☑ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse When moving up
6. Activity or position that makes the pain less Walk
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? _____
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 11-2014

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 10/09/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

worse R pain

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

same

WRITTEN RX REQUIRED

DIAGNOSES (Include ICD-9 code, if possible) DJD R knee

surgical R knee chondroplasty + debrid

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 _____

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( )
( ) Other limit stair climb

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 10/09/14

Specialty: _____ Lic G43382 Signature _____

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 10/09/14 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel.: (949) 720-4020 Fax: 949 720-4020

Claims Administrator: CHUBB SERVICES/GALLAGHER BASSETT Tel.: (213) 612-5400 Fax: _____

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

☐ improved as expected ☐ improved, but slower than expected ☐ work status pending PR2

☒ worsened ☐ reached plateau and no further improvement is expected ☐ not improved significantly

☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R

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 _____

☐ Consultation /☒ Referral ☒ Requested /☐ Pending. Specialty SURGERY ☐ 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.

☐ Off work until (Date)_____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date)_____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 10/09/14 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery

( ) No / ( ) Limited use of R / L hand to ___ hrs/day

( ) No / ( ) Limited standing or walking to ___ hrs/day

( ) No / ( ) Limited overhead work to ___ hrs/day

( ) No / ( ) Limited stooping and bending to ___ hrs/day

( ) No / (X) Limited kneeling or squatting to ___ hrs/day

( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push

Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs

( ) No climbing

( ) Sit down job.

( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage

( ) Other _____

( ) Must keep _____ elevated

( ) Keep wound/bandage clean and dry

( ) Must take a ___ minute stretch break every ___ minutes from

( ) Keyboard / ( ) _____

(X) Other LIMIT STAIR CLIMBING

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 10/09/14

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:00 PM Checkout Time 2:33 PM Next Visit Date 11/20/14 Time 2:00 PM

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

September 18, 2014

Chubb Services
Attention Claims Examiner
PO Box 660403
Dallas TX 75266-0403

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Co

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for an osteochondral defect in the right knee. She was treated initially with arthroscopic surgery for chondroplasty and debridement on 06/17/13. She had persistent pain. She was referred to Dr. Woodson for evaluation of possible chondral graft and it was felt she was not a candidate. She has been treated conservatively since that time. She recently underwent a series of Synvisc injections. Her condition has minimally improved. She was last seen by me on 08/07/14. She still is having occasional sharp pain, which is aggravated by prolonged standing. She is not wearing the brace as it gave her a skin rash. She was advised to continue an exercise program. She returns at this time for followup. Her condition is not getting any better. She continues to complain of 5/10 pain, which is aggravated by activity and partially relieved by rest. She is taking Norco on a p.r.n. basis and Naproxen on a daily basis for an antiinflammatory effect. She is getting frustrated with the persistent pain which seems to be located over the front of her knee joint.

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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, female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 61
Blood Pressure: 141/98
Respiration: 16
Temperature: 98.5

Examination of the Right Knee

Inspection

There is mild swelling in the right knee. There is no sign of infection.

Palpation

She continues to have tenderness well localized to the anteromedial joint line.

Range of Motion

She can range from 0 to 120 degrees. There is no instability.

DIAGNOSTIC TESTING

Previous x-rays did show 30% narrowing of the joint consistent with progressive osteoarthritis.

ASSESSMENT

Osteochondral defect, right knee with progressive osteoarthritis.

PLAN

The patient was given the option of considering repeat arthroscopic chondroplasty and debridement which might provide temporary relief of pain if it is getting worse. Long-term

solution would include total knee arthroplasty but she is not symptomatic enough at this time to warrant that surgery. I reviewed Dr. Woodson's report once again in which he states that the chondral grafting would be contraindicated in his opinion. Therefore, the patient will discuss the possibility of repeat arthroscopic surgery with her family before making a definite decision.

Reevaluation will be in three weeks.

WORK STATUS

Work status remains modified with limited kneeling or squatting and limited stair climbing.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.DTY
D: 09/18/14
T: 09/20/14
PerezC0918Graham2272

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U.S. Healthworks
MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation

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

5 Additional pages attached

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 9/18/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES/GALLAGHER BASSETT Tel: (213) 612-5400 Fax: _____

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)

some occas episodes sharp pain & locking

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

no Δ

DIAGNOSES (Include ICD-9 code, if possible) osteo chondral defect WRITTEN RX REQUIRED
R knee

TREATMENT discuss poss repeat prepe - expect only temporary relief - will discuss w family

☑ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a _____ minute stretch break every _____ minutes from
( ) Keyboard / ( ) _____
(✓) Other limit stair climb

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 9/18/14

Specialty: _____ Signature S Graham MD

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 3 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 9/18/14 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel.: (949) 720-4020 Fax: 949 720-4020

Claims Administrator: CHUBB SERVICES/GALLAGHER BASSETT Tel.: (213) 612-5400 Fax: _____

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

☐ improved as expected ☐ improved, but slower than expected ☐ work status pending PR2

☐ worsened ☐ reached plateau and no further improvement is expected ☒ not improved significantly

☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R

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 _____

☐ 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.

☐ Off work until (Date)_____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date)_____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 9/18/14 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery

( ) No / ( ) Limited use of R / L hand to ___ hrs/day

( ) No / ( ) Limited standing or walking to ___ hrs/day

( ) No / ( ) Limited overhead work to ___ hrs/day

( ) No / ( ) Limited stooping and bending to ___ hrs/day

( ) No / (X) Limited kneeling or squatting to ___ hrs/day

( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push

Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs

( ) No climbing

( ) Sit down job.

( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage

( ) Other _____

( ) Must keep _____ elevated

( ) Keep wound/bandage clean and dry

( ) Must take a ___ minute stretch break every ___ minutes from

( ) Keyboard / ( ) _____

(X) Other LIMIT STAIR CLIMBING

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 9/18/14

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:00 PM Checkout Time 2:32 PM Next Visit Date 10/09/14 Time 2:00 PM

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

August 7, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for osteochondral defect of the right knee. She has undergone arthroscopic surgery on 06/17/13. A chondral defect was noted at that time, secondary opinion regarding chondroplasty was obtained and was not felt she was candidate for chondral implants. She has been treated conservatively since that time. She had recently undergone a series of Synvisc injections, which did help. She was last seen by me on 07/10/14. She had noticed some improvement at that time. She was advised to try to increase daily activities and home exercises. She returns at this time for followup. Overall, she feels about the same. She has pain over the front of her knee. She describes it as level 4/10 with 10 being worse and it feels like pins-and-needles. It seems to be aggravated with prolonged standing and walking and partially relieved by rest. She uses naproxen and Norco on an as needed basis for pain relief. She has continued to work on modified duties. She is not able to wear her neoprene knee brace since it caused skin rash.

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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, female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 62
Blood Pressure: 130/80
Respirations: 16
Temperature: 98.3

Examination of the Right Knee

Visual Inspection

There is mild effusion of the knee. There is no sign of infection.

Skin

No 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.

Range of Motion

	Right	Normal
Flexion	120 degrees	135 degrees
Extension	0 degrees	0 degrees

Palpation

There is tenderness along the anteromedial joint line near the area of the medial femoral condyle defect.

Special Tests

There is no instability to varus or valgus or to Lachman's test.

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Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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 TESTING

X-rays were repeated today. They do show about 50% narrowing of the medial compartment consistent with progressive osteoarthritis.

DIAGNOSIS

Osteochondral defect of the right knee with early onset arthritis.

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PLAN

The patient will continue to try home exercise program and use of medications. It appears this is a progressive problem, which ultimately may end up requiring more surgery in the future. Her work status remains modified with limited kneeling and squatting, and limited stair climbing. She will return in six weeks for followup.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.FTB
D: 08/08/14
T: 08/11/14
PerezC0807Graham22728267

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U.S. HealthWorks MEDICAL GROUP

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

5

☐ ~~Additional pages attached~~

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 8/07/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

occas sharp pain front joint lt. pcol standing ok walk
no brace -> pain

OBJECTIVE FINDINGS (Document significant exam findings, lab, imaging, and other diagnositic testing) Xray R Knee 3V

mild eff 0-120 + ant M/L
mIV - L X 50% narrow med

WRITTEN RX REQUIRED

013

DIAGNOSES (Include ICD-9 code, if possible) osteo chondral defect R knee

H. 2

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 _____

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

REF 79-80327
HCPC: 1.A9270
SURROUND PATELLA STRAP,L

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
(✓) Other limit stair climb

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 8/07/14
Specialty: Lic G43382 Signature S Graham MD

Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103** 6 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

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IRVINE CO./CORP. 164551
DOS: 8/07/14 DOI: 3/10/13 : 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 62 BP: 150/80 RESP: 16 TEMP: 98.3

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☑ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Circle one: NO PAIN — MOST PAIN

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse Up & out to Walk
6. Activity or position that makes the pain less Moving and walking
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking? Naproxen, Norco
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☐ Yes ☐ No
   If yes, please explain Penicillin WRITTEN RX REQUIRED
10. Are you receiving therapy? ☐ Yes ☐ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☐ No

Please explain.

Patient Signature Consuelo Perez Date 8-7-14

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 - Fax (949) 863-1337

BIL

July 10, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for an osteochondral defect in the medial femoral condyle. She has undergone arthroscopic surgery in the knee on 06/17/13. Postoperatively, she has had persistent problem. She was seen by Dr. Woodson for a second opinion who felt that cartilage grafting was not necessary. She has been treated conservatively. She went through a series of Synvisc injections. The last injection was given on 05/15/14. Since that time, her condition seems to have gotten better. She was last seen on 06/05/14. She still has some soreness, but the pain is not intense. She was advised to go to the gym and do home exercises. She was continued on modified duties. She returns at this time for reevaluation. She states her knee feels a little bit better. Her soreness is mostly aggravated when she pivots or twists but straight ahead movements are not problem. She still has difficulty going up and down stairs. She is taking pain medications only on an occasional basis.

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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 63
Blood Pressure: 178/89
Respirations: 16
Temperature: 99.0

Examination of the Right Knee

Visual Inspection

Knee shows mild effusion. There is no sign of reaction to previous injections.

Gait

Gait is normal with heel and toe.

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.

Range of Motion

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

She continues to have pain over the anteromedial joint line.

Special Tests

There is no instability to varus or valgus. McMurray's test is negative. Pivot shift is negative.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Osteochondral defect, right knee medial femoral condyles.

PLAN

Plan will be to continue home exercises and to try to increase daily activities as tolerated. Work status will continue to be modified with limited stair climbing, but no further restrictions are imposed on limitations of standing or walking. She still is to continue to limit kneeling and squatting. Reevaluation will be in four to six weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.FTB
D: 07/10/14
T: 07/11/14
PerezC0710Graham2272

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J.S. HealthWorks
MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)
☐ *Additional pages attached*

atient Last: Perez First: Consuelo DOB: 3/15/52 Date of Exam: 7/10/14 Case #: 32251644

ccupation: Laundry Attendent SS#: 570-85-1146 Date of Injury: 3/10/13 Claim #: 2013419849

mployer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4020 Fax: 949 720-4020

laims Administrator: CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

EASON 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: _____

'ATIENT 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)

Injury neck / wrist / arm med

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

0-120 mild eff low med

DIAGNOSES (include ICD-9 code, if possible) osteo Chondral defect R knee

↑ ADL

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 _____

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard ( ) _____
(✓) Other limit stair climb

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 7/10/14

Specialty: _____ Signature S Grahamm MD

Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103** 4-6 wks

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

IRVINE, CO./CORP. 164551

DOS: 7/10/14 DOI: 3/10/13 DOB: 3/15/52 **ESTABLISHED PATIENT UPDATED HISTORY**

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

FOR OFFICE USE

VITALS: HT: _____ WT: _____ PULSE: 63 BP: 176/89 RESP: 16 TEMP: 99.0

JAMAR: RIGHT: _____ _____ _____ LEFT: _____ _____ _____ SETTING # _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☑ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today PLEASE SEE BACK PAGE FOR DESCRIPTION OF PAIN LEVELS

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse When up and start to walk
6. Activity or position that makes the pain less _____
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? For pain sometimes

a. Do you need refills? ☐ Yes ☑ No

9. Do you have any allergies? ☑ Yes ☐ No
If yes, please explain. Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☐ No

Please explain.

Patient Signature Consuelo Perez Date 7/10/14

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

June 5, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

No interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is being followed for a large osteochondral defect in the medial femoral condyle. Her response to surgery has been incomplete. She was referred to Dr. Woodson to evaluate for possible chondral graft. It was felt this was not appropriate. She went through a series of three Synvisc injections and her last injection was given on 05/15/14. She comes back at this time for followup. She states she feels better. She still has soreness over the inner aspect of the knee, but the effects of the shot have helped. She has less pain and discomfort. She had some increased symptoms yesterday after working a 12-hour shift, but overall has seen improvement. She describes her pain as throbbing and pins-and-needles and rates it as 4/10 with 10 being worst. It seems to be aggravated by standing on her feet and doing work in the stockroom. She gets some relief when she sits down. She is currently working modified duties.

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 female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 64
Blood Pressure: 121/87
Respirations: 17
Temperature: 98.3

Examination of the Right Knee

Visual Inspection

The right knee shows mild fullness as noted previously.

Skin

There is no sign of infection.

Range of Motion

	Right	Left	Normal
Flexion	120 degrees	150 degrees	150 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

There is tenderness over the anteromedial joint line near the area of the medial femoral condyle.

Special Tests

There is no gross instability.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

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Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Osteochondral defect, right knee.

PLAN

Plan will be to monitor and see how long the effects of the shot last. This series can be given twice a year as this seems to be helpful to the patient. She will start to go to the gym to work out. She has been advised to do low impact exercises and activities. She will continue modified duties at work which limit standing, walking, kneeling, squatting, and stair climbing. Reevaluation will be in four to six weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.FTB
D: 06/06/14
T: 06/09/14
PerezC0605Graham22727678

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U.S. HealthWorks MEDICAL GROUP

(5)

STATE OF CALIFORNIA
Division of Workers' Compensation

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

(2) ☐ Additional pages attached

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 6/05/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

shots helped still sore ant med 12 hr shift yesterday ↑ pa

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

same

DIAGNOSES (Include ICD-9 code, if possible) osteo chondral defect R knee

monitor effect of shots Pt going to gym to ex

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 _____ WRITTEN RX REQUIRED

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / (✓) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other limit stair climb

☐ 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 § 139.3.

Name Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 6/05/14

Specialty: _____ Signature _____

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 4.6 wks

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

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U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 6/05/14 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: IRVINE CO./CORP. Contact: ACCTS. PAYABLE Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

☐ improved as expected ☒ improved, but slower than expected ☐ work status pending PR2

☐ worsened ☐ reached plateau and no further improvement is expected ☐ not improved significantly

☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R

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 _____

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 6/05/14 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery

( ) No / ( ) Limited use of R / L hand to ___ hrs/day

( ) No / (X) Limited standing or walking to 4 hrs/day

( ) No / ( ) Limited overhead work to ___ hrs/day

( ) No / ( ) Limited stooping and bending to ___ hrs/day

( ) No / (X) Limited kneeling or squatting to ___ hrs/day

( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push

Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs

( ) No climbing

( ) Sit down job.

( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage

( ) Other _____

( ) Must keep _____ elevated

( ) Keep wound/bandage clean and dry

( ) Must take a ___ minute stretch break every ___ minutes from

( ) Keyboard / ( ) _____

(X) Other LIMIT STAIR CLIMBING

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 6/05/14

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

CheckIn Time 2:30 PM Checkout Time 2:55 PM Next Visit Date 7/10/14 Time 2:30 PM

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

May 15, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

SUBJECTIVE COMPLAINTS

Ms. Perez returns for an evaluation of her right knee. She is being followed for a large osteochondral defect, medial femoral condyle of the right knee. Dr. Woodson did not feel she is a candidate for chondral graft. She has elected to proceed with Synvisc injections. She received her second injection last week on May 8, 2014. Since that time she indicates she is a little bit better. She has a little bit worst pain, but she describes a catching sensation in the medial aspect of her knee when she pivots or twists. She is concerned about that. She is not taking medications specifically for her knee at this time. She continues to work her job with restrictions.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 63
Blood Pressure: 181/104
Respiration: 16
Temperature: 99

Examination of the Right Knee

Visual Inspection

There is moderate effusion.

Skin

There is no sign of infection. There is no erythema or ecchymosis.

Range of Motion

Knee motion is restricted.

	Right	Left	Normal
Flexion	120 degrees	150 degrees	135 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

Pain is located over the medial compartment of the knee joint.

Special Tests

There is no instability to varus or valgus or to Lachman's test.

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Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Osteochondral defect, right knee.

PLAN

The patient was given her third Synvisc injection into the anteromedial aspect of the right knee under sterile technique. She has been advised that she will feel whether or not this has helped her within the next three weeks, she will return at that time for followup.

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WORK STATUS

In the meantime, her work status remains modified with limited standing, walking, kneeling and squatting and limited stair climbing.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.DQO
D: 05/15/14
T: 05/17/14
PerezC0515Graham2272

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 5/15/14 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

- ☐ Improved as expected
- ☒ Improved, but slower than expected
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☐ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R

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 SYNVISC #3

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 5/15/14 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

- ( ) No work near moving machinery
- ( ) No / ( ) Limited use of R / L hand to ___ hrs/day
- ( ) No / (X) Limited standing or walking to 4 hrs/day
- ( ) No / ( ) Limited overhead work to ___ hrs/day
- ( ) No / ( ) Limited stooping and bending to ___ hrs/day
- ( ) No / (X) Limited kneeling or squatting to ___ hrs/day
- ( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
  Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
- ( ) No climbing
- ( ) Sit down job.
- ( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
  ( ) Other _____
- ( ) Must keep _____ elevated
- ( ) Keep wound/bandage clean and dry
- ( ) Must take a ___ minute stretch break every ___ minutes from
  ( ) Keyboard / ( ) _____
- (X) Other LIMIT STAIR CLIMBING

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 5/15/14

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2352 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 1:45 PM Checkout Time 2:26 PM Next Visit Date 6/05/14 Time 2:30 PM

Recv'd Date: 20150630 Bill DCN: 2015182GJ000376

U.S. HealthWorks MED CAL GROUP

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

Patient Last: Perez First: Consuelo DOB: 3/15/52 Date of Exam: 5/15/14 Case #: 32251644

Occupation: Laundry Attendent SS#: 570-85-1146 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax:

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)

little less pain feels catching med

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

mod no repert 0-120

DIAGNOSES (Include ICD-9 code, if possible): osteo chondral defect R knee
3rd synvisc inj med

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 WRITTEN RX REQUIRED
☐ 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.
☐ Off work until (Date) ___ Estimated period of total temporary disability ___ days.
☐ Off the balance of this shift only. Then RTW on (Date) ___ to ☐ Full ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) ___ with the restrictions indicated below. Estimated duration of modified duty is ___ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / (✓) Limited standing or walking to ___ hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / (✓) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ___ lbs
( ) No climbing

Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cane
☐ Other
( ) Must keep ___ elevated
( ) Keep wound\bandage clear and dry
( ) Must take a ___ minute stretch break every ___ minutes from
( ) Keyboard
( ) Other limit stair climb

☐ 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 the information contained in this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Name Stephen Graham M.D. Cal. Lic #: Lic G43382 Date of Exam: 5/15/14
Specialty: Signature:
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

3 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: ___ TIME: ___ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: ___ TIME: ___ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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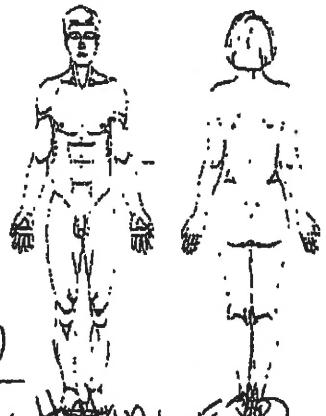
Corvel Scan Date: 8/12/2014

US HealthWorks MEDICAL GROUP

MEDICAL-SURGICAL PROCEDURE



Vital Signs: Pulse:____ /min BP:_____ mmHg Resp:____ /min Temp:_____ °F

Location: ☐ Cutaneous ☐ Subcutaneous. Mark on diagram.

DIAGNOSIS Pre-Operative_____

Post-Operative:_____

Premedication: ☑ No ☐ Yes Type:_____

☑ Risks, benefits and alternatives were discussed with the patient including, but not limited to:

_____

PROCEDURE

☑ Cryotherapy applied locally with: ☐ Ice Pack ☑ Ethyl Chloride

☐ A surgical tray was prepared with sterile gauze and instruments

☑ The area was cleansed and disinfected with: ☐ Iodine Solution ☑ Betadine Swab

☐ A sterile surgical field was placed and the procedure was performed under strict asepsis.

☐ Trigger Point / ☑ Joint Injection Site: R knee Med: (2ml) Synvisc Hylan G-F 20

☐ Anesthesia ☐ Local ☐ Regional ☐ Digital block with ____ ml of: ☐ Lidocaine ☐ Marcaine ☐ 0.5% ☐ 1% ☐ 2% ☐ with / ☐ without epinephrine

☐ Joint Aspiration Site:_____ Description:_____

☐ Incision and Drainage Results:_____

☐ Drain placed ☐ Packed with ☐ Nu-Gauze ☐ Iodine gauze ☐ Other:_____

☐ Excision ☐ Biopsy by ☐ Shave Biopsy ☐ Punch Biopsy ☐ Linear Incision ☐ Elliptical Incision Incision Size:_____ cm

☐ Foreign body removed by: ☐ Forceps ☐ Incision Incision Size:_____ cm

☐ Skin debridement (Describe):_____

☐ Hemostasis with ☐ Electrocautery ☐ Surgical

☐ Sutures / ☐ Staples were placed: ☐ Skin Sutures: #_____ Type:_____

☐ Subcutaneous: #_____ Type:_____

☐ Fascia Sutures: #_____ Type:_____

☐ Complications:_____

_____

_____

☐ Estimated Blood Loss:_____

☑ Dressed with: ☐ Antibiotic ointment ☑ Band-Aid ☐ Sterile dressing:_____

_____

COMMENTS:

☑ Patient tolerated the procedure well.

PHYSICIAN ORDERS:

Laboratory: ☐ Specimen sent to pathology ☐ Culture and Sensitivity ☐ Other:_____

After Care Instructions

☐ Keep clean and dry. Return to clinic immediately if redness, swelling, fever or purulent drainage appears.

☐ Return for wound check in: ☐ 1 day ☐ 2 days ☐ 3 days ☐ Other:_____

Out of ☐ Work / ☐ School for _____

Other:

SYNVISC HYLAN G-F 20 Lot R13022 Exp.2016-04
Remove label and place on patient record.

PHYSICIAN: Signature:_____ Name: Stephen Graham M.D. Lic G43382 Date:_____

THE IRVINE CO./CORP. 164551

DOS: 5/15/14 DOI: 3/10/13 DOB: 3/15/52

Corvel Scan Date: 8/12/2014

THE IRVINE CO./CORP. 164551

DOS: 5/15/14 DOI: 3/10/1[illegible] DOB: 3/15/52

Patient: Perez, Consuelo

ESTABLISHED PATIENT UPDATED HISTORY

Case # : 32-251644 Ref # : EMR/JB

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE 63 BP 181/104 RESP: 16 TEMP: 99.0

DAMAP: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTERPRETER NAME: First:_____ Last:_____

DATE OF SURGERY:_____ DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today. Please see back for description of pain levels

Circle one

NO PAIN										MOST PAIN
0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse: When Stop Walk
6. Activity or position that makes the pain less: Sit and Walk
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking?_____
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain: Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic

WRITTEN RX REQUIRED

11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☐ Modified Work ☑ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☐ No

Please explain.

Patient Signature: Consuelo Perez Date: 5-15-14

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

May 8, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is being followed for osteochondral defect of her right knee, which is chronic. She has elected to try conservative course of treatment, which consists of a series of Synvisc injections. She received her first injection last week on 05/01/14. She comes back at this time for her second injection. Her condition is not improved. She still has a throbbing-type pain, which she rates as 5/10 with 10 being worst. It is located over the medial aspect of her knee. She does have mild swelling. Pain is aggravated by walking and partially relieved by rest.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 65
Blood Pressure: 172/80
Respirations: 16
Temperature: 98.4

Examination of the Right Knee

Visual Inspection

There is moderate effusion in the right knee.

Skin

There are no signs of infection.

Range of Motion

	Right	Left	Normal
Flexion	120 degrees	135 degrees	135 degrees
Extension	0 degrees	0 degrees	0 degrees

Palpation

There is tenderness along the medial joint line.

Special Tests

There is no gross instability.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

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Motor Strength Examination

	Right	Left
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

DIAGNOSIS

Osteochondral defect, right knee.

PLAN

The patient was given a second Synvisc injection into the anteromedial aspect of her right knee under sterile technique.

WORK STATUS

She will continue modified duties at work, which limit standing and walking, kneeling and squatting and stair climbing.

FOLLOW-UP APPOINTMENT

Reevaluation in one week for her third and final injection.

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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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.EES
D: 05/09/14
T: 05/11/14
PerezC0508Graham2272

Recv'd Date: 20150630 Bill DCN: 2015182GJ000375
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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: Perez First: Consuelo DOB: 3/15/52 Date of Exam: 5/08/14 Case #: 32251644

Occupation: Laundry Attendent SS#: 570-85-1146 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

no better

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

same med eff + MJL

DIAGNOSES (Include ICD-9 code, if possible) osteochondral defect R knee

2nd opinion surgeon ant med

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 _____ WRITTEN RX REQUIRED
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability ____ days
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No ( ) Limited use of R / L hand to _____ hrs/day
( ) No ( ) Limited standing or walking to _____ hrs/day
( ) No ( ) Limited overhead work to _____ hrs/day
( ) No ( ) Limited stooping and bending to _____ hrs/day
( ) No ( ) Limited kneeling or squatting to _____ hrs/day
( ) No ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing
( ) Sit down job
( ) Must wear: ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cane ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from Keyboard
( ) Other limit stair climb

☐ 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 § 139.3.

Name: Stephen Graham M.D. Ca. Lic #: _____ Date of Exam: 5/08/14
Specialty: Lic G43382 Signature: S Graham MD
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 (arb)

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: ___ ___ ___ TIME: ___ ___ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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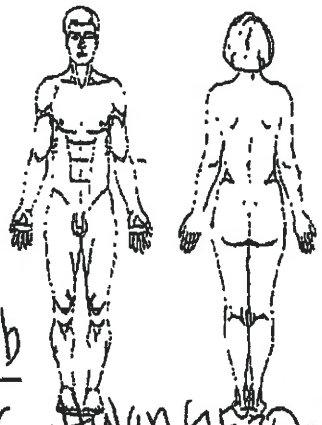
U.S. HealthWorks MEDICAL GROUP

MEDICAL-SURGICAL PROCEDURE



Vital Signs: Pulse:____ /min BP:_____ mmHg Resp:____ /min Temp:_____ °F

Location: ☐ Cutaneous ☐ Subcutaneous. Mark on diagram

DIAGNOSIS Pre-Operative_____

Post-Operative:_____

Premedication: ☑ No ☐ Yes Type:_____

☑ Risks, benefits and alternatives were discussed with the patient including, but not limited to:

_____

PROCEDURE

☑ Cryotherapy applied locally with: ☐ Ice Pack ☑ Ethyl Chloride

☐ A surgical tray was prepared with sterile gauze and instruments

☑ The area was cleansed and disinfected with ☐ Iodine Solution ☑ Betadine Swab

☐ A sterile surgical field was placed and the procedure was performed under strict asepsis

☐ Trigger Point / ☑ Joint Injection Site: R-Knee Med: (2ml) Synvisc Hylan GF 20.

☐ Anesthesia ☐ Local ☐ Regional ☐ Digital block with (____ml) of ☐ Lidocaine ☐ Marcaine ☐ 0.5% ☐ 1% ☐ 2% ☑ with / ☐ without epinephrine

☐ Joint Aspiration Site:_____ Description:_____

☐ Incision and Drainage Results:_____

☐ Drain placed ☐ Packed with ☐ Nu-Gauze ☐ Iodine gauze ☐ Other:_____

☐ Excision ☐ Biopsy by ☐ Shave Biopsy ☐ Punch Biopsy ☐ Linear Incision ☐ Elliptical Incision Incision Size:_____ cm

☐ Foreign body removed by: ☐ Forceps ☐ Incision Incision Size:_____cm

☐ Skin debridement (Describe):_____

☐ Hemostasis with ☐ Electrocautery ☐ Surgical

☐ Sutures / ☐ Staples were placed: ☐ Skin Sutures: #_____ Type:_____

☐ Subcutaneous: #_____ Type:_____

☐ Fascia Sutures: #_____ Type:_____

☐ Complications:_____

_____

_____

☐ Estimated Blood Loss:_____

☑ Dressed with: ☐ Antibiotic ointment ☑ Band-Aid ☐ Sterile dressing:_____

_____

COMMENTS:

☑ Patient tolerated the procedure well.

PHYSICIAN ORDERS:

Laboratory: ☐ Specimen sent to pathology ☐ Culture and Sensitivity ☐ Other_____

After Care Instructions

☐ Keep clean and dry. Return to clinic immediately if redness, swelling, fever or purulent drainage appears.

☐ Return for wound check in: ☐ 1 day ☐ 2 days ☐ 3 days ☐ Other_____

Out of ☐ Work / ☐ School for_____

Other:

SYNVISC Lot:R13022 Exp.2016-04 Hylan G-F 20

Remove label and place on patient record.

PHYSICIAN: Signature:_____ Name: Stephen Graham M.D. Lic G43382 Date: 5/8/14

IE IRVINE CO./CORP. 164551

AS: 5/[illegible] DOT: 3/10/13 DOB: 3/15/52

LABEL HERE

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Corvel Scan Date: 8/12/2014

THE IRVINE CO./CORP. 164551

DOS: 5/08/14 DOI: 3/10/1[illegible] DOB: 3/15/52

Patient: Perez, Consuelo

STABLISHED PATIENT UPDATED HISTORY

Case # : 32-251644 Ref # : EMR/JB

FOR OFFICE USE

VITALS: HT.____ WT:____ PULSE: 65 BP: 172/80 RESP 16 TEMP: 98.4

JAMAR: RIGHT:____ ____ ____ LEFT:____ ____ ____ SETTING #:____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY:_____ DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☑ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see back page for description of pain levels

Circle one.	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse Walk
6. Activity or position that makes the pain less_____
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking?_____
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☐ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☐ No

WRITTEN RX REQUIRED

Please explain.

Patient Signature Consuelo Perez Date 5/8/14

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 5/01/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax:

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

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☐ 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)

sonal pain med ADL unch

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

mild eff + MJL + AMJL 0-120 v/v -

DIAGNOSES (Include ICD-9 code, if possible) osteochondral defect R knee

1st injection ant med

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 WRITTEN RX REQUIRED

☐ 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.

☐ Off work until (Date) ___ Estimated period of total temporary disability ___ days.

☐ Off the balance of this shift only. Then RTW on (Date) ___ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) ___ with the restrictions indicated below. Estimated duration of modified duty is ___ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / ( ) Limited standing or walking to ___ hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / ( ) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ___ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other
( ) Must keep ___ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ___ minute stretch break every ___ minutes from ( ) Keyboard / ( )
( ) Other: limit stair climb

☐ 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 § 139.3.

Name Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 5/01/14
Specialty: Signature

Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

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

THE IRVINE CO./CORP. - 164551
DOS: 5/01/14 DOI: 3/10/[illegible] DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

'ABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE 68 BP 169/99 RESP: 18 TEMP: 98.4

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY:_____ DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today PLEASE SEE BACK PAGE FOR DESCRIPTION OF PAIN LEVELS

Circle one	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse: Walk
6. Activity or position that makes the pain less: rest
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? WRITTEN RX REQUIRED
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain: Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature: Consuelo Perez Date: 5-1-14

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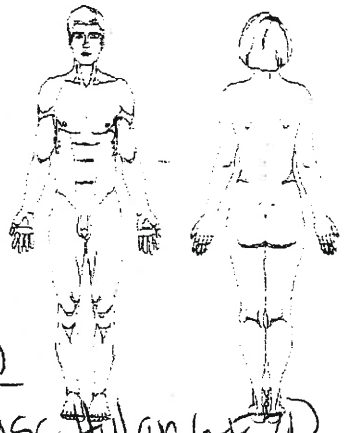
U.S. HealthWorks MEDICAL GROUP

MEDICAL-SURGICAL PROCEDURE



Vital Signs: Pulse:_____ /min BP:_____ mmHg Resp:____ /min Temp:_____ °F

Location: ☐ Cutaneous ☐ Subcutaneous. Mark on diagram

DIAGNOSIS Pre-Operative_____

Post-Operative:_____

Premedication: ☑ No ☐ Yes Type:_____

☑ **Risks, benefits and alternatives were discussed with the patient** including, but not limited to:

_____

PROCEDURE

☑ **Cryotherapy applied locally** with: ☐ Ice Pack ☑ Ethyl Chloride

☐ A **surgical tray was prepared** with sterile gauze and instruments

☑ The **area was cleansed and disinfected** with: ☐ Iodine Solution ☑ Betadine Swab

☐ A sterile **surgical field was placed and the procedure was performed under strict asepsis.**

☐ **Trigger Point** / ☑ **Joint Injection** Site: R-knee Med: (2ml) Synvisc Hylan G-F 20

☐ **Anesthesia** ☐ Local ☐ Regional ☐ Digital block with (____ml) of ☐ Lidocaine ☐ Marcaine ☐ 0.5% ☐ 1% ☐ 2% ☑ with / ☐ without epinephrine

☐ **Joint Aspiration** Site:_____ Description:_____

☐ **Incision and Drainage** Results:_____

☐ Drain placed ☐ Packed with ☐ Nu-Gauze ☐ Iodine gauze ☐ Other:_____

☐ **Excision** ☐ **Biopsy** by: ☐ Shave Biopsy ☐ Punch Biopsy ☐ Linear incision ☐ Elliptical incision Incision Size:_____ cm:

☐ **Foreign body removed** by: ☐ Forceps ☐ Incision Incision Size:_____cm:

☐ **Skin debridement** (Describe):_____

☐ **Hemostasis** with: ☐ Electrocautery ☐ Surgical

☐ **Sutures** / ☐ **Staples** were placed: ☐ Skin Sutures: #_____ Type:_____

☐ Subcutaneous: #_____ Type:_____

☐ Fascia Sutures: #_____ Type:_____

☐ **Complications:**_____

_____

_____

☐ **Estimated Blood Loss:**_____

☑ **Dressed with:** ☐ Antibiotic ointment ☑ Band-Aid ☐ Sterile dressing:_____

_____

COMMENTS:

☑ Patient tolerated the procedure well.

PHYSICIAN ORDERS:

Laboratory: ☐ Specimen sent to pathology ☐ Culture and Sensitivity ☐ Other_____

After Care Instructions

☐ Keep clean and dry. Return to clinic immediately if redness, swelling, fever or purulent drainage appears.

☐ Return for wound check in: ☐ 1 day ☐ 2 days ☐ 3 days ☐ Other_____

Out of ☐ Work / ☐ School for_____

Other:

SYNVISC HYLAN G-F 20 Lot R13022 Exp.2016-04 80321201

Remove label and place on patient record.

PHYSICIAN: Signature:_____ Name: Stephen Graham M.D. Lic G43382 Date: 5/1/14

THE IRVINE CO./CORP. 164551

DOS: 5/01/14 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

LABEL HERE

Last Name:_____ Sex:____

Occupation:_____

© US HealthWorks

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

May 1, 2014

Chubb Services Corp
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Co

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

We have communicated without an interpreter today.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is being followed for an osteochondral defect in the medial femoral condyles. She has undergone arthroscopic surgery on 06/17/13. Because of persistent pain, she was referred to Dr. Woodson to consider chondral implant. It was felt that she was not a candidate for that. She comes back at this time. She would like to try a series of Synvisc injections to see if this would improve her situation. Her level of pain is 5/10 with 10 being worst. It is aggravated by walking and partially relieved by rest.

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.

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PLAN

She may return to modified duties at work, which limit standing and walking, kneeling or squatting, and limit stair climbing. Reevaluation will be in one week for the second in a series of three injections.

PROCEDURE

The patient was given her first Synvisc injection into the anteromedial aspect of her right knee under sterile technique.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.FTB
D: 05/02/14
T: 05/03/14
PerezC0501Graham2272

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 5/01/14 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

☐ Improved as expected ☐ Improved, but slower than expected ☐ work status pending PR2
☐ worsened ☐ reached plateau and no further improvement is expected ☒ not improved significantly
☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R

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 SYNVISC #1

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 5/01/14 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / (X) Limited standing or walking to 4 hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / (X) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
( ) No climbing

( ) Sit down job.
( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
( ) Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ___ minute stretch break every ___ minutes from
( ) Keyboard / ( ) _____
(X) Other LIMIT STAIR CLIMBING

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

DISCHARGE STATUS ☐ Return to full duty on (Date) _____ with no limitations or restrictions. Released from care without retable 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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 5/01/14

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2352 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:00 PM Checkout Time 2:25 PM Next Visit Date 5/08/14 Time 2:15 PM

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BIL

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

March 27, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Co

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

We communicated with the assistance of Lucero Herrera who interpreted.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of her right knee. She is being followed for an osteochondral defect of the right knee. She has previously undergone arthroscopic surgery on 06/17/13. Postoperatively, she has had persistent pain. When last seen, it was thought that perhaps chondral implant might be of benefit. She was referred to Dr. Woodson for his evaluation. I do not have his written report, but she indicates through an interpreter that she apparently does not appear to be a candidate for the chondral replacement. He recommended instead consideration of arthroscopic debridement. Her pain remains the same. She describes it as throbbing and pins-and-needles and 4/10 with 10 being worst. It is aggravated by walking and weightbearing and partially relieved by rest. She is taking naproxen and pain medications on a p.r.n. basis. She would prefer a nonsurgical approach at this time.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 72
Blood Pressure: 144/98
Respiration: 16
Temperature: 98.4

Examination of the Right Knee

Knee examination is unchanged.

Visual Inspection

There is mild swelling.

Range of Motion

Range of motion is 0 to 120 degrees with pain along the anterior medial joint line but there is no gross instability.

ASSESSMENT

Osteochondral defect, right knee.

PLAN

The patient prefers a conservative approach. One thing we can try is a series of Synvisc injections to see if they help to reduce her symptoms, otherwise she may need to consider arthroscopic debridement of the knee joint. She is agreeable to proceeding with the injections. Authorization will be requested.

She will return for her series of Synvisc injections when it has been approved.

WORK STATUS

She will continue on modified duties at work which limits standing and walking to four hours per day, limits kneeling or squatting and limits stair climbing.

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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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.DTY
D: 03/28/14
T: 03/30/14
PerezC0327Graham2272

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 3/27/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

Dr. Woodson - not candidate for cartilage replacement
pt walk would like more pain Rx

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

no Rx

DIAGNOSES (Include ICD-9 code, if possible) osteochondral defect R knee

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 _____

☐ Consultation / ☐ Referral ☑ Requested / ☐ Pending. Specialty Pain visc injections ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / (✓) Limited standing or walking to 4 hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / (✓) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other limit stair climb

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 3/27/14

Specialty: _____ Signature _____ for Pain Mgt

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
TIME: _____ ☐ Before / After Shift

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THE IRVINE CO./CORP. 164551

DOS: 3/27/14 DOI: 3/10/13 D[redacted]: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE 72 BP: 144/98 RESP: 16 TEMP: 98.4

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☑ Throbbing ☑ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today. Please see back page for description of pain levels

Circle one:

NO PAIN									MOST PAIN
0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☑ Intermittent ☐ Constant
5. Activity or position that makes the pain worse: When up, Start to walking
6. Activity or position that makes the pain less: Depend / walk, sit, relax
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? Pain pill, naproxen
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain: Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 3-27-14

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CHRISTOPHER J. WOODSON, M.D.
Orthopedic Surgery
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
1045 North Tustin Avenue • Orange, CA 92867
Phone: (714) 288-8303 • Fax: (714) 744-1991

BIL

March 12, 2014

Chubb Services Corporation
PO Box 30570
Los Angeles CA 90030-0570

Attention Claims Adjuster

RE:	**PEREZ, CONSUELO**
Claim #:	**2013419849**
Inc. #:	032-251644
Date of Injury:	03/10/13
Employer:	The Irvine Company

INITIAL SECOND OPINION EVALUATION

Dear Claims Adjuster:

This is the initial second opinion evaluation of Consuelo Perez.

This patient is being evaluated at the request of Dr. Stephen Graham, with respect to an alleged work-related injury sustained while working for The Irvine Company on 03/10/13.

She is here today for evaluation of the right knee.

CHIEF COMPLAINT

Right knee pain, status post arthroscopy.

HISTORY OF PRESENT INJURY

Ms. Perez is a 61-year-old female who previously had surgery underwent knee arthroscopy by Dr. Stephen Graham on 06/17/13. She underwent a lateral meniscectomy, chondroplasty, debridement of the right knee with a major joint injection. Currently, she is complaining of pain in the knee. The pain varies anywhere from 2-7/10. Her primary complaint is sensation of catching and locking. There are no other associated signs or symptoms. She is currently working on limited duty.

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OCCUPATIONAL HISTORY

She has been working at The Irvine Company for the past four-and-half years. She is a uniform attendant. She delivers uniforms to employees, lists them off conveyor belts which were sometimes overhead. She has to pick up to carry laundry. She does bending, stooping, lifting, pulling, and pushing.

ACTIVITIES OF DAILY LIVING

Activities of daily living were not filled out by the patient.

MEDICAL TREATMENT TO DATE

As reported in History of Present Injury.

HISTORY OF PREVIOUS INJURIES

The patient denies history of injury or disability to the right knee on an industrial or nonindustrial basis.

Work-Related Injuries

Carpal tunnel syndrome of the right wrist, which was work-related.

PAST MEDICAL HISTORY

Medical History

She has hypertension. The patient denies a history of diabetes or cardiac, pulmonary, renal or gastrointestinal disorders.

Surgical History

C-sections, appendectomy, carpal tunnel syndrome of the right wrist, which was work-related.

Allergies

PENICILLIN.

Immunizations

The patient's immunization status is reviewed and is up to date.

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Medications

Diovan, Carvedilol, Prilosec and tramadol.

SOCIAL HISTORY

Habits

Alcohol
The patient denies alcohol consumption.

Tobacco
The patient denies smoking tobacco.

Recreational Drugs
The patient denies use of recreational drugs.

FAMILY HISTORY

The patient's family history is noncontributory.

REVIEW OF SYSTEMS

Constitutional

The patient denies fever, weakness, fatigue or appetite loss. There has been no significant weight loss or gain.

Skin

The patient has no skin disease or problems. There are no pigmentation changes or discoloration. There are no tumors/cancer or cysts.

Head

The patient denies frequent or severe headaches.

Eyes/Vision

The patient denies eye injury, infection or pain. The patient denies blurred, double or decreased vision, eye itching, burning or tearing and light sensitivity.

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Ears, Nose, Throat, Mouth

The patient denies ear pain, infection, discharge or decreased or loss of hearing. The patient denies sinus problems, recurrent throat problems, voice change or dental disease.

Cardiovascular

Positive for hypertension. The patient denies chest pain, heart palpitations, shortness of breath, swelling of the feet or ankles or varicose veins.

Respiratory

The patient denies chronic cough, asthma, emphysema or chronic bronchitis, pneumonia, tuberculosis or coughing of blood.

Gastrointestinal

The patient denies frequent indigestion or reflux, nausea or vomiting, vomiting of blood, or abdominal pain. The patient denies liver disease, change in bowel habits, frequent constipation or diarrhea, blood in stools or hemorrhoids/rectal disease.

Genitourinary

The patient denies painful or difficulty urination, blood in the urine, kidney infection/stones or venereal disease.

Musculoskeletal

The patient denies musculoskeletal problems with the exception of those associated with this injury.

Neurologic

The patient denies epilepsy or convulsions. The patient denies other neurologic problems with the exception of those associated with this injury.

Psychiatric

The patient denies depression, nervousness, mood swings or sleep disturbances. The patient denies alcoholism or drug abuse treatment.

Endocrine

The patient denies increased thirst, appetite or urination. The patient denies diabetes or hair loss.

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Ears, Nose, Throat, Mouth

The patient denies ear pain, infection, discharge or decreased or loss of hearing. The patient denies sinus problems, recurrent throat problems, voice change or dental disease.

Cardiovascular

Positive for hypertension. The patient denies chest pain, heart palpitations, shortness of breath, swelling of the feet or ankles or varicose veins.

Respiratory

The patient denies chronic cough, asthma, emphysema or chronic bronchitis, pneumonia, tuberculosis or coughing of blood.

Gastrointestinal

The patient denies frequent indigestion or reflux, nausea or vomiting, vomiting of blood, or abdominal pain. The patient denies liver disease, change in bowel habits, frequent constipation or diarrhea, blood in stools or hemorrhoids/rectal disease.

Genitourinary

The patient denies painful or difficulty urination, blood in the urine, kidney infection/stones or venereal disease.

Musculoskeletal

The patient denies musculoskeletal problems with the exception of those associated with this injury.

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The patient denies epilepsy or convulsions. The patient denies other neurologic problems with the exception of those associated with this injury.

Psychiatric

The patient denies depression, nervousness, mood swings or sleep disturbances. The patient denies alcoholism or drug abuse treatment.

Endocrine

The patient denies increased thirst, appetite or urination. The patient denies diabetes or hair loss.

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Hematologic

The patient denies bleeding gums, easy bruising or spontaneous nose bleeding. The patient denies easy bleeding or bleeding that is hard to stop.

PHYSICAL EXAMINATION

General Appearance

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

Vital Signs

Blood Pressure:	159/72
Pulse:	68
Respiration:	14
Temperature:	98.8

Examination of the Left Hip

Range of Motion

Examination of the hip reveals full range of motion without pain. Active range of motion of the hip reveals:

	Left	Expected Normal
Extension	0 degrees	0 degrees
Flexion	120 degrees	120 degrees
Abduction	45 degrees	45 degrees
Internal rotation	35 degrees	35 degrees
External rotation	45 degrees	45 degrees

Special Tests

The patient has a negative Trendelenburg test of the hip. There is a negative FABERE test of the hip.

Examination of the Right Hip

Range of Motion

Examination of the hip reveals full range of motion without pain. Active range of motion of the hip reveals:

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	Right	Expected Normal
Extension	0 degrees	0 degrees
Flexion	120 degrees	120 degrees
Abduction	45 degrees	45 degrees
Internal rotation	35 degrees	35 degrees
External rotation	45 degrees	45 degrees

Special Tests

The patient has a negative Trendelenburg test of the hip. There is a negative FABERE test of the hip.

Examination of the Left Knee

Range of Motion

Examination of the knee reveals full range of motion.

	Left	Expected Normal
Extension	0 degrees	0 degrees
Flexion	135 degrees	135 degrees

Special Tests

Anterior stability	Stable
Posterior stability	Stable
Varus stability (0 degrees)	Stable
Varus stability (30 degrees)	Stable
Valgus stability (0 degrees)	Stable
Valgus stability (30 degrees)	Stable
Medial McMurray test	Negative
Lateral McMurray test	Negative
Pivot shift (rotatory instability)	Negative
Patellofemoral crepitus	None
Patellofemoral tracking	Normal
Patellar compression test	Normal
Patellar apprehension	Negative
Effusion/swelling	None
Deep knee bend	Full

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Examination of the Right Knee

Skin

She has a well-healed arthroscopic incisions. She has no erythema or ecchymosis.

Range of Motion

Her range of motion is

	Right	Expected Normal
Extension	0 degrees	0 degrees
Flexion	110 degrees	135 degrees

With flexion and extension, there is crepitus noted medially over the medial joint line and over the anteromedial compartment.

Palpation

She is tender over the medial joint line.

Special Tests

Anterior stability	Stable
Posterior stability	Stable
Varus stability (0 degrees)	Stable
Varus stability (30 degrees)	Stable
Valgus stability (0 degrees)	Stable
Valgus stability (30 degrees)	Stable
Medial McMurray test	Negative
Lateral McMurray test	Negative
Pivot shift (rotatory instability)	Negative
Patellofemoral crepitus	Positive
Patellofemoral tracking	Normal
Patellar compression test	Positive
Patellar apprehension	Negative
Effusion/swelling	Trace
Deep knee bend	Full

Examination of the Left Ankle

Examination of the ankle reveals full range of motion without abnormalities. Active range of motion of the ankle reveals:

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	Left	Expected Normal
Dorsiflexion	10 degrees	10 degrees
Plantar flexion	45 degrees	45 degrees
Inversion	30 degrees	30 degrees
Eversion	15 degrees	15 degrees

Examination of the Right Ankle

Examination of the ankle reveals full range of motion without abnormalities. Active range of motion of the ankle reveals:

	Right	Expected Normal
Dorsiflexion	10 degrees	10 degrees
Plantar flexion	45 degrees	45 degrees
Inversion	30 degrees	30 degrees
Eversion	15 degrees	15 degrees

Neurological Examination of the Lower Extremities

Sensory Examination

The neurological examination reveals normal sensation to light touch of the bilateral lower extremities.

	Right	Left
L1	Normal	Normal
L2	Normal	Normal
L3	Normal	Normal
L4	Normal	Normal
L5	Normal	Normal
S1	Normal	Normal

Peripheral Nerve Sensory Examination

	Right	Left
Sciatic	Normal	Normal
Tibial	Normal	Normal
Peroneal	Normal	Normal

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Motor Strength Testing

There is 5/5 motor strength of all major muscle groups of the bilateral lower extremities without any noted atrophy.

	Right	Left
L1-L3 (hip flexors)	5/5	5/5
L4 (quadriceps)	5/5	5/5
L4-S1 (hamstrings)	5/5	5/5
L5 (extensor hallucis)	5/5	5/5
L5 (anterior tibialis)	5/5	5/5
S1 (gastrocnemius)	5/5	5/5
S1 (peroneal)	5/5	5/5

Deep Tendon Reflexes

Deep tendon reflexes are physiologic and symmetric at the knee jerks and ankle jerks.

	Right	Left
L4 (patella/knee jerk)	2/4	2/4
S1 (Achilles/ankle jerk)	2/4	2/4

Straight Leg Raising

	Right	Left
Sitting	Negative to 90 degrees	Negative to 90 degrees
Supine	Negative to 90 degrees	Negative to 90 degrees

Gait

The patient is walking with no limp. Ambulation is without assistive devices. Heel walk and toe walk are not performed.

DIAGNOSTIC TESTING

MRI from SimonMed dated 05/14/13 shows a radial tear of the posterior horn of the medial meniscus near the posterior root ligament with mild extrusion. There is a focal longitudinal vertical oblique tear of the posterior horn of the medial meniscus. There is a focal full-thickness chondral defect at the central portion of the medial femoral condyle measuring 8 x 14 mm. She has moderate-to-severe chondromalacia. She has subchondral bone marrow edema in the peripheral aspect of the femoral condyle and large joint effusion with a small popliteal cyst.

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Right knee, three views from 04/10/13 shows degenerative joint disease which would be considered mild-to-moderate primarily and medially and in the patellofemoral compartment.

ASSESSMENT

1. Right knee pain, status post right knee arthroscopy.
2. Right knee degenerative joint disease.
3. Right knee chondromalacia.
4. Right knee degenerative meniscal pathology.

CAUSATION

In reviewing the patient's history and medical records and examination today, it appears that the patient did sustain an injury to the right knee arising out of and caused by the industrial exposure of 03/10/13.

RECOMMENDATIONS

Treatment recommendations were discussed and/or communicated with the patient's treating physician. On the basis of today's evaluation and in reviewing the patient's job responsibilities, my recommendations are as follows:

Thank you very much Dr. Graham for referring Ms. Perez over for second opinion consultation.

At this point, I would not recommend an OATS procedure for the osteochondral defect. On my examination today, she primarily has pain over the anteromedial portal and there is significant scar tissue and crepitus in this region, which appears to be causing the mechanical locking and catching symptoms that she is having. My recommendation today would be to perform a second right knee arthroscopy with lysis of adhesions and scar removal. I would also address any loose cartilaginous debris or cartilage fragments at that time. Essentially, she will be undergoing a complete synovectomy with lysis of adhesions primarily in the anterior interval as well as chondroplasty and possible microfracture of the medial femoral condyle. Secondary to the degenerative joint disease that is more diffuse in nature, an OATS procedure in my opinion is contraindicated in this case. However, I do think she will get significant relief from the pain with the simple secondary knee arthroscopy.

I will see her back only on an as needed basis.

WORK STATUS

She will return back to her usual and customary job duties per Dr. Graham.

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REVIEW OF RECORDS

After examination of the patient and prior to dictating this report, I spent 30 minutes reviewing the medical records on Consuelo Perez including operative report that was dated on 06/17/13, all of the patient's follow-up visits from Dr. Graham's office starting with his initial orthopedic consultation dated 05/16/13 up until her most recent followup visit with Dr. Graham dated 02/13/14. These reports have been used in the assistance of formulating the patient's scope of previous treatment as well as the current diagnosis and the anticipated course of treatment and prognosis.

DISCLOSURE

The conclusions and opinions expressed in this report were dictated by me and are mine, based on my personal evaluation of the patient and any records available to me.

In compliance with Labor Code §4628(b), §4628(j), §5703(a)(2) and Regulations 9795, I declare under penalty of perjury that the information in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, I believe it to be true.

I further declare under penalty of perjury that I personally performed the evaluation on the date and at the location stated on the face sheet of this report and that, except as stated herein, the evaluation was performed under, and the time spent performing the evaluation was in compliance with, the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to §5307.6 of the California Labor Code.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code §139.3 with regard to the evaluation of this patient or the preparation of this report.

Executed at Orange County, California, on _____.

Physician Signature _____ CA Lic. #: A80613

Christopher J. Woodson, M.D.

OUSHW:CW:TDY:ftg.HBB
D: 03/28/14
T: 03/29/14
PerezC0312Woodson22734689

cc: Dr. Stephen Graham

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 3/12/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

- b/l c

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

- (+) SCOR MYOFASCIAL

, NL SCOR reward

WRITTEN REQUIRED

DIAGNOSES (Include ICD-9 code, if possible)

(R) knee DJD

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 _____

☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

PUSH DR. FOR

☐ 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 Christopher Woodson, M.D. Cal. Lic # A80603 Date of Exam 3/12/14

Specialty: _____ Signature _____

Executed at: **USHW of California - Orange, 1045 N. Tustin Avenue, Orange, CA 92867 Tel: (714) 288-8303**

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

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U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

AUTHORIZATION / SPECIALTY EVALUATION

Date of Request: 01/16/14 Clinic: USHW of California - Irvine Case #: 32-251644

PATIENT INFORMATION

Patient Name: Perez, Consuelo Soc. Security #: 570-85-1146

Date of Birth: 3/15/52 Date of Injury: 03/10/13 Sex: F Tel: (714)865-1227

Address: 1919 N. Sherry Ln Apt 37 City: Santa Ana State: CA Zip: 92705

INSURANCE INFORMATION

Carrier: CHUBB SERVICES CORP. Claim #: 2013419849

Address: PO BOX 30570 City: LOS ANGELES State: CA Zip: 90030-0570

Adjuster: SHAUN RAO Tel: (213)612-5389 Fax: (213)612-5718

Email:

EMPLOYER INFORMATION

Employer: THE IRVINE CO./CORP. Tel: (949)720-4055

Address: 550 NEWPORT CENTER DR. City: NEWPORT BEACH State: CA Zip: 92660

Contact Person: ERMA WORCESTER Tel: (949)720-4055 Fax: (949)720-3455

Email: eworcester@irvinecompany.com

REQUEST INFORMATION

** Diagnosis 1. 715.16 / R LOC PRIM OSTEOART-L/LEG

Reasons for Request: See attached medical notes.

Request for: Evaluation: ☒ Consult ☐ Referral ☐ AOE/COE Evaluation ☐ Other:

Specialty: ☐ Orthopedist: ☐ General / ☐ Hand / ☐ Spine ☐ PM&R ☐ Ophthalmologist ☐ Neurologist ☐ Psychiatrist ☐ General Surgery ☐ Plastic Surgery ☐ Other:

Type: ☐ Routine ☒ Urgent ☐ Emergent

Therapy: ☐ PT ☐ OT ☐ Chiropractor ☐ Acupuncturist ☐ Other: Frequency: Duration:

Diagnostics: ☐ MRI ☐ CT Scan ☐ w/contrast ☐ w/o contrast ☐ EMG/NCV (w/consult) ☐ Other:

☐ Right ☐ Left Body Part:

AUTHORIZATION INFORMATION

☒ Authorized/ ☐ Denied by: Name: Shaun Rau Date: 2/12/14

Carrier Authorization #:

If request is denied, document reasons for denial:

Appointment: Date: 3/12/14 Time: 230 Transportation Provider: Dr. Woolson

Patient Notified by (Name): on (Date):

Employer Notified by (Name): on (Date):

REQUESTING PROVIDER COMMENTS

REQUESTED BY:

Provider: GRAHAM, STEPHEN, M.D.

Address: 2362 Morse Avenue City: Irvine State: CA Zip: 92614

Tel: (949)863-9103 Fax: (949)863-1337

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(2)

THE IRVINE CO./CORP. 164551

DOS: 3/12/14 DOI: 3/10/13 DOB: 3/15/52 **PATIENT MEDICAL HISTORY**

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

VITALS: HT:_____ WT:_____ PULSE: 63 BP: 169/9 RESP: 20 TEMP: 98.1

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING:_____

Referring Physician (Name, facility):_____

Age: 61 Sex: ☐ Male ☒ Female Dominant Hand ☐ Left ☒ Right ☐ Both

Interpreter Name First: Selin Last: Cacao

CURRENT COMPLAINTS

1. Do you have any pain? ☒ Yes ☐ No (Skip to question # 10)
   Where is it? Right Knee
2. Rate the intensity of your pain today

   Circle one: NO PAIN ... MOST PAIN

   0 (No Pain) 1 2 (Mild symptoms) 3 4 5 (Moderate symptoms) (6) 7 8 (Severe) 9 10 (Debilitating)
3. What does the pain feel like? ☐ Dull ☒ Sharp ☒ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
   ☐ Other, explain_____
4. Did any of these symptoms exist prior to your injury/illness? ☒ Yes ☐ No
   Explain :_____
5. Does your present pain travel? ☐ Yes ☒ No
   Where? _____
6. How often does it happen?_____
7. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☒ Constant
8. Activity or position that makes the pain worse Walking & when I first wake
9. Activity or position that makes the pain less ~~Walking up, walk~~ Medication & cold
10. Is there any stiffness? ☐ Yes ☒ No Where is it?_____
11. Is there any weakness? ☐ Yes ☒ No Where is it?_____
12. Is there any swelling? ☐ Yes ☒ No Where is it?_____
13. Is there any grinding? ☐ Yes ☒ No Where is it?_____
14. Is there any locking? ☒ Yes ☐ No Where is it?_____
15. Is there any giving way? ☐ Yes ☒ No Where is it?_____
16. Do you have difficulty with bowel, bladder or sexual functions? ☐ Yes ☒ No
17. Do you have any deformity/scar? ☐ Yes ☒ No_____

HISTORY OF PRESENT INJURY

18. Have you had an injury at work? ☒ Yes ☐ No
19. What part (s) of the body was/were injured? Right Knee.
20. What were the date(s) of injury? 3-10-13.
21. How did the injury/accident/condition happen? (mechanism of injury)
    Repetative work related injury. Climbing up & down stairs

22. Any new symptoms since your first visit with this specialist. ☐ Yes ☑ No
Explain: _____

List below any doctors (outside of US HealthWorks) that you have seen for this injury

Name of provider and Specialty: No
Address: _____
Month/Year Seen: _____
Who referred you to this doctor: _____

Name of provider and Specialty: _____
Address: _____
Month/Year Seen: _____
Who referred you to this doctor: _____

HISTORY OF PREVIOUS INJURIES

23. Have you ever had any other worker's compensation injuries:
If yes please explain: No
24. Are any of these claims still open? _____
25. Prior to the date(s) above have you ever injured the same area of your body? ☐ Yes ☐ No
Please explain: _____

PAST MEDICAL HISTORY

ANY PREVIOUS ILLNESSES OR MEDICAL CONDITIONS:
High blood pressure

ANY PREVIOUS HOSPITALIZATIONS:

NAME OF HOSPITAL	REASON	DATE
N/A.	Right Knee Surgery.	June 2013

SURGICAL HISTORY:

OPERATION	SURGEON & CITY	DATE

MEDICATION ALLERGIES IF NONE: ☐

NAME OF MEDICATION	REACTION
Penicillin	☐RASH ☐UPSET STOMACH ☐WHEEZING ☑SHOCK ☐OTHER _____
	☐RASH ☐UPSET STOMACH ☐WHEEZING ☐SHOCK ☐OTHER _____

MEDICATIONS CURRENTLY TAKING: IF NONE: ☐

NAME OF MEDICATION	DOSAGE AND FREQUENCY	NAME OF MEDICATION	DOSAGE AND FREQUENCY
Naproxen		Diovan	Furosmide
Hydrocodone		Pantoprazole	Carvedilol

MEDICATIONS YOU HAVE TRIED FOR THIS INJURY:
Naproxen & Hydrocodone

SOCIAL HISTORY:

SPORTS & HOBBIES _____

MARITAL STATUS: ☐MARRIED ☑SINGLE ☐DIVORCED

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To better assess your health condition, please provide the following information (Para evaluar mejor su salud, por favor proporcione la siguiente información)

PLEASE ANSWER ALL QUESTIONS — POR FAVOR, CONTESTE TODAS LAS PREGUNTAS

Yes/Sí	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	
	✓	1. Allergies or hives	Alérgias o urticaria
	✓	2. Major illnesses or injuries	Enfermedades/lesiones importantes
	✓	3. Motor vehicle accidents	Accidentes de tránsito
	✓	4. Blood transfusions	Transfusiones de sangre
	✓	5. Worked in a hazardous environment	Trabajo en ambientes peligrosos
	✓	6. Permanent disabilities	Incapacidad permanente
Yes/Sí	**No**	**SOCIAL HISTORY / ANTECEDENTES SOCIALES**	
	✓	7. Tobacco use. How much? ____ week	Uso de tabaco. Cuanto? ____ /semana
	✓	8. Alcohol use. How much? ____ week	Uso de alcohol. Cuanto? ____ /semana
Yes/Sí	**No**	**FAMILY HISTORY / ANTECEDENTES FAMILIARES**	
	✓	9. Blood diseases in relatives	Familiares con enfermedades de la sangre
	✓	10. Cancer or leukemia in relatives	Familiares con cáncer o leucemia
✓		11. Diabetes in relatives	Familiares con diabetes
	✓	12. Heart Disease	Familiares con enfermedades del corazón
	✓	13. High Blood Pressure	Familiares con presión alta
	✓	14. Strokes in relatives	Familiares con trombosis / ataques cerebrales
	✓	15. Mental illnesses in relatives	Familiares con enfermedades mentales

REVIEW OF SYSTEMS / REVISION DE SISTEMAS

Have you had or do you commonly have: Tiene usted normalmente o ha tenido:

Yes/Sí	No	CONSTITUTIONAL	
✓		16. Recent gain or loss of weight	Ganancia o pérdida de peso reciente
	✓	17. Weakness, fatigue, or appetite loss	Debilidad, fatiga o pérdida de apetito
	✓	18. Fever	Fiebre
Yes/Sí	**No**	**SKIN**	
	✓	19. Skin diseases or problems	Enfermedades en la piel
	✓	20. Discoloration, pigmentation changes	Cambios de color en la piel
	✓	21. Cancer/Tumors or cysts	Cáncer, tumores o quistes
		HEAD	
	✓	22. Frequent or severe headaches	Dolores de cabeza frecuentes o severos
Yes/Sí	**No**	**EYES / VISION**	
	✓	23. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos
	✓	24. Blurred, double or decreased vision	Visión borrosa, doble, o disminuida
	✓	25. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos
	✓	26. Light sensitivity	Sensibilidad a la luz
Yes/Sí	**No**	**EARS, NOSE, THROAT, MOUTH**	
	✓	27. Loss or decreased hearing	Pérdida o disminución de la audición
	✓	28. Ear pain, infection, discharge	Dolor, infección o secreción en oídos
	✓	29. Nose / Sinus Problems	Problemas en la nariz o en senos nasales
	✓	30. Dental/Gum Disease	Enfermedades dentales o de las encías
	✓	31. Recurrent throat problems	Problemas de garganta recurrentes
	✓	32. Voice Change / Hoarseness	Ronquera o cambios en la voz
Yes/Sí	**No**	**CARDIOVASCULAR SYSTEM**	
	✓	33. Shortness of Breath	Dificultad para respirar
	✓	34. Chest Pain or Pressure	Opresión o dolor en el pecho
	✓	35. Palpitation/Pounding Heart	Palpitaciones o saltos del corazón
	✓	36. High Blood Pressure	Presión sanguínea elevada
	✓	37. Swelling Feet/Ankles	Hinchazón de pies o tobillos
	✓	38. Varicose Veins	Venas varicosas

Yes/Sí	No	RESPIRATORY SYSTEM	
	✓	39. Chronic/Recurrent Cough/Cold	Resfriado / tos crónica o recurrente
	✓	40. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho
	✓	41. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica
	✓	42. Pneumonia	Pneumonía o pulmonía
	✓	43. Tuberculosis	Tuberculosis
	✓	44. Coughing of Blood	Tos con sangre
Yes/Sí	**No**	**GASTROINTESTINAL TRACT**	
✓		45. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes
	✓	46. Nausea or vomiting	Náusea o vómitos
	✓	47. Vomiting of Blood	Vómitos con sangre
	✓	48. Abdominal pain	Dolor abdominal
	✓	49. Liver disease	Enfermedades del hígado
	✓	50. Change in Bowel Habits	Cambios en hábitos intestinales
	✓	51. Frequent Constipation/Diarrhea	Constipación o diarea frecuentes
	✓	52. Blood in stools/Black stools	Heces negras o con sangre
	✓	53. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto
		GENITOURINARY TRACT	
	✓	54. Painful or difficult urination	Dificultad o dolor al orinar
	✓	55. Blood in urine	Sangre en la orina
	✓	56. Kidney infection/stones	Infecciones o cálculos del riñón
	✓	57. Venereal Disease	Enfermedades venéreas
		MUSCULOSKELETAL	
	✓	58. Joint pain or disease	Enfermedades o dolor en las articulaciones
	✓	59. Neck or back injury	Lesiones del cuello o de la espalda
	✓	60. Foot Problems	Problemas en los pies
		NEUROLOGICAL	
	✓	61. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques
	✓	62. Dizziness	Mareos o vértigo
	✓	63. Muscle weakness or paralysis	Parálisis o debilidad muscular
	✓	64. Numbness in arms or legs	Adormecimiento de manos o pies
		PSYCHIATRIC PROBLEMS	
	✓	65. Depression	Depresión
	✓	66. Nervousness	Nerviosismo
	✓	67. Mood swings	Cambios del humor o del carácter
	✓	68. Sleep disturbances	Trastornos del sueño
	✓	69. Alcoholism	Alcoholismo
	✓	70. Drug abuse treatment/rehabilitation	Rehabilitación por adicción a drogas
		ENDOCRINE SYSTEM	
	✓	71. Increased appetite	Apetito exagerado
	✓	72. Increased thirst	Sed exagerada
	✓	73. Increased urination	Aumento en la frecuencia o cantidad de orina
	✓	74. Diabetes/High Blood Sugar	Diabetes / Azúcar en la sangre
	✓	75. Hair loss	Pérdida del cabello
		BLOOD DISORDERS	
	✓	76. Bleeding gums	Sangramiento por las encías
	✓	77. Bruising	Moretones o cardenales
	✓	78. Spontaneous nose bleeding	Sangramiento espontáneo por la nariz
	✓	79. Easy bleeding or hard to stop	Sangramiento fácil o difícil de detener
		FOR WOMEN ONLY	
	✓	80. Pregnant?	Embarazada?
	✓	81. Date last menstrual period?	Fecha última menstruación
		82. Irregular Menstruation?	¿Menstruación o períodos irregulares?
		83. Painful Menstruation	¿Menstruación o períodos dolorosos?

Please write the number of any Yes answers and explain each one of them in the space below.

Patient Signature (Firma del Paciente): X Consuelo Pérez Date. (Fecha): 3-12-14

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ACTIVITIES OF DAILY LIVING (ADL'S)

(Patient: Please answer each question once with an X in the appropriate column. Note that these questions should be answered as they pertain to your activities of daily living based on your current injury. If the activity does not apply to you please answer N/A)

Name: Consuelo Perez. Date: 3-12-14

Are you able to:	Yes	No	N/A	If NO please explain
1. Dress yourself including shoes	X			
2. Wash and dry yourself	X			
3. Take a bath	X			
4. Get on and off the toilet	X			
6. Cut your food	X			
7. Lift a full cup to your mouth	X			
8. Make a meal	X			
9. Write a note	X			
10. Type a message on a computer	X			
11. Use a telephone	X			
12. Work outdoors on flat ground	X			
13. Climb up 1 flight of stairs (10 steps)		X		
14. Stand		X		
15. Sit	X			
16. Recline	X			
17. Rise from a chair	X			
18. Run errands	X			
19. Light housework	X			
20. Feel what you touch	X			
21. Open car doors	X			
22. Turn faucets on and off	X			
23. Get in and out of a car	X			
24. Sleep	X			
25. Engage in sexual activity	X			

(rev 1-2012)

Patient Signature: Consuelo Perez Date: 3-12-14

Provider Initials _____ Date_____

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

February 13, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

We communicated well today without the assistance of an interpreter.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post arthroscopy, lateral meniscectomy, chondroplasty and drilling of chondral defect medial femoral condyle of right knee on 06/17/13. Postoperatively, she has had persistent pain. She has been treated with medications and injections. She was last seen on 01/16/14 and it was felt that she might want to consider an osteochondral graft. She was referred to Dr. Woodson for his evaluation and treatment. She comes back at this time. Her condition is not any better. Her appointment with Dr. Woodson is on 03/12/14. She continues to have pain mostly with weightbearing. It is not too painful when she is sitting or resting. Medications have been helpful, but she is out of medication. She has been taking Norco and naproxen.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 61
Blood Pressure: 168/90
Respirations: 18
Temperature: 98.8

Examination of the Right Knee

Visual Inspection

The right knee shows mild swelling. There is no erythema or ecchymosis.

Range of Motion

She can extend her knee fully, flex to 120 degrees. There is no instability to varus or valgus.

Palpation

There is tenderness along the medial jointline and over the area of the anteromedial compartment. She is able to walk full weightbearing.

Special Tests

Pivot shift maneuver is negative for rotatory instability. Lachman maneuver is negative for anterior cruciate ligament laxity.

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ASSESSMENT

Osteochondral defect, medial femoral condyle, right knee.

PLAN

The plan will be to follow through with her appointment with Dr. Woodson. Meantime, Norco 5/325 will be renewed for q.4h. p.r.n. for pain. Naproxen 550 mg will be taken one time twice a day after meals.

WORK STATUS

Work status remains the same. She will limit standing and walking to four hours per day during the eight-hour workday. She should limit kneeling and squatting and limit stair climbing.

FOLLOW-UP APPOINTMENT

Reevaluation will be in six weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.DTY
D: 02/14/14
T: 02/17/14
PerezC0213Graham2272

U.S. HealthWorks
MEDICAL GROUP

6

STATE OF CALIFORNIA
Division of Workers' Compensation

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

☒ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 2/13/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

Pain is wt bear & at rest knee support helps
out of meds appt Dr Worden 3/10/14

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

mild swell 0-120 + MJL

DIAGNOSES (Include ICD-9 code, if possible) osteochondral defect R knee

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 Tenex norco / naproxen ~~WRITTEN RX REQUIRED~~
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / (✓) Limited standing or walking to 4 hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other limit stair climbing

☐ Medical status was discussed with employer representative _____

DISCHARGE STATUS

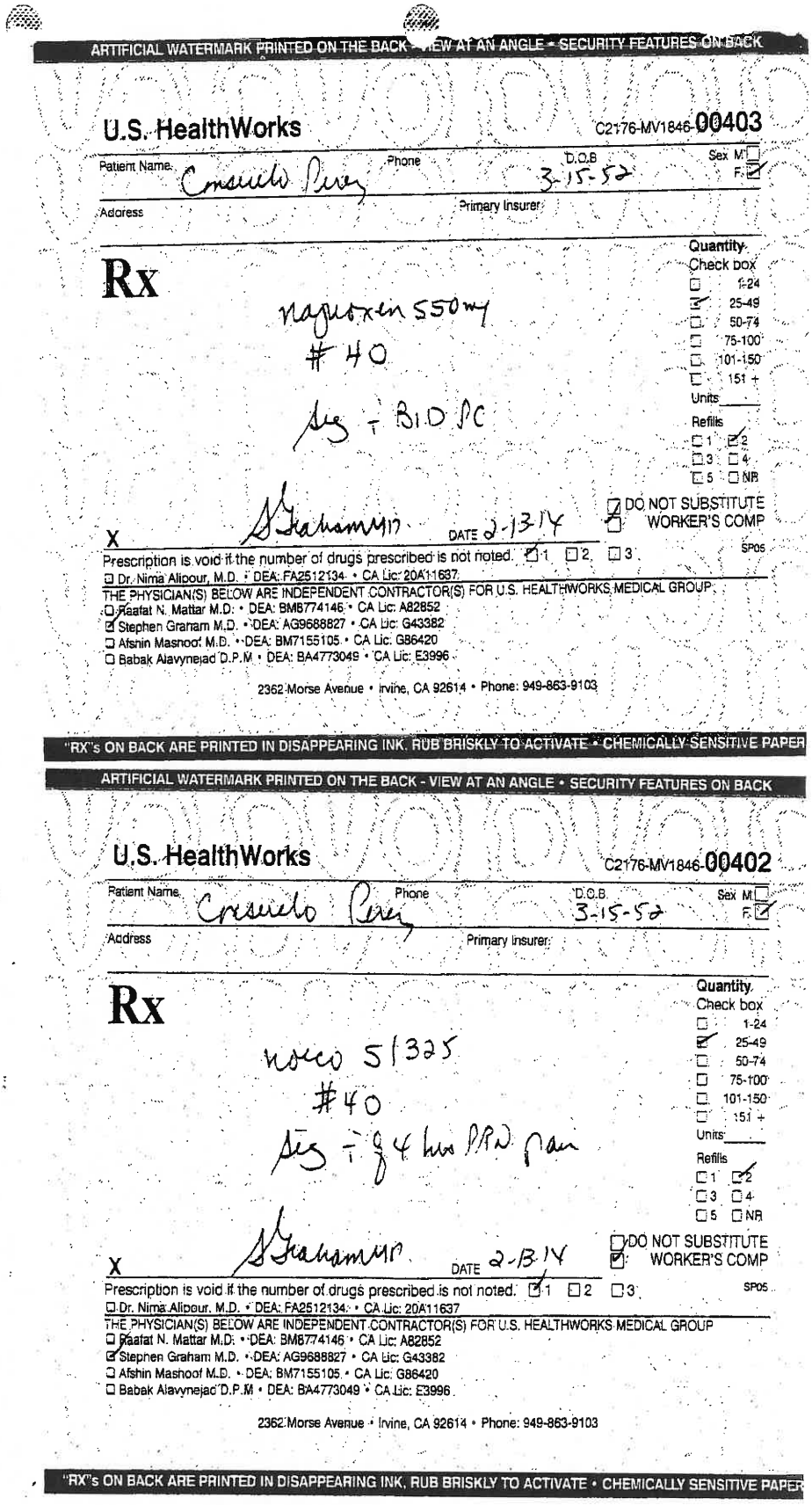
☐ Return to full duty on (Date) _____ with no limitations or restrictions. Released from care without ratable disability or need for future medical care.
☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
☐ **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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 2/13/14
Specialty: _____ Signature S Graham MD
Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103** 6 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☑ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: 2/27 TIME: 2:15 ☐ Before / After Shift	DATE: TIME: ☐ Before / After Shift



ARTIFICIAL WATERMARK PRINTED ON THE BACK - VIEW AT AN ANGLE • SECURITY FEATURES ON BACK

U.S. HealthWorks C2176-MV1846-00403

Patient Name: Consuelo Perez Phone D.O.B 3-15-52 Sex M ☐ F ☑

Address Primary Insurer

Rx

naproxen 550mg
#40
Sig: BID PC

Quantity
Check box
☐ 1-24
☑ 25-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 +
Units

Refills
☐ 1 ☑ 2
☐ 3 ☐ 4
☐ 5 ☐ NR

X S Graham MD DATE 2-13-14

☑ DO NOT SUBSTITUTE
☐ WORKER'S COMP

SP05

Prescription is void if the number of drugs prescribed is not noted. ☑ 1 ☐ 2 ☐ 3

☐ Dr. Nima Alipour, M.D. • DEA: FA2512134 • CA Lic: 20A11637

THE PHYSICIAN(S) BELOW ARE INDEPENDENT CONTRACTOR(S) FOR U.S. HEALTHWORKS MEDICAL GROUP

☐ Raafat N. Mattar M.D. • DEA: BM8774146 • CA Lic: A82852
☑ Stephen Graham M.D. • DEA: AG9688827 • CA Lic: G43382
☐ Afshin Mashoof M.D. • DEA: BM7155105 • CA Lic: G86420
☐ Babak Alavynejad D.P.M • DEA: BA4773049 • CA Lic: E3996

2362 Morse Avenue • Irvine, CA 92614 • Phone: 949-863-9103

"RX"s ON BACK ARE PRINTED IN DISAPPEARING INK. RUB BRISKLY TO ACTIVATE • CHEMICALLY SENSITIVE PAPER

ARTIFICIAL WATERMARK PRINTED ON THE BACK - VIEW AT AN ANGLE • SECURITY FEATURES ON BACK

U.S. HealthWorks C2176-MV1846-00402

Patient Name: Consuelo Perez Phone D.O.B 3-15-52 Sex M ☐ F ☑

Address Primary Insurer:

Rx

norco 5/325
#40
Sig: 1 q 4 hrs PRN pain

Quantity
Check box
☐ 1-24
☑ 25-49
☐ 50-74
☐ 75-100
☐ 101-150
☐ 151 +
Units

Refills
☐ 1 ☑ 2
☐ 3 ☐ 4
☐ 5 ☐ NR

X S Graham MD DATE 2-13-14

☐ DO NOT SUBSTITUTE
☑ WORKER'S COMP

SP05

Prescription is void if the number of drugs prescribed is not noted. ☑ 1 ☐ 2 ☐ 3

☐ Dr. Nima Alipour, M.D. • DEA: FA2512134 • CA Lic: 20A11637

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HE. IRVINE CO./CORP. 164551
)OS: 2/13/14 DOI: 3/10/13 : 3/15/52
>atient: Perez, Consuelo
:ase # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 61 BP 128/90 RESP: 18 TEMP: 98.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☑ Sharp ☐ Burning ☑ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Circle one:	NO PAIN										MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse Walk and up
6. Activity or position that makes the pain less _____
7. Have you kept your treatment as indicated? ☑ Yes ☐ No
8. What medications are you currently taking? Pain pills and naproxen
   a. Do you need refills? ☑ Yes ☐ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
   WRITTEN RX REQUIRED
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐Physical Therapy ☐Acupuncture ☐Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☑ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 2-13-14

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BIL

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

January 16, 2014

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

We communicated with the assistance of Lucero Herrera, office staff, as the patient did speak English fairly well, but had some difficulty communicating some of the problems at this time.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. The patient is status post arthroscopy, lateral meniscectomy, chondroplasty and drilling of the chondral defect of medial femoral condyle of the right knee on 06/17/13. Postoperatively, she has had persistent pain. She was last seen on 12/09/13. She seemed to have increasing discomfort at that time. She complained of more pain, swelling and difficulty when she would pivot or twist. She was taking naproxen and Norco for relief of pain. She was examined and was advised to consider a steroid injection to reduce her pain. She accepted and was given a steroid injection into the anteromedial aspect of her right knee under sterile technique. She comes back at this time for followup. Overall, her condition seems to be getting worse. She is having increasing pain. She describes it as burning. She rates it as a 5/10, with 10 being worst. It is aggravated by prolonged standing, walking or going up and down stairs and partially relieved by rest. She has been using naproxen for an anti-inflammatory effect and occasionally takes Norco for pain relief.

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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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 68
Blood Pressure: 169/85
Respirations: 18
Temperature: 98.3

Examination of the Right Knee

Visual Inspection

The right knee shows moderate swelling. There is no sign of infection.

Range of Motion

She can extend her knee fully. Flexion is possible to 120 degrees.

Palpation

There is pain and tenderness along the medial joint line.

Special Testing

There is no gross instability. McMurray test is uncomfortable.

DIAGNOSES

Osteochondral defect, right knee, status post arthroscopy.

PLAN

The patient's medications will be renewed. I would like to refer the patient to Dr. Woodson to evaluate for possible osteochondral graft to the defect in the medial femoral condyle.

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WORK STATUS

In the meantime, her work status will be modified to limited standing and walking of no more than four hours per day and no more than one hour at a time. She should limit kneeling and squatting and should also limit stair climbing.

FOLLOW-UP APPOINTMENT

Reevaluation will be in four weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.DTY
D: 01/17/14
T: 01/19/14
PerezC0116Graham2272

U.S. HealthWorks MEDICAL GROUP

(7)

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)
☒ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 1/16/14 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

↑ ↑ pain stand walk stairs

(T)

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

mod swell + med

DIAGNOSES (Include ICD-9 code, if possible) osteochondral defect R knee

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 _____ WRITTEN RX REQUIRED

☑ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty Dr Wooden ☐ Work status to be determined by specialist.
eval ostic chondral graft

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / (✓) Limited standing or walking to 4 hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / (✓) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other limit stair 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. A PR-4 to follow.
☐ **NON-INDUSTRIAL.** Patient instructed to see private physician at own expense.

(D)

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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 1/16/14

Specialty: _____ Signature S Graham

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 Lic G43382 4 cop

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

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THE IRVINE CO./CORP. 64551

DOS: 1/16/14 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 68 BP: 169/85 RESP: 18 TEMP: 98.3

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☑ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☑ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Circle one:

NO PAIN — MOST PAIN

0 No Pain | 1 | 2 Mild symptoms | 3 | 4 | 5 Moderate symptoms | 6 | 7 | 8 Severe | 9 | 10 Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse When I Walking and up
6. Activity or position that makes the pain less sitting
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking? Advil, Naproxen,
   a. Do you need refills? ☑ Yes ☐ No WRITTEN RX REQUIRED
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☑ Yes ☐ No
    If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☐ No

Please explain.

Patient Signature Consuelo Perez Date 1-16-14

Provider

Treating Name: **STEPHEN M.D. GRAHAM** License #: **G43382**
Practice Name: **USHW of California - Irvine** Tax ID: **954643269** NABP #:

Practice Address: **IRVINE MEDICAL CENTER** City: **Irvine** State: **CA** ZIP: **92614** Practice NPI: **1316927338**
Billing Name: **U.S. HEALTHWORKS MEDICAL GROUP, PC**
Billing Address: **P.O. BOX 50042** City: **LOS ANGELES** State: **CA** ZIP: **90074** Billing NPI: **1316927338**

Patient

Name: **Perez, Consuelo** DOB: **03/15/1952** Sex: **F** Phone:
Address: **1919 N. Sherry Ln Apt 37** City: **Santa Ana** State: **CA** ZIP: **92705**
SSN: Country:
Marital Status: Payee: **NO** Control#: **032251644**

Claim

Number: **WP81R0EM5B8** DOI: **03/10/13** Client ID:
Insured's Name: **THE IRVINE CO./CORP.**

Bill

Admit Date: / / Service Start: / / Service End: / /
FS/UL Allowance: **$0.00** Discharge Status: DRG Code:
Provider Billed: **$96.90** Provider Billed Date: **01/31/14** Bill Type: **000**
Foreign Bill Control #: **032251644** DCN: **14031006004210874008**
Reprice State:

Prescribing/Referring Doctor

Name: DEA #:
Address: City: State: ZIP:

Diagnosis Code

Primary: **71516** 2: 3: 4: 5:
6 : 7: 8: 9: 10:
Adm. Diag Code:

Procedure Codes - Dates

Principal: - / / Second: - / / Third: - / /
Fourth: - / / Fifth: - / / Sixth: - / /

General Fields

General 1:
General 2:
General 3:
General 4:

Comments

Line#	Type	Code	Rev. Code	POS	TOS	Service Start	Actual Charge	DXR Nbr.	Mod	Units	FS/UC Allowance	HCPCS/ Rates
1	P	99213				01/16/14	$84.99			1	$0.00	
2	P	WC002				01/16/14	$11.91			1	$0.00	

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BIL

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

December 19, 2013

Chubb Services Corp.
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post arthroscopy, lateral meniscectomy, chondroplasty, and drilling of the chondral defect of medial femoral condyle of the right knee on 06/17/13. Postoperatively, she has had persistent problems. She does have pain with weightbearing activities. She has been treated with a neoprene knee support, antiinflammatory medications, and Norco for pain relief. She was last seen on 11/21/13. Her pain was not improving. She described it as a burning sensation and rated at 5/10. After that visit, she was advised to continue low-impact exercise program to try to relieve the pressure on the knee. She returns at this time for followup. Her condition now seems to getting worse. She is having increasing pain and swelling, difficulty when she pivots or twists her knees or attempts to go up and downstairs. She has been taking medications as noted, naproxen and Norco, and has had temporary relief of symptoms. Her pain persists at level of 5/10 with 10 being worst. It is aggravated by walking and weightbearing, and partially relieved by rest. She is not presently going to any physical therapy. She does wear a knee brace for support. She is working modified duties.

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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 female appearing her stated age and in no acute distress. The patient stands 5 feet 5 inches tall and weighs 240 pounds.

Vital Signs

Pulse: 65
Blood Pressure: 169/111
Respirations: 18
Temperature: 98.8

Examination of the Right Knee

Visual Inspection

There is only moderate fullness in the knee consistent with osteoarthritis. There is no erythema or ecchymosis to suggest infection.

Range of Motion

	Right	Normal
Flexion	120 degrees	135 degrees
Extension	0 degrees	0 degrees

Palpation

There is tenderness along the medial joint line.

Special Tests

There is no gross instability to varus or valgus stress.

Gait

Her gait is mildly antalgic.

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DIAGNOSIS

Chondral defect and osteoarthritis, right knee, status post arthroscopy.

PLAN

She will continue naproxen and Norco for antiinflammatory and analgesic effect. Her condition will be monitored for change.

PROCEDURE

The patient was given a steroid injection into the anteromedial aspect of the right knee under sterile technique.

WORK STATUS

She will return to modified duties at work, which limit kneeling and squatting activities.

FOLLOW-UP APPOINTMENT

Reevaluation will be in three to four weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.FTB
D: 12/20/13
T: 12/23/13
PerezC1219Graham2272

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 12/19/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

worse ↑ pain some swell meds help
↑ sweat, tears

(I) LH

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

mild pain + MSL 0-120 w/v - antalgic gait

DIAGNOSES (Include ICD-9 code, if possible) OSteo arthritis R knee

urgent cont naproxen now

TREATMENT

☒ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other ~~WRITTEN RX REQUIRED~~
☐ Meds / Supplies Dispensed _____
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☒ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ 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.

(D)

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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 12/19/13
Specialty: _____ Signature S Graham MD
Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103** 3-4 wks

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

THE IRVINE CO./CORP. 164551

DOS:12/19/13 DOI: 3/10/13 B: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT: 65 WT: 240 PULSE: 65 BP: 169/111 RESP: 18 TEMP: 98.8

JAMAR: RIGHT: _____ _____ _____ LEFT: _____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better · ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today
Please see reverse (back) of form for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse When stand up, walk
6. Activity or position that makes the pain less Walk on flat
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking? Naproxen and for Pain

a. Do you need refills? ☐ Yes ☐ No WRITTEN RX REQUIRED

9. Do you have any allergies? ☑ Yes ☐ No
If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
What kind of therapy? ☐Physical Therapy ☐Acupuncture ☐Chiropractic
11. Have you experienced any new symptoms? ☑ Yes ☐ No
If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

/

Patient Signature Consuelo Perez Date 12-19-13

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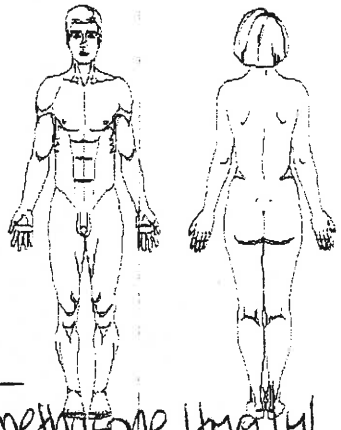
U.S. HealthWorks MEDICAL GROUP

MEDICAL-SURGICAL PROCEDURE



Vital Signs: Pulse:_____ /min BP:_____ mmHg Resp:____ /min Temp:_____ °F

Location: ☐ Cutaneous ☐ Subcutaneous. Mark on diagram

DIAGNOSIS Pre-Operative_____

Post-Operative:_____

Premedication: ☐ No ☐ Yes Type:_____

☑ **Risks, benefits and alternatives were discussed with the patient** including, but not limited to:

_____

PROCEDURE

☑ **Cryotherapy applied locally** with: ☐ Ice Pack ☑ Ethyl Chloride

☐ A **surgical tray was prepared** with sterile gauze and instruments

☑ The **area was cleansed and disinfected** with ☐ Iodine Solution ☑ Betadine Swab

☐ A sterile **surgical field was placed and the procedure was performed under strict asepsis.**

☐ **Trigger Point** / ☑ **Joint Injection** Site: R knee Med: (IM) Dexamethasone 4mg/ml

☑ **Anesthesia** ☑ Local ☐ Regional ☐ Digital block with (4 ml) of ☑ Lidocaine ☐ Marcaine ☐ 0.5% ☑ 1% ☐ 2% ☐ with / ☐ without epinephrine

☐ **Joint Aspiration** Site:_____ Description:_____

☐ **Incision and Drainage** Results:_____

☐ Drain placed ☐ Packed with ☐ Nu-Gauze ☐ Iodine gauze ☐ Other:_____

☐ **Excision** ☐ **Biopsy** by ☐ Shave Biopsy ☐ Punch Biopsy ☐ Linear Incision ☐ Elliptical Incision Incision Size:_____ cm

☐ **Foreign body removed** by: ☐ Forceps ☐ Incision Incision Size:_____cm

☐ **Skin debridement** (Describe):_____

☐ **Hemostasis** with ☐ Electrocautery ☐ Surgical

☐ **Sutures** / ☐ **Staples** were placed: ☐ Skin Sutures: #_____ Type:_____

☐ Subcutaneous: #_____ Type:_____

☐ Fascia Sutures: #_____ Type:_____

☐ **Complications**:_____

_____

_____

☐ **Estimated Blood Loss**:_____

☑ **Dressed with:** ☐ Antibiotic ointment ☑ Band-Aid ☐ Sterile dressing:_____

_____

COMMENTS:

☑ Patient tolerated the procedure well.

PHYSICIAN ORDERS:

Laboratory: ☐ Specimen sent to pathology ☐ Culture and Sensitivity ☐ Other_____

After Care Instructions

☐ Keep clean and dry. Return to clinic immediately if redness, swelling, fever or purulent drainage appears.

☐ Return for wound check in: ☐ 1 day ☐ 2 days ☐ 3 days ☐ Other_____

Out of ☐ Work / ☐ School for _____

Other: Dexamethasone 4mg/ml lot 41057H1 exp 8/14

Lidocaine 1% Lot 20-404-DK exp 8/1/14

PHYSICIAN: Signature:_____ Name: **Stephen Graham M.D.** Date:_____

Lic G43382

PLACE LABEL HERE

THE IRVINE CO./CORP. 164551 Last Name:_____ Sex:____

DOS:12/19/13 DOI: 3/10/13 DOB: 3/15/52 ___ Occupation:_____

Patient: Perez, Consuelo

© US HealthWorks

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 12/19/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

☐ Improved as expected ☐ Improved, but slower than expected ☐ work status pending PR2
☒ worsened ☐ reached plateau and no further improvement is expected ☐ not improved significantly
☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

715.16 LOC PRIM OSTEOART-L/LEG R

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 CORTISONE INJECTION
☐ 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.
☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☒ Return to work as of (Date) 12/19/13 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / ( ) Limited standing or walking to ___ hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / (X) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
( ) No climbing

( ) Sit down job.
( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
( ) Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ___ minute stretch break every ___ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 12/19/13

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2352 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:15 PM Checkout Time 3:08 PM Next Visit Date 1/16/14 Time 2:30 PM

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

November 21, 2013

Chubb Services Corp.
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Co./Corp.

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

No interpreter was necessary.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for evaluation of the right knee. The patient is status post arthroscopy lateral meniscectomy chondroplasty and drilling of a chondral defect medial femoral condyle of the right knee on 06/17/13. Postoperatively her recovery has been slow and incomplete. She has had persistent pain in the knee. She was last seen by me on 10/17/13. Her condition was not improving. She rated her pain level as 4/10. She had most pain when she was doing weight-bearing type activities. Throughout her examination, it was felt that she might benefit from a neoprene knee support to wear during periods of high activity and use of anti-inflammatories such as Advil or Aleve and Norco for pain relief. She returns at this time for followup. She indicates her condition remains about the same. She describes her pain as burning. She rates it as 5/10 with 10 being worst. It is aggravated by weight-bearing and partially relieved by rest. She has been using naproxen for an anti-inflammatory effect and Norco for pain relief. She has been able to work modified duties, which limit kneeling and squatting.

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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 female, appearing her stated age and in no acute distress.

Vital Signs

Pulse: 68
Blood Pressure: 155/91
Respirations: 18
Temperature: 98.8

Examination of the Right Knee

Visual Inspection

There is mild fullness of the right knee. There is no erythema or ecchymosis or any signs of infection.

Palpation

Palpation reveals tenderness posterior in the anteromedial joint line and anterior to the medial femoral condyle.

Range of Motion

Movement shows full extension. Flexion to 120 degrees, normal is 135 degrees.

Special Testing

There is no instability to varus or valgus stress. McMurray test is painful. Pivot shift is negative. She has difficulty going up to a stair step. She is able to walk with a relatively normal gait.

Neurovascular appears to be intact.

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DIAGNOSTIC TESTING

X-rays were repeated today. Standing AP x-ray shows increased narrowing of the medial joint space. There is some mild irregularity of the articular surface, which appeared to be increased ever since her previous x-ray of 04/10/13.

ASSESSMENT

Osteoarthritis, right knee.

PLAN

We will attempt to do a chondral drilling to resurface the medial femoral condyle surface. If this is successful, the condition as seen today will stabilize for the next couple of years. If it does not show likely go on to progressive osteoarthritis, medial compartment and knee replacement. She should continue low-impact exercise program at this point, use a brace during the periods of high activity, and use over-the-counter anti-inflammatories as needed and Norco for pain relief as needed.

WORK STATUS

Remains the same. She is capable of modified duties at work, which limit kneeling or squatting.

FOLLOW-UP APPOINTMENT

She will return in four to six weeks for followup.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.DTY
D: 11/22/13
T: 11/23/13
PerezC1121Graham2272

THE IRVINE CO./CORP. 4551

DOS:11/21/13 DOI: 3/10/13 DOB: 3/15/52 **ESTABLISHED PATIENT UPDATED HISTORY**

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

VITALS: HT:_____ WT:_____ PULSE: 68 BP: 155/91 RESP: 18 TEMP: 98.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☑ Sharp ☑ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see reverse (back) of form for Description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☑ Intermittent ☐ Constant
5. Activity or position that makes the pain worse When I up and start to walk
6. Activity or position that makes the pain less Sit
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? naproxen and pain pill
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☑ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 11-21-13

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 11/21/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

↑ pain medial not const ↑ c pivot meds help ↑ stairs

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

tender med mild swell 0-120 gait ok x ↑ narrow med

#cc19

NOV 21 2013

DIAGNOSES (Include ICD-9 code, if possible) osteo arthritis R knee

low impact ex meds PRN brace PRN

XRAY R Knee 3V AP standing

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 _____

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 11/21/13

Specialty: _____ Signature _____

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: TIME: ☐ Before / After Shift

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: TIME: ☐ Before / After Shift

Recvd Date: 20150630 Bill DCN: 2015182GJ000373

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

October 17, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: 2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. The patient is status post arthroscopy, lateral meniscectomy, chondroplasty and drilling of the medial femoral condyle of the right knee on 06/17/13. Postoperatively, she has had slow recovery and she has had persistent pain. When she was last seen by me on 09/19/13, the pain was located over the inner aspect of her knee and she rated it as 3/10. She was examined. The pain was in the area of the defect of the medial femoral condyle, which underwent chondral drilling. She was advised to continue home exercise program to further build up strength and endurance. She returns at this time and again her condition has not improved. She has the same kind of pain. She rates it as 4/10 with 10 being worst. She does not have any pain when she is not weight-bearing or using the exercise bicycle, but when she walks, she has significant discomfort. She is using Norco on a p.r.n. basis for pain relief.

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.

Recvd Date: 20150630 Bill DCN: 2015182GJ000373
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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 59
Blood Pressure: 148/102
Respirations: 16
Temperature: 98.2

Examination of the Right Knee

Visual Inspection

There is mild fullness to the knee. There is no sign of infection.

Palpation

There appears to be tenderness over the anteromedial joint line and in the region of the medial femoral condyle.

Range of Motion

Range of motion is full extension and flexion possible to 120 degrees.

Special Tests

There is no instability to varus or valgus.

Gait

The patient is able to walk with a normal gait.

DIAGNOSIS

Tear of lateral meniscus and chondral defect of the right knee, status post arthroscopy and chondral drilling.

Recv'd Date: 20150630 Bill DCN: 2015182GJ000373
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PLAN

We will attempt to provide the patient with a neoprene knee support to wear during periods of high activities such as work. She may also consider over-the-counter anti-inflammatories such as Advil or Aleve to use in conjunction with her Norco for pain relief.

WORK STATUS

Work status remains modified with limited kneeling or squatting, no stair climbing and ability to sit on a p.r.n. basis.

FOLLOW-UP APPOINTMENT

Follow up evaluation in four to six weeks. If significant improvement is not seen, we may want to consider intra-articular steroid injection.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:vip.EES
D: 10/18/13
T: 10/21/13
PerezC1017Graham2272

THE IRVINE CO./CORP. 164551

DOS:10/17/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

TABLISHED PATIENT UPDATED HISTORY

VITALS: HT:_____ WT:_____ PULSE: 69 BP: 148/102 RESP: 16 TEMP: 98.2

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First: _____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today

Please see reverse (back) of form for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse When up and start to walking
6. Activity or position that makes the pain less _____
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking? pain
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☑ Yes ☐ No
    What kind of therapy? ☐Physical Therapy ☐Acupuncture ☐Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☐ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 10/17/13

Recvd Date: 20150630 Bill DCN: 2015182GJ000373

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 10/17/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # 2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

pain ↑ walk dic non wt bear use pain meds work mod
↳ ant med

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

sore / 0-130 v/u - L-

REF 79-82838 KNEE SUPPORT W/PATELLA,XL HCPC 1.A4461

DIAGNOSES (Include ICD-9 code, if possible) tear lat meniscus chondral defect > R knee

TREATMENT

OTC AID

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

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

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

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / (✓) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard (L) _____
( ) Other no stair climb
allow sit PRN

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 10/17/13
Specialty: Lic G43382 Signature S Graham MD
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 4-6 wk

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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BIL

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

September 19, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: **PEREZ, CONSUELO**
Claim #: **WC2013419849**

Case #: 032-251644
Date of Injury: 03/10/13
Employer: The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

An interpreter, Lucero Herrera, was used in the face-to-face time with this patient during the course of the history and physical examination

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. The patient is status post arthroscopy, lateral meniscectomy, chondroplasty and drilling of medial femoral condyle of her right knee on 06/17/13. Postoperatively, she has had a slow recovery phase. She was last seen by Dr. David Wood when I was on a medical leave, the date of examination was 08/13/13. She continued to have pain in the knee and weakness with quadriceps mechanism. She has been exercising since that time and now comes back for reevaluation. She continues to have pain in the knee over the inner aspect. She rates her pain level as 3/10 with 10 being worst. It is aggravated by going from sitting to standing and prolonged walking, it is partially relieved by rest and she takes Advil for an anti-inflammatory effect. She is anxious to return to work at this time.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Blood Pressure: 149/84
Pulse: 91
Temperature: 98.8
Respirations: 20

Examination of the Right Knee

Visual Inspection

There is noted to be mild swelling in the right knee. There is no sign of infection

Palpation

There is tenderness along the medial joint line.

Range of Motion

Range of motion 0-120 degrees when she first goes from sitting to standing.

Special Tests

Pivot shift maneuver is negative for rotatory instability. Lachman maneuver is negative for anterior cruciate ligament laxity.

Gait

There is a mild antalgic gait, but after a few steps it resolves into a normal heel toe gait.

DIAGNOSIS

Tear lateral meniscus and chondral defect, right knee, status post arthroscopy.

PLAN

The patient will continue home exercise program trying to further build up strength of the quadriceps and hamstring muscles. At the present time her main issue has improved sufficiently

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that she could return to modified duties at work if available, but should not require stair climbing and allow her to sit on p.r.n. basis.

FOLLOW-UP APPOINTMENT

Followup evaluation in four to six weeks.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:OUG
D: 09/20/13
T: 09/22/13
PerezC0919Graham2272

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 9/19/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

- ☐ Improved as expected
- ☒ Improved, but slower than expected
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☐ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

836.1	TEAR LAT MENISC KNEE-CUR R	717.7	CHONDROMALACIA PATELLAE
836.0	TEAR MED MENISC KNEE-CUR		

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 _____

☐ 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.

☒ Off work until (Date) 9/22/13 Estimated period of total temporary disability 4 days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 9/23/13 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

- ( ) No work near moving machinery
- ( ) No / ( ) Limited use of R / L hand to ___ hrs/day
- ( ) No / ( ) Limited standing or walking to ___ hrs/day
- ( ) No / ( ) Limited overhead work to ___ hrs/day
- ( ) No / ( ) Limited stooping and bending to ___ hrs/day
- ( ) No / ( ) Limited kneeling or squatting to ___ hrs/day
- ( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
  Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
- ( ) No climbing
- ( ) Sit down job.
- ( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
  ( ) Other _____
- ( ) Must keep _____ elevated
- ( ) Keep wound/bandage clean and dry
- ( ) Must take a ___ minute stretch break every ___ minutes from
  ( ) Keyboard / ( ) _____
- (X) Other NO STAIR CLIMBING; ALLOW TO SIT AS NEEDED

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 9/19/13

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:30 PM Checkout Time 3:05 PM Next Visit Date 10/17/13 Time 2:30 PM

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 9/19/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

slow improvement still sore ↑ c stairs ready RTW

I

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

+ MSL mild swell 0-120 initial catalyze ⇒ normal

DIAGNOSES (Include ICD-9 code, if possible) Tear lat meniscus Chondral defect > R knee

TREATMENT home ex ↑ strength

☑ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

☐ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____ no stair climb allow sit prn

☐ 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.

D

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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 9/19/13

Specialty: _____ Signature S Graham MD

Lic G43382

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 4-6 wks

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

THE IRVINE CO./CORP. 164551
DOS: 9/19/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 91 BP: 149/84 RESP: 20 TEMP: 98.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY: 9/17/13 DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☑ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see reverse (back) of form for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	6	7	8	9	10
	No Pain		Mild symptoms		Moderate symptoms				Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse When I up start walk
6. Activity or position that makes the pain less_____
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? advil

   a. Do you need refills? ☐ Yes ☐ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐Physical Therapy ☐Acupuncture ☐Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☐ No
12. Are you currently ☑ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 9/19/13

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US HealthWorks MEDICAL GROUP

Corvel Scan Date: 1/22/2014
Treatment Visit #: 11
Authorized Visit #: 12

THE IRVINE CO./CORP. 164551

DOS: 8/30/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

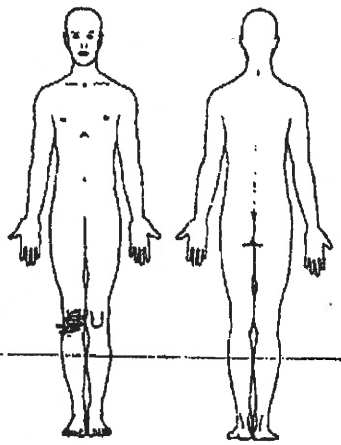
DAILY THERAPY TREATMENT NOTE

Diagnosis: R knee meniscal tear, Chondromalacia

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10 (rest / exercises)

R knee pain still present, improved ROM, but strength still poor. Walking 5 blocks.

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to R knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat light cold therapy to R knee
	☐ Whirlpool (min, F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.0 w / cm² 1 MHz to R knee (area)
	☐ Iontophoresis (ml of Dexamethasone) to (area), at (milliampere-min)
	Rehabilitation:
12	☒ Myofascial Release/Soft Tissue Mobilization R knee/hamstrings
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x 10', HS / Quad stretches 2 x 30" ea, standing hamstring stretch 3 x 30" ea, SAQ x 15, SLR x 15 ea, Modified plank x 30"

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☒ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☐ Other/Supplies:
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Able to sit/stand & ambulate x 5 blocks. Remains limited/weak to stand.

☐ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☒ perform PPE / re-evaluation / DC summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

PTA License Number AT6225

Signature

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U.S. HealthWorks MEDICAL GROUP

Corvel Scan Date: 1/22/2014

Treatment Visit #: 13

Authorized Visit #: 14

THE IRVINE CO./CORP. 164551

DOS: 8/28/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

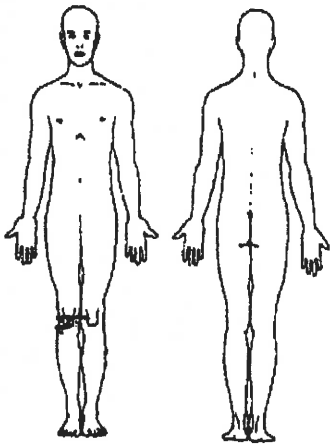
DAILY THERAPY TREATMENT NOTE

Diagnosis: _____

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee slightly stiff today & tol to WB bearing, but limp inside

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
15	☐ Vaso-comp/Edema Control:
	☐ Electrical Stimulation: TENS to (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☑ Infrared Heat Lig Cer (L) & Joints to (R) knee
	☐ Whirlpool (_____ min, _____ °F) to _____
	☐ Paraffin Bath _____
	☐ Mechanical Traction _____
	☐ Other _____
8	☑ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.0 w/cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (_____ ml of Dexamethasone) to _____ (area), at _____ (milliampere-min)
	Rehabilitation:
10	☑ Myofascial Release/Soft Tissue Mobilization _____
	☐ Joint Mobs/Manual Traction: _____
	☐ Orthotic/Splinting Training/Taping _____
	☐ FAs/ADLs/KAs/Ind. Instruct _____
	☐ Biofeedback _____
	☐ Neuromuscular Reeducation _____
	☐ Gait Training/Assistive Device Training _____
10	☑ Supervised Therapeutic Exercises: (specify) Bike L10', HS St + Ad 3x20"
	Tramp LW. Shift 3x30" ea, partial squats
	15, Step ↑ W 4" Step x10 ea, hip Abd x15,

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)

☐ Burn/Wound Care

☐ Other/Supplies: _____

☑ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Able to perform step #5 tramp ex's significantly, initiations, steady, running mild weak & unstable.

☑ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary

☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Steve Honda, PTA

License Number AT [illegible]

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Corvel Scan Date: 3/20/2014

BIL

DAVID L. WOOD, M.D.
Arthroscopy, Spinal Injuries and General Orthopedics
An Independent Contractor of
U.S. HealthWorks Medical Group
A Dignity Health Member
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

August 13, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: WC2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

PHYSICIAN PROGRESS REPORT

Dear Claims Examiner:

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

SUBJECTIVE COMPLAINTS

Consuelo Perez is the patient of Dr. Graham. I am seeing her in his absence due to his medical leave. The patient notes she had a right knee arthroscopy. She continues to complain of pain of 4/10 over the right knee. She states she is out of physical therapy and at this time would like more therapy. She states she is walking a little bit, but still has weakness in the leg.

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 female appearing her stated age and in no apparent distress.

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Corvel Scan Date: 3/20/2014

Vital Signs

Pulse: 64
Blood Pressure: 147/92
Respiration: 16
Temperature: 98.1

Examination of the Right Knee

Visual Inspection

She walks with a slight limp on the right. She squats 60%.

Skin

Arthroscopic portals are healed over the right knee.

Range of Motion

	Right	Normal
Flexion	120 degrees	150 degrees
Extension	0 degrees	0 degrees

Special Tests

She has weakness of quad and hamstrings.

Examination of the Left Knee

Visual Inspection

The knee shows no true suprapatellar swelling.

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.

Range of Motion

Knee motion is unrestricted with no crepitus in the patellofemoral joint. The patella tracks normally.

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Corvel Scan Date: 3/20/2014

	Left	Normal
Flexion	150 degrees	150 degrees
Extension	0 degrees	0 degrees

Palpation

Palpation over the medial and lateral joint spaces of the knee is asymptomatic with a negative McMurray test. There is a negative patellofemoral grind test and negative patellar apprehension test.

Special Tests

Cruciate function of the knee is intact with a negative anterior and posterior drawer sign and a negative Lachman maneuver.

DIAGNOSIS

Status post right knee arthroscopy.

DISCUSSION

The patient progressed along slowly. She needs to get into aggressive therapy two times a week for four weeks. She will follow up with Dr. Graham in three to four weeks.

WORK STATUS

The patient is temporarily partially disabled.

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 Orange County, California, on _____

Physician Signature _____ CA Lic. #: G46774

David L. Wood, M.D.

IUSHW:DW:TDY:fta.CPG
D: 08/13/13; T: 08/14/13
PerezC0813Wood2136

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 8/13/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

- ☒ improved as expected
- ☐ improved, but slower than expected
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☐ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

836.1 TEAR LAT MENISC KNEE-CUR R

TREATMENT

☒ Office Visit / Injury Treatment ☒ Start / ☐ Continue ☒ Therapy: 3 times / week for 4 weeks. ☐ Ergonomic Eval

☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ 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.

☒ Off work until (Date) 9/19/13 Estimated period of total temporary disability 27 days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

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

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name WOOD, DAVID L., M.D. Lic. # G46774 Date of Exam 8/13/13

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 10:30 AM Checkout Time 11:16 AM Next Visit Date 9/19/13 Time 2:45 PM

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 8/13/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

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

DIAGNOSES (Include ICD-9 code, if possible)

836.1 TEAR LAT MENISC KNEE-CUR R

TREATMENT

☒ Office Visit / Injury Treatment ☒ Start / ☐ Continue ☒ Therapy: 3 times / week for 4 weeks. ☐ Ergonomic Eval

☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ 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.

☒ Off work until (Date) 9/19/13 Estimated period of total temporary disability 27 days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

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- ( ) No / ( ) Limited use of R / L hand to ___ hrs/day
- ( ) No / ( ) Limited standing or walking to ___ hrs/day
- ( ) No / ( ) Limited overhead work to ___ hrs/day
- ( ) No / ( ) Limited stooping and bending to ___ hrs/day
- ( ) No / ( ) Limited kneeling or squatting to ___ hrs/day
- ( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
  Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
- ( ) No climbing
- ( ) Sit down job.
- ( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
  ( ) Other _____
- ( ) Must keep _____ elevated
- ( ) Keep wound/bandage clean and dry
- ( ) Must take a ___ minute stretch break every ___ minutes from
  ( ) Keyboard / ( ) _____
- ( ) Other _____

☐ Medical status was discussed with employer representative. Name _____

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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.

TREATING PROVIDER

Name WOOD, DAVID L., M.D. Lic. # G46774 Date of Exam 8/13/13

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 10:30 AM Checkout Time 11:16 AM Next Visit Date 9/19/13 Time 2:45 PM

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Corvel Scan Date: 3/20/2014

U.S. HealthWorks
MEDICAL GROUP

(7)

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

☒ *Additional pages attached*

Patient Last Perez First Consuelo DOB 3/15/52 Date of Exam: 8/13/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

(1) Pain (R) knee.

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

Or 120 weak quad

DIAGNOSES (Include ICD-9 code, if possible)

(1) Meniscus Tear (R)

WRITTEN RX REQUIRED

TREATMENT

☒ Office Visit / Injury Treatment ☒ Start / ☐ Continue ☒ Therapy: 3 times / week for 4 weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ 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.

☒ Off work until (Date) 9/19/13 Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 8/13/13 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / ( ) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
( ) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ Medical status was discussed with employer representative R - Sent

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 David L. Wood M.D. Cal. Lic # Lic G46774 Date of Exam 8/13/13

Specialty: _____ Signature _____

Executed at: USHW of California Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: DR Graham TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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Corvel Scan Date: 3/20/2014

THE IRVINE. CO./CORP. . 164551
DOS: 8/13/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

STABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 64 BP: 147/92 RESP: 16 TEMP: 98.1

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY: 8/7/13 DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better · ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today
Please see reverse (back) of form for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	(4)	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse Start to Walk
6. Activity or position that makes the pain less Walk
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? Blood pressure finished Naproxen
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☑ Yes ☐ No
    What kind of therapy? ☑ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☑ No
12. Are you currently ☑ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 8/13/13

WRITTEN RX REQUIRED
David L. Wood M.D.
Lic G46774

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Corvel Scan Date: 3/20/2014

U.S. HealthWorks
MEDICAL GROUP

USHW of California - Specialty

7

032 25 Case Number : 32-251644 Visit Date : 8/13/13 Time : 10:30

Patient **Perez, Consuelo** Age 61 Sex F DOB 3/15/52
Employer THE IRVINE CO./CORP. Occupation Laundry Attendent
Injury Date 3/10/13 Time 5:00 PM Med Ref# EMR/JB

Employer 164551
THE IRVINE CO./CORP.
550 NEWPORT CENTER DR.
NEWPORT BEACH CA 92660
Phone: (949) 720-4055
Fax: (949) 720-3455

Payor C 014748
CHUBB SERVICES CORP.
PO BOX 30570
LOS ANGELES CA 90030
Phone: (213) 612-5400
Fax: (000)

WRITTEN RX REQUIRED

Check-In _____ Chart Drop _____ Provider _____ Check-Out _____

M.D. SIGNATURE _____

Printed On: 8/12/13 13:47

Cover Sheet

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Corvel Scan Date: 3/20/2014

THE IRVINE.CO./CORP. 164551
DOS: 8/13/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

STABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 64 BP: 147/82 RESP: 16 TEMP: 98.1

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #:_____

INTREPRETER NAME: First:_____ Last:_____

DATE OF SURGERY: 9/17/13 DAYS SINCE SURGERY:_____

Since your last visit with the doctor

1. Do you feel: ☐ Better · ☐ Same ☐ Worse
2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see reverse (back) of form for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	(4)	5	6	7	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☑ Occasional ☐ Intermittent ☐ Constant
5. Activity or position that makes the pain worse Start to Walk
6. Activity or position that makes the pain less Walk
7. Have you kept your treatment as indicated? ☐ Yes ☑ No
8. What medications are you currently taking? Blood pressure, finished Naprosyn
   a. Do you need refills? ☐ Yes ☑ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☑ Yes ☐ No
    What kind of therapy? ☑ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☐ Yes ☑ No
    If yes, are these symptoms related with your injury? ☐ Yes ☑ No
12. Are you currently ☑ Off Work ☐ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 8/13/13

WRITTEN RX REQUIRED
David L. Wood M.D.
Lic G46774

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Corvel Scan Date: 3/20/2014

U.S. HealthWorks
MEDICAL GROUP

USHW of California - Specialty

032 25 Case Number : 32-251644 Visit Date : 8/13/13 Time : 10:30

7

Patient **Perez, Consuelo** Age 61 Sex F DOB 3/15/52
Employer THE IRVINE CO./CORP. Occupation Laundry Attendent
Injury Date 3/10/13 Time 5:00 PM Med Ref# EMR/JB

Employer 164551
THE IRVINE CO./CORP.
550 NEWPORT CENTER DR.
NEWPORT BEACH CA 92660
Phone: (949) 720-4055
Fax: (949) 720-3455

Payor C 014748
CHUBB SERVICES CORP.
PO BOX 30570
LOS ANGELES CA 90030
Phone: (213) 612-5400
Fax: (000)

WRITTEN RX REQUIRED

Check-In _____ Chart Drop _____ Provider _____ Check-Out _____

M.D. SIGNATURE _____

Printed On: 8/12/13 13:47

Cover Sheet

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U.S. HealthWorks MEDICAL GROUP

BIL

Treatment Visit #: 12
Authorized Visit #: 12

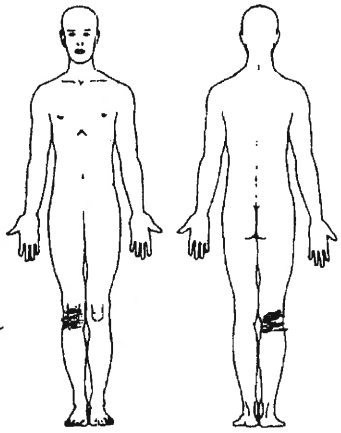
THE IRVINE CO./CORP. 164551
DOS: 8/09/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) med. meniscal tear

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10
(R) M. knee & directly below patella sore & stiff w/ bearing or step ↑.

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat Light @ 6, 2 min to (R) knee
	☐ Whirlpool (____ min, ____ °F) to ____
	☐ Paraffin Bath ____
	☐ Mechanical Traction ____
	☐ Other ____
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 2.0 w / cm² 4 MHz to (R) knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization (R) knee / glutes
	☐ Joint Mobs/Manual Traction: ____
	☐ Orthotic/Splinting Training/Taping ____
	☐ FAs/ADLs/KAs/Ind. Instruct ____
8	☒ Biofeedback to (R) VMO to facilitate recruitment
	☐ Neuromuscular Reeducation ____
	☐ Gait Training/Assistive Device Training ____
15	☒ Supervised Therapeutic Exercises: (specify) LABE x 4', 1

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☒ Other/Supplies: ____ Unigel Electrode Triode HCPCS: A4556 Bill Code: 3186 Item# 922301
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)
Able to perform tramp ex & step ex c mod. (R) knee weakness & fatigue.
☒ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

PTA
ATC225

CORVEL

REFERRED BY:	Janie Stubblefield
NAME:	Consuelo Perez
CLAIM #:	WC2013419849
DOI:	3/10/13
REVIEW TYPE:	Prospective
DATE:	7/26/13

QUESTION: Is the request for additional post-op physical therapy 2x/week for 4 weeks for the right knee medically necessary and appropriate? No

ASSESSMENT: Modified. The recommendation for certification is for four (4) additional Physical Therapy sessions.

EXPLANATION FOR ASSESSMENT:

With regard to the request for additional postoperative physical therapy status post lateral meniscectomy, Official Disability Guidelines specify that the recommended course of physical therapy following meniscectomy is 12 visits. This patient has completed eight postoperative sessions to date. The most recent physical therapy note indicates that the active range of motion is -5 degrees in extension and 112 degrees in flexion. Given the Guidelines, this request for eight additional sessions is modified to allow four additional sessions and remain within Official Disability Guidelines.

MEDICAL RECORDS:

Submitted medical records were reviewed in their entirety.

Medicals sent for review:
RFA dated 07-23-2013
Work Status/Dr. Graham dated 07-15-2013
Progress Report/Dr. Graham dated 07-15-2013
Therapy Progress Notes 07-05-2013 through 07-25-2013
Initial PT evaluation dated 07-02-2013

DIAGNOSIS:

The diagnoses include status post right knee arthroscopy, lateral meniscectomy and chondroplasty done on 06/17/2013.

CLINICAL SUMMARY:

The injured worker's date of injury was 03/10/2013. The patient has had an arthroscopic right knee meniscectomy and chondroplasty performed on 06/17/2013. The most recent work status and physician progress reports were reviewed. A physician progress report, dated 07/15/2013, indicates that the patient has continued pain aggravated by weightbearing and partially relieved by rest. She was advised to start physical therapy. She describes her current pain level as 5 out of 10. Objectively, on physical examination, vital signs are stable. She walks initially with an antalgic gait, but after a few steps returns to normal heel-to-toe gait. Palpation of the right knee reveals tenderness along the lateral joint line and

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U.S. HealthWorks MEDICAL GROUP

Treatment Visit #: 11
Authorized Visit #: 12

THE IRVINE CO./CORP. 164551
DOS: 8/07/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

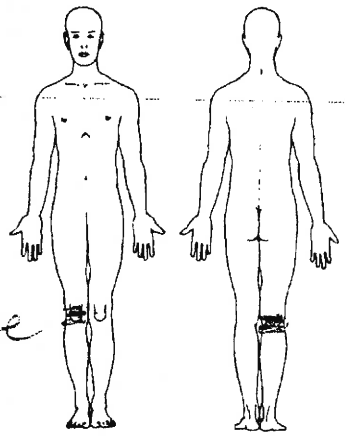
ILY THERAPY TREATMENT NOTE

Diagnosis: (P) tenosynovitis, chondromalacia

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(P) pain & DIST knee (R) & inflammation still/ has been present from prev. visits, walking & standing

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☑ Electrical Stimulation: TENS to (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat Light @ 6" to (R) knee
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.0 w / cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☑ Myofascial Release/Soft Tissue Mobilization (R) Distal Knee
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☑ Supervised Therapeutic Exercises: (specify) Bike x10', HS stretch 3x20"
	Prone SLR 3x20" / Partial squats
	x15 / Step ups on 4" step x10 ea, bridges x10
	x15

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☐ Other/Supplies:
☑ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Able to perform prog ex / step ups & mod (P) knee pain w/ treatment

☑ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Signature [signature] Page 337 License Number

[illegible], PTA
License Number [illegible]

U.S. HealthWorks MEDICAL GROUP

BIL

Treatment Visit #: 10
Authorized Visit #: 12

THE IRVINE CO./CORP. 164551

DOS: 8/02/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

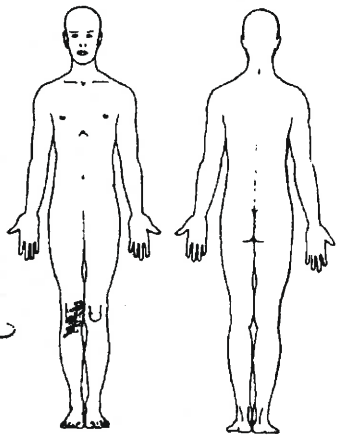
DAILY THERAPY TREATMENT NOTE

Diagnosis: ®meniscal tear ~~chondromalacia~~

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

® knee slightly more tol. to wt bearing & ROM, jnt. stiff exp mod. inflammation in medial joint area

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to ® knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat light ® (at) Joules to ® knee
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ .70 w / cm² 1 MHz to ® knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization ® knee/Quads
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x10', Squats x15, Bridge x15, Add x15, Knee ext 5# x10,

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☐ Other/Supplies:
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)
Able to perform Bike 1 1/4 Squats 3 sets 15 reps
☐ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Signature ____ License Number

CORVEL

REFERRED BY:	Janie Stubblefield
NAME:	Consuelo Perez
CLAIM #:	WC2013419849
DOI:	3/10/13
REVIEW TYPE:	Prospective
DATE:	7/26/13

QUESTION: Is the request for additional post-op physical therapy 2x/week for 4 weeks for the right knee medically necessary and appropriate? No

ASSESSMENT: Modified. The recommendation for certification is for four (4) additional Physical Therapy sessions.

EXPLANATION FOR ASSESSMENT:

With regard to the request for additional postoperative physical therapy status post lateral meniscectomy, Official Disability Guidelines specify that the recommended course of physical therapy following meniscectomy is 12 visits. This patient has completed eight postoperative sessions to date. The most recent physical therapy note indicates that the active range of motion is -5 degrees in extension and 112 degrees in flexion. Given the Guidelines, this request for eight additional sessions is modified to allow four additional sessions and remain within Official Disability Guidelines.

MEDICAL RECORDS:

Submitted medical records were reviewed in their entirety.

Medicals sent for review:
RFA dated 07-23-2013
Work Status/Dr. Graham dated 07-15-2013
Progress Report/Dr. Graham dated 07-15-2013
Therapy Progress Notes 07-05-2013 through 07-25-2013
Initial PT evaluation dated 07-02-2013

DIAGNOSIS:

The diagnoses include status post right knee arthroscopy, lateral meniscectomy and chondroplasty done on 06/17/2013.

CLINICAL SUMMARY:

The injured worker's date of injury was 03/10/2013. The patient has had an arthroscopic right knee meniscectomy and chondroplasty performed on 06/17/2013. The most recent work status and physician progress reports were reviewed. A physician progress report, dated 07/15/2013, indicates that the patient has continued pain aggravated by weightbearing and partially relieved by rest. She was advised to start physical therapy. She describes her current pain level as 5 out of 10. Objectively, on physical examination, vital signs are stable. She walks initially with an antalgic gait, but after a few steps returns to normal heel-to-toe gait. Palpation of the right knee reveals tenderness along the lateral joint line and

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U.S. HealthWorks MEDICAL GROUP

BIL

Treatment Visit #: 9
Authorized Visit #: 14

THE IRVINE CO./CORP. 164551
DOS: 8/01/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

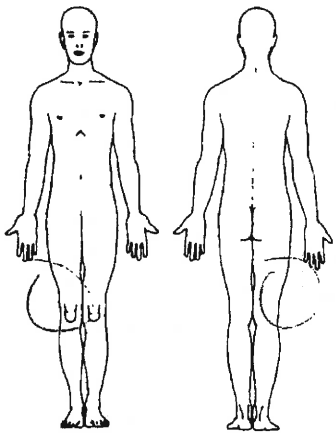
DAILY THERAPY TREATMENT NOTE

Diagnosis: R med meniscus tear, Chondromal.

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

"better" SI scale 6/7/13

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15'	☒ Electrical Stimulation: IFC R knee
5'	☒ Hot Pack or Cold Pack or Ice Massage (circle) to R knee
5'	☒ Infrared Heat Right & L quads R knee
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
5'	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ .8 w/cm² 1 MHz to R knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10'	☒ Myofascial Release/Soft Tissue Mobilization R knee, med. Effl.
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
20'	☒ Supervised Therapeutic Exercises: (specify) Bike x10' PRL partial squats, SLR, bridges & hamstr., knee ext.

☒ ~~Established~~/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☐ Other/Supplies:
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

tol well. Symptom improving

☐ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Cont. per plan

Signature ____ Sondra Wyman, P.T. License Number CA # 7801

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U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

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

Patient Name: Last: Perez **First: Consuelo** **MI:** **DOB: 03-15-1952** **Date of Service: 07-29-2013** **Case #: 032251644**

Occupation: Laundry Attendent **SS#: 570-85-1146** **Date of Injury: 03-10-2013 17:00** **Claim #: WC2013419849**

Employer: THE IRVINE CO./CORP. **Contact: ERMA WORCESTER** **Tel. (949)720-4055** **Fax. (949)720-3455**

Claims Administrator: CHUBB SERVICES CORP. **Tel. (213)612-5400** **Fax.**

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 ( ) Information 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

History Of Present Illness:

Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently off work .
Comments: Patient had surgury with Dr.Graham approx.6 weeks ago.States that she feels like a stitch is remaining under the skin of surgical scar.Feels a "pinching sensation.".

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 141 days. The frequency is intermittent. The symptoms are exacerbated by palpation. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
see 1st visit

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 64/min. BP: 175/87 mmHg. Temperature: 98.5 deg F Respiration: 16 per min.
Severity: The severity of the pain was N/A/10.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .

Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities, open wounds and all - . Following conditions of the right knee are present: scars - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, swelling, masses, deformities and open wounds - .

Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities .

Left knee examined for comparison. The left knee is not tender on the left medial joint line tender at surgical scar region. The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament - . Cruciate function of the left knee is intact with negative anterior and posterior drawer sign. - . There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.

Right knee affected/injured. The right knee is not tender on the right medial joint line tender at surgical scar region. The right knee is not tender on the right lateral joint line . The right patella does not have subluxation . The right patella is not tender . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.

Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.

Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Comments: Patient had surgury with Dr.Graham approx.6 weeks ago.States that she feels like a stitch is remaining under the skin of surgical scar.Feels a "pinching sensation.".

DIAGNOSES: (Include ICD-9 code, if possible)

Meniscus Tear - Lateral, Current (836.1)

Differential Diagnosis / Comments: tender at surgical scar region.Patient had surgury with Dr.Graham approx.6 weeks ago.States that she feels like a stitch is remaining under the skin of surgical scar.Feels a "pinching sensation."

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	( ) Start (**X**) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Clinical Decision Making Comments: Cont.PT Observe.

Treatment Plan Comments: Examined.Off work Follow-up in Dr.Graham.8-13-13.

Additional Treatment: Patient should continue Physical Therapy treatment.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Off- Work until 08-13-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.

Limited standing or walking

No kneeling or squatting.

Limited Lift, Limited Push and Limited Pull up to 10 lbs.

Patient must wear knee support.

DISCHARGE STATUS:

( ) Released from care. Return to full duty on () with no limitations or restrictions.

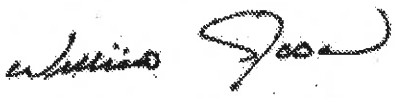
( ) Patient discharged as permanent and stationary with either impairment, work restrictions, and/or need for future medical care. A PR-4 to follow.

( ) 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 139.3.

Signature (Original)



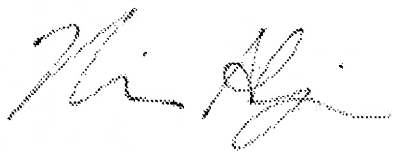
Name: **William Jason, P.A.**

Cal. Lic. #: **PA11102**

Specialty: **Occupational Medicine**

Date of Exam: **07-29-2013**

Signature (Original)



Nima Alipour D.O.

Supervising Provider

Cal. Lic. #: 20A11637

NEXT APPOINTMENT

Next Appointment with on .

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 07-29-2013 1245

MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	07-29-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	WC2013419849
Chart #:	EMR/JB

Patient Status:
Since the last exam, this patient's condition has:

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently off work .
Comments: Patient had surgury with Dr.Graham approx.6 weeks ago.States that she feels like a stitch is remaining under the skin of surgical scar.Feels a "pinching sensation.".
Knee Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 141 days. The frequency is intermittent. The symptoms are exacerbated by palpation. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
Surgeries: Appendectomy 1983.

Medical History: Patient denies history of ulcers or gastritis. No history of Diabetes. Patient states no known major/recurrent illnesses/injuries.

Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure , Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use.

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a complete review of systems obtained from the health history completed on 04-09-2013 was done and any interval changes are noted.

see 1st visit

Current Medications at the start of Encounter:
No known current medication.
Allergies:
PENICILLINS.

Physical Examination:
Pulse: 64/min. BP: 175/87 mmHg. Temperature: 98.5 deg F Respiration: 16 per min.

Severity of the pain is not applicable to the complaint.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities, open wounds and all - . Following conditions of the right knee are present: scars - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, swelling, masses, deformities and open wounds - .
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Left knee examined for comparison. The left knee is not tender on the left medial joint line tender at surgical scar region. The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament - . Cruciate function of the left knee is intact with negative anterior and posterior drawer sign. - . There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is not tender on the right medial joint line tender at surgical scar region. The right knee is not tender on the right lateral joint line . The right patella does not have subluxation . The right patella is not tender . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
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Diagnoses
Meniscus Tear - Lateral, Current (836.1)

Medical Assessment: tender at surgical scar region.Patient had surgury with Dr.Graham approx.6 weeks ago.States that she feels like a stitch is remaining under the skin of surgical scar.Feels a "pinching sensation."

Treatment Plan
Last Saved By: Admin Admin 07-29-2013 13:16:32

Medications Completed or Stopped:
Nabumetone 750 mg Tabs #20 (07-29-2013)
Tramadol/Acet HCL 37.5/325 mg #20 . (07-29-2013)
Omeprazole D.R. 20mg #20 . (07-29-2013)
Medications to be Continued until Next Visit:
Clinical Decision Making Comments: Cont.PT Observe.

Treatment Plan Comments: Examined.Off work Follow-up in Dr.Graham.8-13-13.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Off- Work until 08-13-2013.
Expected Maximum Medical Improvement (MMI) date 04-26-2013.
Work Restrictions:
Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull
up to 10 lbs.
Patient must wear knee support.

Additional Treatment: Patient should continue Physical Therapy treatment.

William . Jason, P.A.
This has been electronically signed on 07-29-2013

Nima Alipour D.O.
Supervising Provider

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U.S. HealthWorks

THE IRVINE CO./CORP. 164551

DOS: 7/29/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

WC

Ni ro Social): _____ Date (Fecha): _____

Te ar): _____

Di iia): _____

1. Since your last visit, are you: ☑ improved? ☐ worse? ☐ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?

2. Since your last visit, have you developed any new complaints? ☑ Yes (Si) ☐ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

If you have not improved since your last visit, or if you have developed new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

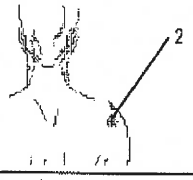
PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***

If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

SYMPTOMS (SÍNTOMAS)

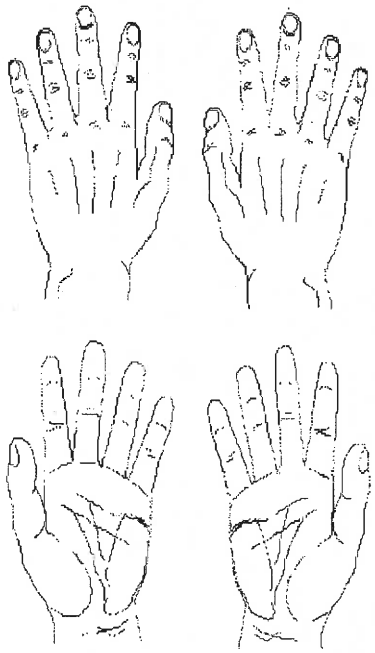
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

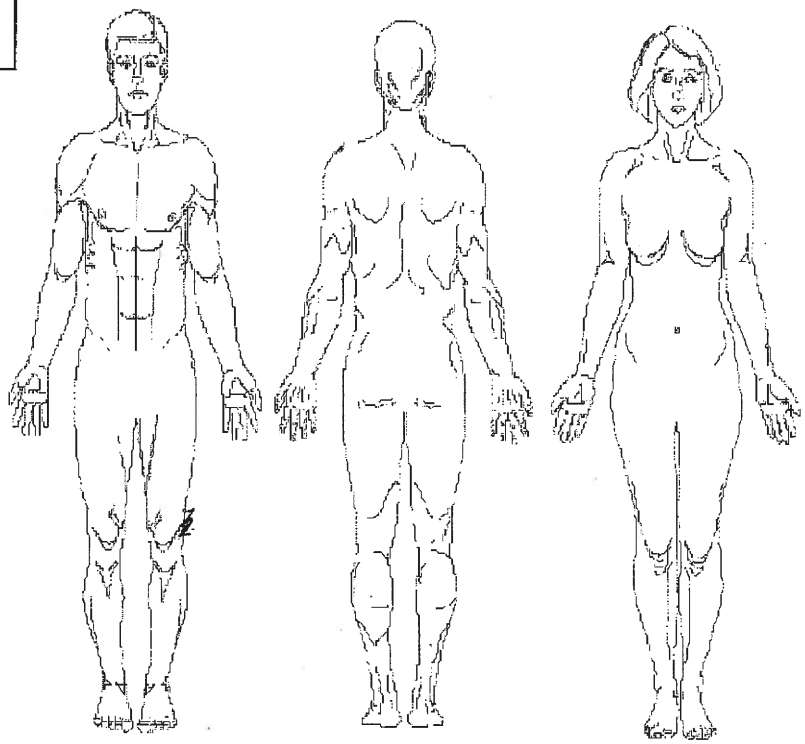
Example (Ejemplo)



Rate the intensity of your pain: NO PAIN — MOST PAIN
Indique la intensidad de su dolor: *SIN DOLOR* — *DOLOR INTENSO*

0 1 2 3 4 5 6 7 8 9 10





Patient Signature (Firma del Paciente) _____ Date (Fecha) 7/29/13

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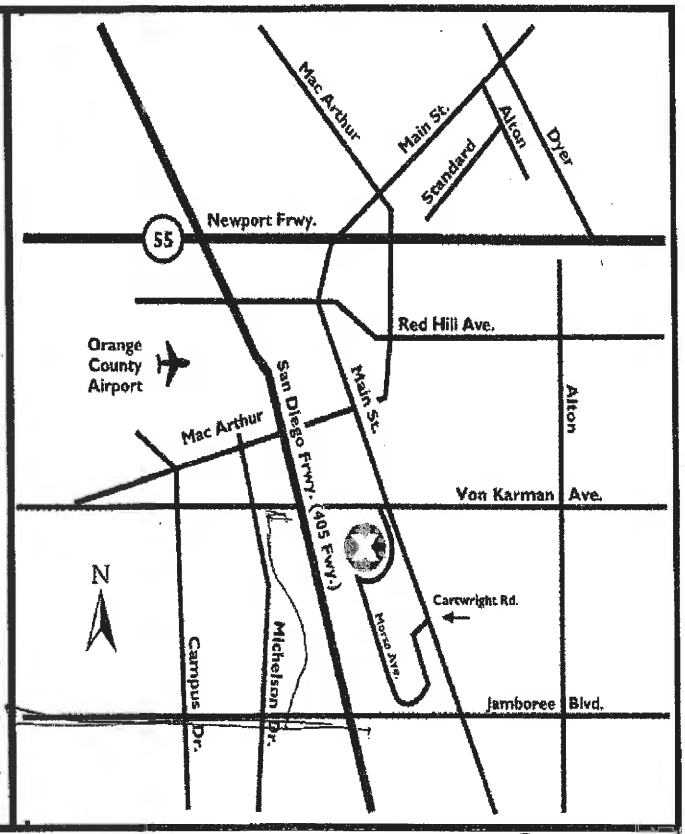
TREATMENT AUTHORIZATION

U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

We are authorizing the below listed U.S. HealthWorks location to provide services to our employees:

2362 Morse Ave
Irvine, CA 92614
PH: (949) 863-9103
FX: (949) 863-1337
Open 24 hours a day, 7 days a week!



Pelican Hill Resort #164551
EMPLOYER NAME EMPLOYER #

PRIMARY CONTACT NAME 22701 Pelican Hill Rd. S.
ADDRESS LINE 1

ADDRESS LINE 2 Newport Beach CA
CITY 949-467-6838 STATE ZIP

PH PH (after HRs/Cell)

FAX

EMAIL

EMPLOYEE DETAILS

DATE: 4-9-13 TIME: 1030 AM OR (PM)

PATIENT NAME: Consuelo Perez DEPARTMENT: Laundry - Uniforms

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ☐ YES ☒ NO NAME OF TEMP AGENCY:

AUTHORIZED BY: NAME (PRINT): Patrick BRASS PHONE: 949-467-6838 (24hrs)

TITLE: Security AFTER HRS / CELL PH:

SIGNATURE: Patrick Brass ( ) VERBAL

INSURANCE

INSURANCE COMPANY NAME:

CLAIMS ADDRESS:

PHONE#: EFFECTIVE DATE:

POLICY #: EXPIRATION DATE:

SERVICES

☒ INJURY: DATE OF INJURY: 3/10/13 LAST WORKED: 4/9/13

INJURED BODY PART: left knee CLAIM #:

O RETURN-TO-WORK EVALUATION

O PHYSICAL EXAM TYPE: PROTOCOL #:

O DRUG/ALCOHOL TEST. SPECIFY TYPE AND REASON/PURPOSE BELOW PROTOCOL #

TYPE:

- ☐ INSTANT DRUG TEST
- ☐ NON-DOT DRUG TEST
- ☐ DOT DRUG TEST
- ☐ NON-DOT BREATH ALCOHOL TEST
- ☐ DOT BREATH ALCOHOL TEST

(CIRCLE BRANCH: FMCSA FAA FTA FRA PHMSA USCG)

REASON/PURPOSE:

- ☐ POST-OFFER
- ☐ POST-ACCIDENT
- ☐ RETURN TO DUTY
- ☐ REASONABLE SUSPICION
- ☐ RANDOM
- ☐ POST-INJURY

NOTE: PICTURE ID REQUIRED FOR DRUG TESTING

Thank you for choosing U.S. HealthWorks Medical Group!

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U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Date Generated: 07-29-2013 13:17:29

NAME: Last: Perez **First: Consuelo** **Date of Exam: 07-29-2013** **Case #: 032251644**

Occupation: Laundry Attendent **DOB: 03-15-1952** **DOI: 03-10-2013 17:00** **Claim #: WC2013419849**

Employer: THE IRVINE CO./CORP. **Contact: ERMA WORCESTER** **Tel.: (949)720-4055** **Fax: (949)720-3455**

Claims Administrator: CHUBB SERVICES CORP. **Tel.: (213)612-5400** **Fax:**

DIAGNOSES

Meniscus Tear - Lateral, Current (836.1)

TREATMENT

Physical Therapy	( ) Start (X) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

WORK STATUS

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Off- Work until 08-13-2013.
Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull up to 10 lbs.

Patient must wear knee support.

TREATING PROVIDER

Name: **William . Jason,P.A.** Lic. #: **PA11102** Signature (Original)

Specialty: **Occupational Medicine** Date of Exam: **07-29-2013**

NEXT APPOINTMENT

Next Appointment with on .

Executed at: US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103

Check In Time: 07-29-2013 1245 Check Out Time: 01:17 pm

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U.S. HealthWorks MEDICAL GROUP

Treatment Visit #: 8
Authorized Visit #: 9

THE IRVINE CO./CORP. 164551
DOS: 7/25/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

DAILY THERAPY TREATMENT NOTE

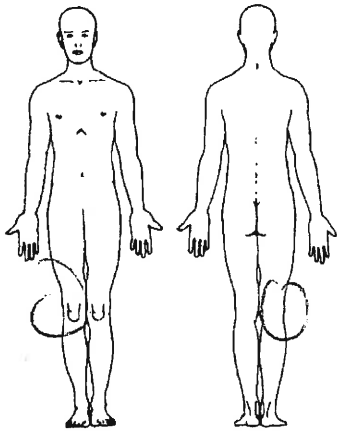
Diagnosis: R med meniscus tear, chondromalacia

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

only pain when walking

Objective: (i.e. **ROM, MMT, Posture, Girth, Color**)

AROM R knee -5° ext
112° flex.



Time	Modalities:
15'	☐ Vaso-comp/Edema Control:
	☒ Electrical Stimulation: IFC R knee
15'	☒ Hot Pack or ☒ Cold Pack or Ice Massage (circle) to R knee ICE
8'	☒ Infrared Heat light R knee, R knee
___	☐ Whirlpool (____ min, ____ °F) to
___	☐ Paraffin Bath
___	☐ Mechanical Traction
	☐ Other
8'	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ .8 w / cm² 1 MHz to R knee (area)
___	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10'	☒ Myofascial Release/Soft Tissue Mobilization R knee, med sph
___	☐ Joint Mobs/Manual Traction:
___	☐ Orthotic/Splinting Training/Taping
___	☐ FAs/ADLs/KAs/Ind. Instruct
___	☐ Biofeedback
___	☐ Neuromuscular Reeducation
___	☐ Gait Training/Assistive Device Training
20'	☒ Supervised Therapeutic Exercises: (specify) Bike x 10', fitt #2, partial squats,
___	SLR, bridges + ball squeeze, knee ↑ 4 /
___	

☒ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☐ Other/Supplies:
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

ft with Tightness

☐ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Recommend addl PT Rx Needs addl Stretching

Sondra Wyman, P.T.
CA # 7801

License Number

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U.S. HealthWorks

THE IRVINE CO./CORP. 164551

DOS: 7/23/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

RII

Treatment Visit #: 7

Authorized Visit #: 8

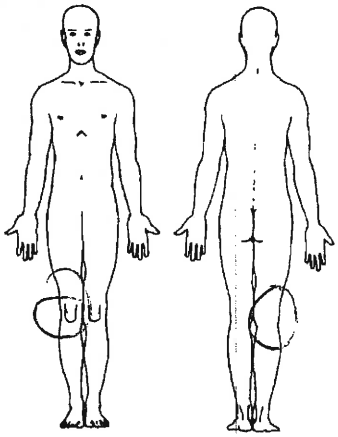
LY THERAPY TREATMENT NOTE

Diagnosis: R med. meniscus tear Chondromalacia

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

better — States is walking better —

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15'	☒ Electrical Stimulation: IFC R knee
15'	☒ Hot Pack or Cold Pack or Ice Massage (circle) to R knee = ES
8'	☒ Infrared Heat light @ 6.0 joules R knee
___	☐ Whirlpool (____ min, ____ °F) to ____
___	☐ Paraffin Bath ____
___	☐ Mechanical Traction ____
	☐ Other ____
8'	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.5 w / cm² 1 MHz to R knee (area)
___	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10'	☒ Myofascial Release/Soft Tissue Mobilization R knee
___	☐ Joint Mobs/Manual Traction: ____
___	☐ Orthotic/Splinting Training/Taping ____
___	☐ FAs/ADLs/KAs/Ind. Instruct ____
___	☐ Biofeedback ____
___	☐ Neuromuscular Reeducation ____
___	☐ Gait Training/Assistive Device Training ____
20'	☐ Supervised Therapeutic Exercises: (specify) Bike x10', Partial squat,
SW	SLR, bridges = ball squeeze, knee ext

☒ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)

☐ Burn/Wound Care

☐ Other/Supplies: ____

☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

tol well. Improving —

☐ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary

☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

one more month (?)

Sondra Wyman, P.T.

CA # 7801

Signature

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U.S. HealthWorks MEDICAL GROUP

THE IRVINE CO./CORP. 164551

DOS: 7/19/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

Bill

Treatment Visit #: 6

Authorized Visit #: 8

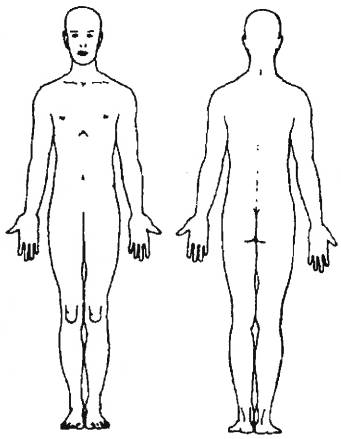
DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) meniscal tear, Chondromalacia

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee still/little more sore, 5/10 today for unknown reasons

Objective: (i.e. **ROM, MMT, Posture, Girth, Color**)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☐ Electrical Stimulation: IFC's to (R) knee.
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☑ Infrared Heat Light @ 60 Joules to (R) knee
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
6	☑ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ .70 w / cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☑ Myofascial Release/Soft Tissue Mobilization (R) knee / Quads
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☑ Supervised Therapeutic Exercises: (specify) Bike x 6', partial squats x 10 SLRs x 10, hamstrings x 10, knee ext. x 10

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)

☐ Burn/Wound Care

☐ Other/Supplies:

☑ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Able to perform ½ squat & bike c mod knee stiffness

☑ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary

☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Steve Honda, PTA

License Number ATC[illegible]

Signature [signature] License Number

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STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

July 15, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: WC2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

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, Lucio Herrera, was used in the face-to-face time with this patient during the course of the history and physical examination.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. She is status post arthroscopy, lateral meniscectomy, chondroplasty and drilling of medial femoral condyle of her right knee on 06/17/13. Postoperatively, she was seen on 06/27/13, she had pain and is using crutches for support. Pain was aggravated by weightbearing and partially relieved by rest. She was advised to start physical therapy to improve motion, strength and endurance. She comes back at this time for followup. She still is having pain, but is improving. She describes her pain level as 5/10 with 10 being worst. It was aggravated by weightbearing activities such as going downstairs and prolonged walking, especially relieved by rest and applying ice. She is no longer taking any medications, although she does have Norco available for pain relief. She is attending therapy three times per week.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 80.
Blood Pressure: 153/82.
Respirations: 20.
Temperature: 98.8

Examination of the Right Knee

Visual Inspection

There is mild swelling and effusion in the right knee. There is no sign of infection.

Palpation

There is tenderness along the lateral joint line and over the tibial tubercle. There is also pain over the popliteal region.

There is no calf tenderness.

Gait

She initially walks with an antalgic gait, but after few steps returns into normal heel and toe gait.

Range of Motion

	Right	Normal
Flexion	120 degrees	135 degrees
Extension	0 degrees	0 degrees

Special Tests

There is no instability to varus or valgus. Lachman test is negative. Homans test is negative.

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DIAGNOSIS

Tear of lateral meniscus and chondral defect with chondral drilling right knee, status post arthroscopy.

PLAN

The patient is making slow and steady improvement in chondral defect, would probably be the limiting factor. I would recommend that she continue therapy two times a week for four more weeks. She will be provided with a cane to assist her when ambulating and weightbearing.

WORK STATUS

The patient remains on temporary total disability.

FOLLOW-UP APPOINTMENT

She will return in three to four weeks for followup evaluation and to determine if there is enough improvement that she may return to her work related activities.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:oug.BGP
D: 07/15/13
T: 07/16/13
PerezC0715Graham2272

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Corvel Scan Date: 3/20/2014

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 7/15/13 Case #: 32251644

Occupation Laundry Attendant SS# 570-85-1146 Date of Injury 3/10/13 Claim # WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

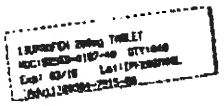
myosx pain + swell 9 ± stairs no meds

I

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

mild stiff 0-120 sore tib tub + popliteal Homan - . contralat mild

DIAGNOSES (Include ICD-9 code, if possible) Tear lat meniscus > R knee
chondral defect



TREATMENT

☑ Office Visit / Injury Treatment ☐ Start / ☑ Continue ☑ Therapy: 2 times / week for 4 weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____
☑ Meds / Supplies Dispensed cane
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

☐ Return / ☐ Continue... to work without restrictions.
☑ Off work until (Date) _____ Estimated period of total temporary disability 28 days.
☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ___ hrs/day
( ) No / ( ) Limited standing or walking to ___ hrs/day
( ) No / ( ) Limited overhead work to ___ hrs/day
( ) No / ( ) Limited stooping and bending to ___ hrs/day
( ) No / ( ) Limited kneeling or squatting to ___ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ___ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ___ minute stretch break every ___ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

POST OP VISIT

Cane, Alum Adj 28-34" ___
HCPCS: E0100 ___
Bill Code: 6106 Item#79-91091 ___

☐ 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.

D

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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 7/15/13
Specialty: _____ Signature _____
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

3-4 wks

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 7/15/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

- ☐ Improved as expected
- ☒ Improved, but slower than expected
- ☐ worsened
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☐ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

836.1	TEAR LAT MENISC KNEE-CUR R	717.7	CHONDROMALACIA PATELLAE R
836.0	TEAR MED MENISC KNEE-CUR R		

TREATMENT

☒ Office Visit / Injury Treatment ☐ Start / ☒ Continue ☒ Therapy: 2 times / week for 4 weeks. ☐ Ergonomic Eval

☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ 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.

☒ Off work until (Date) 8/13/13 Estimated period of total temporary disability 28 days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

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

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 7/15/13

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2352 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:15 PM Checkout Time 2:47 PM Next Visit Date 8/13/13 Time 10:30 AM

Bala, Adrian

From: taquino@chubb.com
Sent: Wednesday, May 01, 2013 3:47 PM
To: GM-SACA-Sacramento UR
Subject: Re: FW: Approval to Process: Consuelo Perez WC2013419849 4/30 @ 2:13pm
Attachments: 810f29c0J8040000.TIF

yes please process

thanks.

CHUBB
Teresita H. Aquino • Medical Only Adjuster • Worker's Compensation Claims • Chubb Services Corporation
P.O. Box 660403 • Dallas, TX 75266-0403 • Phone: 213-612-5342 • Fax: 213-612-5718 • taquino@chubb.com

Follow us:
www.chubb.com

From: GM-SACA-Sacramento UR <Sacramento_UR@corvel.com>
To: "taquino@chubb.com" <taquino@chubb.com>, "dtaylor@chubb.com" <dtaylor@chubb.com>
Cc: GM-SACA-Sacramento UR <Sacramento_UR@corvel.com>
Date: 04/30/2013 02:14 PM
Subject: FW: Approval to Process: Consuelo Perez WC2013419849 4/30 @ 2:13pm

Would you like CorVel to process the attached request? Please advise.

PLEASE NOTE: If we do not receive a response within 24 hours, we will go ahead and process in order to meet UR timeframes.

Thank you,

Joe Coverdell | Case Management Supervisor
CorVel Corporation | Sacramento Office
PO Box 279350, Sacramento, CA 95827
T 916-605-3837 | F 866-449-8586
joseph coverdell@corvel.com | www.corvel.com

-----Original Message-----
From: 9498631601 [mailto:IMCEAFAX-9498631601@Corvel.com]
Sent: Tuesday, April 30, 2013 11:48 AM
To: GM-SACA-Sacramento UR
Subject: Approval to Process: Consuelo Perez WC2013419849 4/30 @ 2:13pm

Fax Message Delivery

Date: 2013-04-30 11:47:31

Job ID: XXMN10429874
DID/DTMF: 4352
Elapsed Transmission Time: 00:02:16
Line: 10
Pages: 9
Server: CRVL1FAX1-N1
Signal Noise: 0
Signal Quality: 0
Signal Speed: 26400
Signal Strength: 0

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U.S. HealthWorks MEDICAL GROUP

BIL

Treatment Visit #: 5
Authorized Visit #: 6

THE IRVINE CO./CORP. 164551
DOS: 7/15/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

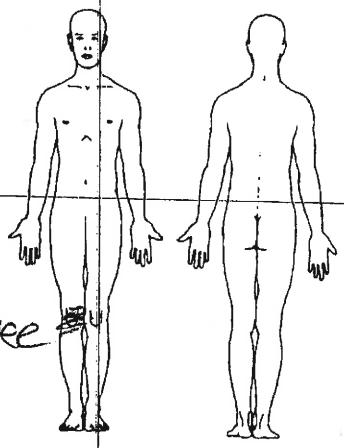
Y THERAPY TREATMENT NOTE

Diagnosis: (R) meniscal tear ~~chondromalacia~~

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee pain (@) slightly 1/d to restful weekend. Did not temperature of knee before pain.

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
15	☐ Vaso-comp/Edema Control:
	☒ Electrical Stimulation: TENS to (R) knee
8	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
	☒ Infrared Heat Light @ 6 @ Joules to (R) knee
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.0 w/cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization (R) knee/Quads
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x 10', SLR's x 10 bridges x 10, SAQ x 15, partial squats x 10, knee ~~ext~~ x 10.

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
~~☐ TENS Issue & Instruction~~ ~~☐ NCV Testing~~ ~~☐ FCE/Return to Work PAT~~ ~~☐ PePAT/PPE (see report)~~
☐ Burn/Wound Care
☐ Other/Supplies:
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)
Able to do SLR and bridges ~~s~~ significant limitations.
~~☐ Treatment Plan Reviewed by Supervising Therapist~~

Plan: ☐ progress therapeutic treatment program (specify below) ☑ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Steve Honda, PTA
License Number A 6225

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U.S. HealthWorks

Treatment Visit #: 4
Authorized Visit #: 8

THE IRVINE CO./CORP. 164551
DOS: 7/12/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

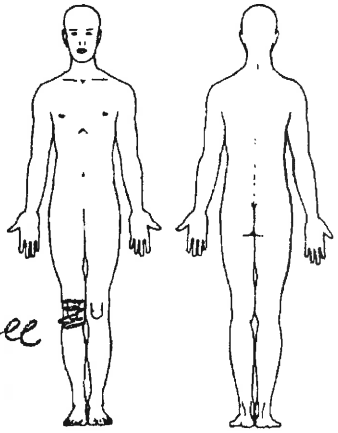
Y THERAPY TREATMENT NOTE

Diagnosis: (R) med. meniscal tear Chondromalacia

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee burning @ remains med -> high despite limited WB bearing.

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat LIGHT @ 6.0 inches to (R) knee
	☐ Whirlpool (min, °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ .70 w / cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (ml of Dexamethasone) to (area), at (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization (R) knee/Quads.
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☒ ~~Biofeedback~~ error.
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x 8' / Quad sets x 15 1/4 squats x 10, bridges x Add x 15, knee ext x 10.

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☒ ~~Other/Supplies:~~
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)
Able to perform Bike & bridges c mod (R) knee symptoms

☒ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non-compliant

Stephen Honda, PTA
License Number AT6225

Signature Page 245 License Number

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U.S. HealthWorks MEDICAL GROUP

BIL

Treatment Visit #: 3
Authorized Visit #: 8

THE IRVINE CO./CORP. 164551
DOS: 7/09/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

DAILY THERAPY TREATMENT NOTE

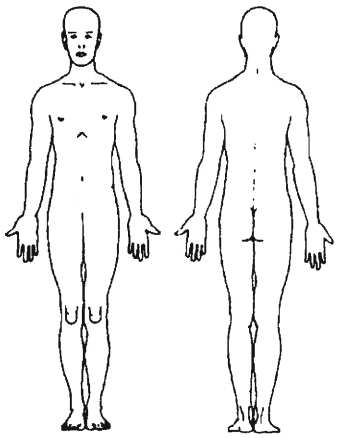
Diagnosis: (R) meniscal tear
chondromalacia

Subjective:

Pain level 0 1 2 3 4 5 6 7 8 9 10

Pain in (R) knee

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat light to (R) knee
	☐ Whirlpool (min, °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
10	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.5 w/cm² MHz to (R) knee (area)
	☐ Iontophoresis (ml of Dexamethasone) to (area), at (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization STM to (R) knee
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
10	☒ Biofeedback MMG to T exercises.
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x 10
	Quad Sets x15 1/4 Squats x10 Add SLR x15
	Bridge x15.
	HS Stretch x3

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☐ Other/Supplies:

Unigel Electrode Triode
HCPCS: A4556
Bill Code: 3186 Item# 922301

☒ Skin checked and clear following treatment

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Ambulating c Liq c (R) c Tramadol
ft. Rtg.

☒ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Signature

7/9/13

License Number

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U.S. HealthWorks MEDICAL GROUP

BIL

Treatment Visit #: 2

Authorized Visit #: 9

THE IRVINE CO./CORP. 164551

DOS: 7/05/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

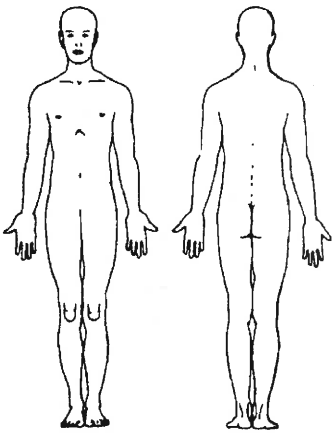
DAILY THERAPY TREATMENT NOTE

Diagnosis: (2) med ½ Lat meniscal tear

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee & IT Br (R)

Objective: (i.e. **ROM, MMT, Posture, Girth, Color**)



Time	Modalities:
___	☐ Vaso-comp/Edema Control: ___
15	☑ Electrical Stimulation: (2) 4w
___	☐ Hot Pack or Cold Pack or Ice Massage (circle) to ___
8	☑ Infrared Heat light Cs for (R) knee
___	☐ Whirlpool (___ min, ___ °F) to ___
___	☐ Paraffin Bath ___
___	☐ Mechanical Traction ___
___	☐ Other ___
10	☑ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1 w / cm² ___ MHz to (R) knee (area)
___	☐ Iontophoresis (___ ml of Dexamethasone) to ___ (area), at ___ (milliampere-min)
___	**Rehabilitation:**
10	☑ Myofascial Release/Soft Tissue Mobilization (R) quads
___	☐ Joint Mobs/Manual Traction: ___
___	☐ Orthotic/Splinting Training/Taping ___
___	☐ FAs/ADLs/KAs/Ind. Instruct ___
8	☑ Biofeedback VMO + ? recruit
___	☐ Neuromuscular Reeducation ___
___	☐ Gait Training/Assistive Device Training ___
17	☑ Supervised Therapeutic Exercises: (specify) Bike x10, (R) SLR x5
___	Bridges x10 Abd x10
___	Prone KF 1/1' x10 HS stretch
___	

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)

☐ Burn/Wound Care

☐ Other/Supplies: ___ Unigel Electrode Triode HCPCS: A4556 Bill Code: 3186 Item# 922301 ___

☐ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Ambulating c no brace, no assistive device

☑ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary

☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Signature ___ Page 155 License Number ___

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U.S. HealthWorks MEDICAL GROUP

BIL

REHABILITATION EVALUATION

THE IRVINE CO./CORP. 164551
DOS: 7/02/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Date of Surgery: 6/17/13 Next MD visit:
Referred by: Graham
Diagnosis: MCL of meniscal tear (R) 836.0
ICD 9#: Lateral knee sprain (L) 836.1
Contusion 717.7

Injury Mechanism: Standing, twisted (R) knee (L) knee

P.M.H./Past Surgeries: 6/17/13 meniscal debridement, arthroplasty (R) heart (-) HTN (-) CA (-) DM

Medications: unknown meds
Allergies: Penicillin
Diagnostic Tests: Xrays (-) MRI (+)
Previous TX: PT x 4 visits
Social/Leisure Activities:

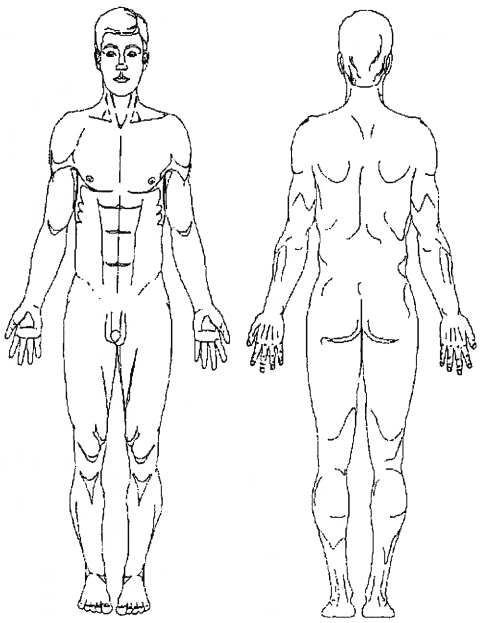
Occupation/Work Status: Laundry, currently not working
Work Requirements: Standing, lifting
Symptoms-C/O: (R) knee (L) knee 1 or 2

Increase Symptoms: WB flexion
Decrease Symptoms: NWB
Pain: Current: 5 /10 Worst: 5 /10 Best: 5 /10
___ same ___✓___ better ___ worse

24 hour pain cycle:
am: noon: pm: night time:

Other/Special Questions: Ache + Sleep

Patient Goals: L (R) knee
Knee to work



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THE IRVINE CO./CORP. 164551
DOS: 7/02/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

EVALUATION / RI

Name: _____

		AROM		PROM		STRENGTH	
LEVEL	MOTION	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
L1/2/3	Hip Flex. (0-120)	100	100			5	4+
L5/S1-2	Hip Ext. (0-30)	0	0			5	4+
L4/5-S1	Hip Abd. (0-45)	45	45			5	4
L4/5-S1	Hip Add. (0-30)	0	0			5	4
L4/5-S1	Hip Int. Rot. (0-45)	-	-				
L3/4/5-S1	Hip Ext. Rot. (0-45)	-	-				
L2/3/4	Knee Ext. (0)	0	10		0	5	3+
L5/S1/S2	Knee Flex (0-135)	130	90		100	5	3+
L4/5	Ankle DF (0-20)	10	5			5	5
S1/2	Ankle PL (0-50)	45	45			5	5
L5/S1	Ankle Ev. (0-15)	5	5			5	5
L5	Ankle Inv. (0-35)	35	35			5	5
L4/5/S1	EHL						
	Abdominals					4-	

Gait: Normal/Antalgic R L Limp (R)

Posture: Standing: Genu valgum (B) knee flexed 2°

Sitting: _____

Neurological:

Sensation: Intact

Reflexes: _____

Patellar (L4) (L) 2+ (R) _____

Achilles (S1) (L) 1+ (R) 1+

Babinski/Clonus (C7) (L) 0 (R) 0

Dural Signs: 0

Other: _____

Lumbar Spine Active Range of Motion	
Flexion	WFL
Extension	
L Side Flexion	
R Side Flexion	
L Rotation	
R Rotation	

Special Tests:

	(R)	(L)
Mcl	NT	NT
Lcl		1+
Acl		1+

Palpation/Structural Alignment/Atrophy/Edema:

2+ Inflammation (R) knee

↓ patellar mobility due to inflammation

Functional Mobility:

Sit to Stand: WNL

Heel/Toe Walk: unable/unable

Squat: unable or (R)

Balance: WNL

Other: _____

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THE IRVINE CO./CORP. 164551

EVALUATION / DOS: 7/02/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Name: _____ Case # : 32-251644 Ref # : EMR/JB

SUBJECTIVE: Sx #1

ASSESSMENT: 1. Hx of GI upset, pt c/o loss appetite, fear of medications.
2. Sinus c/o pain
3. URI Ethmoid c/o pain
4. HTN c/o dizziness
5. No HEP

GOALS STG	GOALS LTG		TIME FRAME
☑	☑	Increase strength c/o UE's 3/5	3-8 wks
☐	☐	Increase AROM c/o pain	1-4
☑	☑	Restore prior function, including return to work	1-8
☑	☑	Independent with strengthening home exercise program for continued carryover of functional gains made during skilled therapy.	
☐	☐	Pt able to lift ____ # floor to knuckle and ____ # knuckle to shoulder to	
☑	☑	Upper back pain	1-3
☑	☐	Tinnitus decreased	1-3
☑	☐	Vertigo c/o pain	1-3 wks

Frequency: 2-3 Estimated Length of Treatment: 8

Therapy assessment, goals and treatment plan have been discussed with patient and patient is in agreement. ☑ Yes ☐ No

- ☑ Strengthening
- ☑ Stretching
- ☑ Stabilization
- ☑ A/AA/PROM
- ☑ Neuromuscular re-ed
- ☐ Gait training
- ☐ Aquatics
- ☐ ADL training
- ☐ Paraffin
- ☐ Post Injury PAT
- ☑ Postural education/exercise
- ☑ Body mechanics/Joint protection training
- ☑ Joint mobilizations
- ☑ Soft tissue mobilization
- ☑ Home exercise program
- ☐ Tape/brace support
- ☐ Symptom management
- ☐ Work conditioning
- ☐ Splinting/Orthotic training
- ☐ Balance/Proprioceptive training
- ☑ Heat
- ☐ Ice
- ☐ Traction
- ☐ US/Phono
- ☐ Iontophoresis
- ☐ E-Stim
- ☐ SEMG Biofeedback
- ☐ Whirlpool
- ☐ TENS issue & instruction
- ☐ VASO-Compression
- ☑ Patient Education
- ☑ Continue with therapy

☐ Recommend Discharge ☐ Follow up with P

☑ Reusable Electrodes dispensed HCPCS: E0190 DMI158 BLUE ORTHO BED WEDGE, 8" X 20" X 24"

☐ Other/Supplies Dispensed: HCPCS: A9273 COR746610 CORPAK 6" X 10" HOT/COLD THERAPY PACK

HCPCS: A4556 552381 VALUTRODE CLOTH 2" ROUND - 4/P

Today's Treatment:

Time: EVC

Time:

____ ☐ Patient education regarding nature of their injury.

15 ☑ Home exercises as per handouts/log.

____ ☐ Upper ROM x10

____ ☐ BFPF x10

Quads x15

Hamstrings x15

10 ☑ Stm/Mob posterior neck

15 ☑ ES to CP (E) trap

8 ☑ Light G x10 (E) bicep

10 ☑ ESS c Sup Cuff to (E) bicep

☑ Treatment Plan Discussed/Reviewed with PTA

Signature: _____ Lic #: _____

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

June 27, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: WC2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company

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, Lucio Herrera, was used in the face-to-face time with this patient during the course of the history and physical examination.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of her right knee. The patient is status post arthroscopy, lateral meniscectomy, chondroplasty and drilling of medial femoral condyle of her right knee on 06/17/13. Postoperatively, she has had pain. She continues to use crutches for support when ambulatory as her pain is increased when she is full weightbearing without assistance. She also complains of pain in the back of her knee joint. She has not described numbness or tingling nor does she describe any febrile episodes.

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.

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OBJECTIVE FINDINGS

General Appearance

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

Vital Signs

Pulse: 70
Blood Pressure: 160/82
Respirations: 14
Temperature: 98.4

Examination of the Right Knee

Visual Inspection

There is moderate swelling in the right knee. There is popliteal swelling. There is no sign of infection.

Palpation

There is popliteal tenderness.

Range of Motion

	Right	Normal
Flexion	90 degrees	135 degrees
Extension	0 degrees	0 degrees

Special Tests

Homans test is negative.

Neurological Examination of the Lower Extremities

Sensory Examination

Sensation is intact to light touch and pinprick in all dermatomes in the bilateral lower extremities.

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Motor Strength Examination

	Right	Left
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 TESTING

Intraoperative pictures were reviewed with the patient.

DIAGNOSIS

Tear of the lateral meniscus and chondral defect of medial femoral condyle of right knee, status post arthroscopy.

PLAN

The patient will have her sutures removed. She will start physical therapy two times a week for the next four weeks to improve range of motion, strength and endurance. She should discontinue using the crutches as soon as possible.

WORK STATUS

The patient is temporarily totally disabled.

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FOLLOW-UP APPOINTMENT

She will return in three to four weeks for followup evaluation.

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 Orange County, California, on 7-1-13.

Physician Signature S Grahamm.D. CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:oug.JNB
D: 06/27/13
T: 06/28/13
PerezC0627Graham22724999

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Stephen P. Graham, M.D., Inc.
1760 Termino Ave.
Suite #G-21
Long Beach, CA 90804
Phone: (562) 597-9062
Fax: (562) 597-9063

Usste. Insure.
32. 25716-RT

Date: 6-24-13

Patient Name: Perez, Consuelo

Date of Surgery: 6-17-13

DX:

1) 836.1
2) 717.7
3)
4)

CPT4:

1) 29881
2) 29877-59
3) 20610-59
4)

OK AM

Authorization: 460167 23-UHO-5

Date Sent to Biller: JUN 2 4 2013

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 6/27/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax:

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: Post op

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)

Post op do pain report (T)

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

mod eff no infect N.V OIC Sutures removed
- soc report Homan's (-)

DIAGNOSES (Include ICD-9 code, if possible) tear lat meniscus
chondral defect > Rknee

TREATMENT D/c sutures

☑ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☑ Therapy: 2 times / week for 4 weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other

☐ Meds / Supplies Dispensed

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty ☐ Work status to be determined by specialist.

Estimated length of treatment is now ____ weeks

WORK STATUS ☐ First Aid Case

POST OP VISIT

☐ Return / ☐ Continue... to work without restrictions.

☑ Off work until (Date) ____ Estimated period of total temporary disability 28 days.

☐ Off the balance of this shift only. Then RTW on (Date) ____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) ____ with the restrictions indicated below. Estimated duration of modified duty is ____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / ( ) Limited standing or walking to ____ hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / ( ) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other
( ) Must keep ____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( )
( ) Other

☐ 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 Stephen Graham M.D. Cal. Lic # Date of Exam 6/27/13

Specialty: Lic G43362 Signature

Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 3-4 wk

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: ____ TIME: ____ ☐ Before / After Shift	DATE: ____ TIME: ____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Name, Last: Perez First: Consuelo Date of Exam: 6/27/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

☐ improved as expected ☐ improved, but slower than expected ☐ work status pending PR2
☒ not improved significantly
☐ worsened ☐ reached plateau and no further improvement is expected ☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

836.1 TEAR LAT MENISC KNEE-CUR R
836.0 TEAR MED MENISC KNEE-CUR R
717.7 CHONDROMALACIA PATELLAE R

TREATMENT

☒ Office Visit / Injury Treatment ☒ Start / ☐ Continue ☒ Therapy: 2 times / week for 4 weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

☐ 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.

☒ Off work until (Date) 7/15/13 Estimated period of total temporary disability 28 days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / ( ) Limited standing or walking to ____ hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / ( ) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
( ) No climbing

( ) Sit down job.
( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
( ) Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 6/27/13

Specialty _____ Signature Signature on File

Issued at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103

Checkin Time 2:45 PM Checkout Time 3:20 PM Next Visit Date 7/15/13 Time 2:45 PM

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Corvel Scan Date: 12/3/2013

REAGAN STREET SURGERY CENTER
10904 REAGAN STREET
LOS ALAMITOS, CA 90720
562-596-3140

OPERATIVE REPORT

PATIENT NAME: Perez, Consuelo
DATE OF OPERATION: 06/17/13
HOSPITAL NUMBER: 51564
SURGEON: Stephen Graham, M.D.

PREOPERATIVE DIAGNOSES: Tear of the medial and lateral menisci, chondromalacia, and possible loose body, right knee.

POSTOPERATIVE DIAGNOSES: Tear of the lateral meniscus and chondral defect, right knee.

PROCEDURES PERFORMED: Arthroscopy, lateral meniscectomy, chondroplasty, and debridement, right knee, followed by injection of Marcaine and Duramorph.

ANESTHESIA: General.

ANESTHESIOLOGIST: Yanqin Lou, M.D.

ESTIMATED BLOOD LOSS: Tourniquet.

TOURNIQUET PRESSURE: 300 mm for 32 minutes.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and induced under general anesthesia. She had received some vancomycin preoperatively. There was a mild reaction, which fairly resolved. It was continued for an antibiotic effect. A tourniquet was applied to the proximal aspect of the right leg. The right leg was then prepped and draped sterilely. The leg was exsanguinated with an Esmarch bandage, and the tourniquet was inflated to 300 mm of pressure. Arthroscopic portals were established over the anteromedial and anterolateral joint line, and the third one was made in the medial suprapatellar area. Fluid was instilled using the arthroscopic pump. Inspection of the joint showed chondromalacia of the undersurface of the patella and grade 2 to grade 3 of the anterior femoral trochlea. There was redundant synovium with mild acute synovitis in the inferior patellar area. The medial compartment showed a large chondral defect at the weightbearing surface of the medial femoral condyle down to the subchondral bone and was circular in nature. The medial meniscus appeared to be intact. The anterior cruciate ligament was intact. The lateral meniscus showed a vertical tear in the posterolateral corner. There was fraying of the edges. There was also grade 3 chondromalacia of the lateral tibial plateau. The lateral meniscus was addressed first. A basket forceps was inserted and the torn portion of the meniscus was removed back to good tissue. The edges of the meniscus were then smoothed down using a meniscus shaver and then the ArthroCare at low setting. Partial synovectomy was performed in the inferior patellofemoral area and in the suprapatellar area. The edges of the chondral defect and medial femora condyle were then smoothed down using a meniscus shaver and then the ArthroCare at a low setting.

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Corvel Scan Date: 12/3/2013

The scope was then placed within the lateral compartment and an attempt to further smoothed down the edges of the meniscus, and then two small bony pieces and cartilage were floating into the joint, possibly from the chondral defect. These were removed with basket forceps. Further suction on the shaver was used to irrigate further small bony and chondral debris. It was elected to make holes in the chondral defect in an attempt to stimulate fibrocartilage development on the medial femoral condyle. A 0.062 K-wire was used to make several holes in the defect. The edges were then smoothed down once again with the ArthroCare and the joint was irrigated. The scope was then removed. The stab wounds were closed with 4-0 nylon sutures. Then, 15 mL of 0.25% Marcaine with epinephrine and 5 mg of Duramorph was then injected for analgesic effect. Sterile dressings were applied using Xeroform, 4x4's, ABD, and an Ace bandage applied loosely. The tourniquet was released after 32 minutes with good return of circulation. The patient was awakened. She tolerated the procedure well and was sent to the recovery room in satisfactory condition.

Stephen Graham, M.D.
SG/SN/sndovmt076/FST-15415557
D: 06/17/13 11:04 A
T: 06/18/13 05:21 A

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From Surgical Notes 1.214.723.7588 Tue Jun 18 15:05:29 2013 CST Page 2 of 7

REAGAN STREET SURGERY CENTER
10904 REAGAN STREET
LOS ALAMITOS, CA 90720
562-596-3140

OPERATIVE REPORT

BIL

PATIENT NAME: Perez, Consuelo
DATE OF OPERATION: 06/17/13
HOSPITAL NUMBER: 51564
SURGEON: Stephen Graham, M.D.

PREOPERATIVE DIAGNOSES: Tear of the medial and lateral menisci, chondromalacia, and possible loose body, right knee.

POSTOPERATIVE DIAGNOSES: Tear of the lateral meniscus and chondral defect, right knee.

29881-RT 29879

PROCEDURES PERFORMED: Arthroscopy, lateral meniscectomy, chondroplasty, and debridement, right knee, followed by injection of Marcaine and Duramorph.

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29879

29881

6-18-13

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From Surgical Notes 1.214.723.7588 Tue Jun 25 15:05:29 2013 CST Page 3 of 7

RE: Perez, Consuelo
OPERATIVE REPORT
PAGE 2

29881

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REAGAN STREET SURGERY CENTER
10904 REAGAN STREET
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OPERATIVE REPORT

BIL

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DATE OF OPERATION: 06/17/13
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6-18-13

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From Surgical Notes 1.214.723.7588 Tue Jun 18 15:05:29 2013 CST Page 3 of 7

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Stephen P. Graham, M.D., Inc.
1760 Termino Ave.
Suite #G-21
Long Beach, CA 90804
Phone: (562) 597-9002
Fax: (562) 597-9003

Ustia Irvine
32.251644

Date: 6-24-13

Patient Name: Perez, Consuelo

Date of Surgery: 6-17-13

DX:

1) 836.1
2) 717.7
3) _____
4) _____

CPT4:

1) 29881
2) 29877-59
3) 20610-59
4) _____

OK M

Authorization: 460116723-UMO-5

Date Sent to Biller: JUN 24 2013

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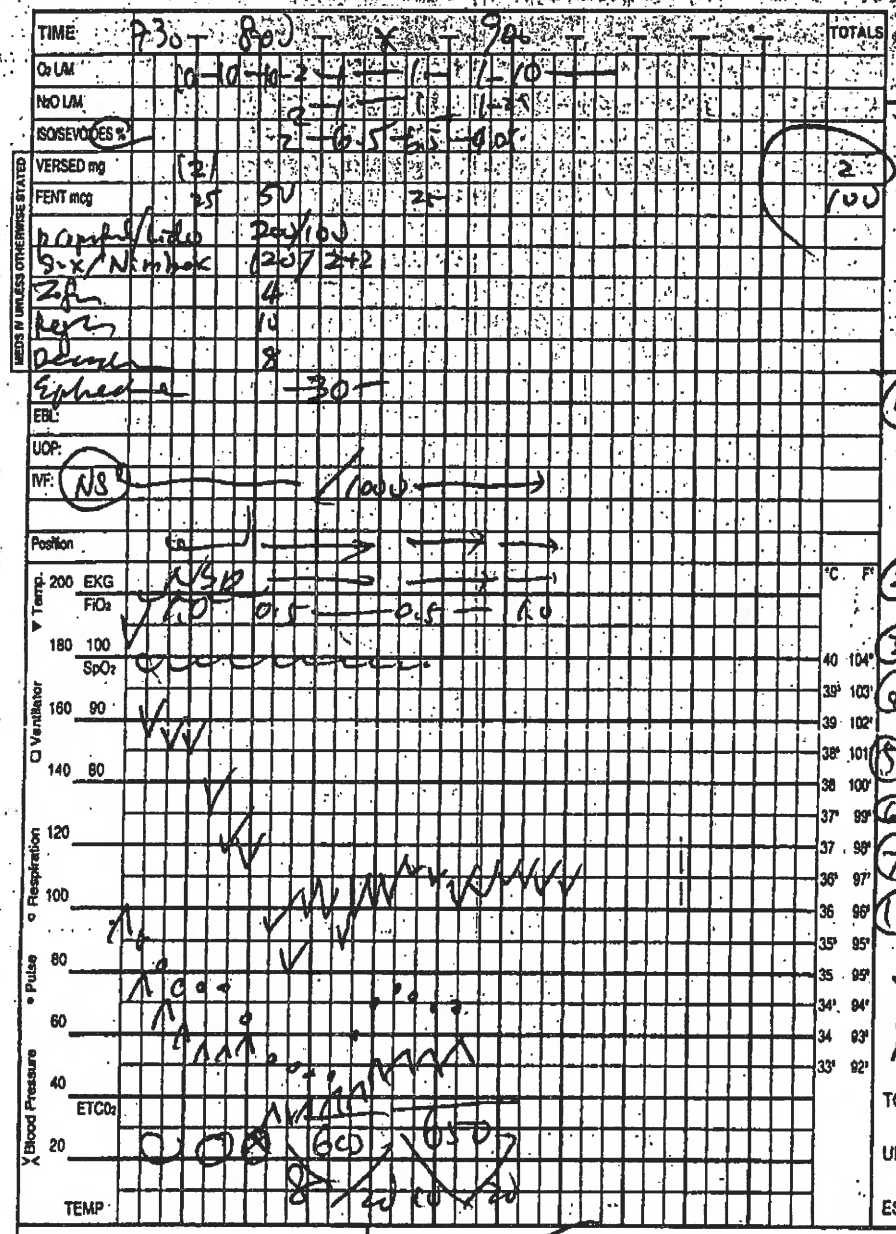
Corvel Scan Date: 7/17/2013

Reagan Street SURGERY CENTER



NOTES

preop @ 7:20

prepared @ 7:45

To OR @ 7:56

1. preO2. induced. relaxed & DL c Glidescope w/ intubated. EtCO2 @ BSBZ @ 8:10
2. prep & drape @ 8:18
3. tourniquet ↑ @ 8:22.
4. incision @ 8:23.
5. To Extubated @ 9:07
6. To Awake @ 9:09
7. To PACU @ 9:10
10. Report @ 9:14

T 97.6. 98%O2 98% RA
BP 143/69.
HR 80
RR 20

TOTAL FLUID 1000ml.

URINE OUTPUT 0

EST. BLOOD LOSS 0 cc

☐ PT ID/MACHINE CHECKED
☐ MONITORS/SUCTION
☐ PROCEDURE SITE/SIDE VERIFIED
☐ EYES TAPED ☐ OINTMENT
☐ BEAR HUGGER
☐ FINAL PT ASSESSMENT PRIOR TO IND 7:45
☐ ABX Ancef 2gm IV @ 7:45 ☐ N/A

MONITORS: BP CUFF R L STETH: ☐ PRECORD ☐ ESOPH ☐ ECG
☐ DIRECT ARTERIAL R L ☐ SWAN GANZ OR CENTRAL LINE
☐ PULSE OXIMETER (SpO2) ☐ END - TIDAL CO2 ☐ O2 ANALYZER
☐ TEMP
Other

Tourniquet Pressure 300 mmHg
RL (R thigh) RL
On 8:22 On
Off 8:54 Off
Total Time 32min

REGIONAL
☐ Spinal ☐ Epidural ☐ Time Out
PREP: ☐ Betadine ☐ Other
Pontocaine Lidocaine
Bupivacaine
Dextrose Water
Morphine Fentanyl
Epinephrine
Meq NaHCO3
Other
Needle Size Location
☐ Easy ☐ Moderate ☐ Difficult ☐ # times
CSF: Level:
Paresthesia ☐ No ☐ Yes
☐ Catheter ☐ Removed Intact ☐
Date:

GENERAL
SEMI-CLOSED, ABS: ☐ MASK ☐ ENDO
☐ LARYNGEAL MASK
AIRWAY: ☐ ORAL # ☐ NASAL R L #
ENDO TECHNIQUE
☐ ORAL ☐ EASY ☐ MODERATE ☐ DIRECT VISION
☐ NASAL R L ☐ DIFFICULT ☐ BLIND
☐ CUFF INFLATED cc SIZE:
mm Glidescope
BLADE & SIZE VL Sein intubated
☐ Light Wand
☐ Trach Pressure Endo @ BSBZ
Comments:

Operation(s): (R) knee open arthroscopy with synovectomy, meniscectomy, chondroplasty, debridement

Surgeons: Graham, Stephen

6/17/2013

Anesthesiologist
Signature Date/Time: 7:20.

START	X-ANES 7:45	O-SURG 9:04
END	O-SURG 9:23	X-ANES 9:14

PATIENT ID

NAME: PEREZ, CONSUELO
ACT#: 51564 DOS: 06/17/13
DOB: 03/15/52 AGE: 61
DR: GRAHAM, STEPHEN P
SEX: F

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Corvel Scan Date: 7/17/2013

Pre-op Diagnosis (R) nine centimeter tumor Date/Time 6-17-2013

Proposed Surgery ☐ Left ☒ Right lower anterior resection NPO > 8 hrs.

Medical History (1) morbid obesity meniscectomy

(2) HTN cholecystectomy

Systems Review abdominoplasty

Respiratory ϕ COPD

Cardiovascular HTN ϕ MI/CVA

GI-GE ϕ GERD

Endocrinology/Metabolic ϕ DM

NAME: PEREZ, CONSUELO
ACT#: 51564 DOS: 06/17/13
DOB: 03/15/52 AGE: 61
DR: GRAHAM, STEPHEN P
SEX: F

CNS ϕ

Hematology ϕ

Allergies PCN – "fainting"

Medications Vicodin. @7:35
Diovan.
Mirabec.
Carvedilol

Habits ϕ smoke/ETOH

Anesthesia History → 188/88 → 157/67 at 7:46
s/p c/s. ovarian surg → appendectomy → no complications

Physical Exam BP 200/108 PR 89 /min RR 20 /min Ht. 5'1" Wt 229

Mallampati class I (II) III IV FRom, some dentures removed

Heart Regular rhythm. S1 S2

Lungs CTA (B)

Abdomen obese (+)

Extremities ϕ C/C/E except (R)

Neuro

Other

ASA III

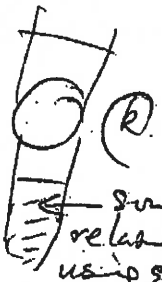
Anesthesia Plan GETA

Yes No Glidescope.

☐ ☐ A-line ☐ CVP ☐ Swan-Ganz

☐ ☒ Discussed possible blood transfusion, risks and benefits

☒ ☐ Anesthesia procedure, alternatives, and risks ranging from tooth damage to life threatening events have been explained questions were answered and informed consent was obtained



Lab Results

CBC 13.6 / 60.4 / 178

Chemistry 141 / 106 / 16 / 3.7 / 20 / 0.83 / 12

PT / PTT ϕ

EKG NSR

CXR ϕ

UA: neg

If no, explain

Sign / Print name [signature] C.Y. Lou

POST OPERATIVE NOTE

☒ No anesthesia complication

☐ Other

Date / Time 6/17/2013 9 + 30

Sign / Print name [signature] C.Y. Lou

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06/Jul./2013 3:09PM

Corvel Scan Date: 7/17/2013

STEPHEN P. GRAHAM, M.D., INC.

Diplomate American Board Orthopedic Surgery
1760 Termino Ave., G21 • Long Beach, CA 90804
(562) 597-9002 • Fax (562) 597-9003

☐ PL - (714) 993-2000
☐ LBMH - (562) 933-2000 ☐ LOS ALAMITOS - (562) 598-1311
☐ LBCH - (562) 498-1000 ☐ RSSC - (562) 596-3140

PLEASE BRING INSURANCE CARD

PRE-SURGICAL TESTING SERVICES

Patient Name: Perez, Consuelo Home Phone: 714-865-1227
Work Phone: 949-720-4055 Cell Phone: _____ Other: _____
Pre-Op Diagnosis: tear Medial and lateral Menisci and Chondromalacia Right Knee
Date of Surgery: 6-17-13 Time of Surgery: 8:00 AM
Admitting/Attending Physician: Stephen P. Graham MD PCP: Stephen P. Graham MD
☒ OPS ☐ AM Admit: auth#4001672 3-Umo-5
Insurance ☐ PPO/POS ☐ HMO ☐ Medicare ☐ Medi-Cal ☒ Worker's Comp ☐ Self Pay

TESTS REQUIRED

ICD-9 DIAGNOSIS CODES: 1.) 836.0 2.) 836.1 3.) 717.7 (MANDATORY) 4.) _____ 5.) _____

LABORATORY
TO BE DONE AT:
- CBC ☒
- UA ☒
- Basic Metabolic Panel ☒
- Comprehensive Metabolic Panel ☐
- PT ☐
- PTT ☐
- OTHER _____

- Type and Screen ☐
- Type and Cross ☐
  No. of Units _____
  Autologous Blood _____
  Directed Donor Blood _____
- Gann Act - Transfusion Options Discussed with Patient by Physician ☐ Yes ☐ No ☐ N/A

RADIOLOGY
TO BE DONE AT:
- Chest 2- View ☒
- Other ☐

CARDIOLOGY/RESPIRATORY CARE
TO BE DONE AT:
- EKG ☒
- Pulmonary Screen ☐

SPECIAL INSTRUCTIONS PRE-OP
– SHAVE AND PREP WITH HIBICLENS
– HAVE PATIENT MARK OPERATIVE SIDE WITH PEN

ALLERGIES Penicillin

IV/PRE-OP MEDS.
ANCEF 2 GRAMS IVPB PRE-OP WITHIN 60 MINUTES OF CUT-TIME/OR IF ALLERGIC TO PENICILLIN THEN GIVE VANCOMYCIN 1 GRAM IVPB PRE-OP WITHIN 60 MINUTES OF CUT-TIME

SURGICAL CONSENT
Arthroscopy, Meniscectomy, Chondroplasty and debridement Right Knee.

Signed S Graham M.D.
Date 6-4-13

ADDRESSOGRAPH

WHITE: CHART YELLOW: LAB PINK: RADIOLOGY

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

June 13, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE: PEREZ, CONSUELO
Claim #: WC2013419849

Inc. #:	032-251644
D.O.I.:	03/10/13
Employer:	The Irvine Company/Corporation

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, Lucero Herrera, was used in the face-to-face time with this patient during the course of the history and physical examination.

SUBJECTIVE COMPLAINTS

Ms. Perez returns for reevaluation of right knee and for preoperative evaluation. She was seen in initial orthopedic consultation on 05/16/13. Her examination and review of MRI studies were consistent with tear of the medial and lateral meniscus and chondromalacia with possible loose body. Right knee arthroscopic surgery was recommended, she agreed and authorization has been obtained. She is now scheduled for surgery at Reagan Street Surgery Center on 06/17/13. Her situation has not improved. She continues to have pain, swelling and discomfort.

Her medical history was reviewed.

Surgical History

Include appendectomy, cesarean sections, and oophorectomy.

Allergies

SHE IS NOTED BE ALLERGIC TO PENICILLIN.

Medications

She is taking medications for hypertension and reflux. She also takes Vicodin for pain relief.

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 female appearing her stated age and in no acute distress.

Vital Signs

Pulse: 69
Blood Pressure: 161/83
Respirations: 18
Temperature: 98.8

Heart

Heart has regular rate and rhythm. No murmur is heard.

Lungs

Lungs are clear to auscultation.

Abdomen

Abdomen is soft.

Examination of the Right Knee

Visual Inspection

Mild swelling.

Palpation

There is pain along the medial joint line and lateral joint line. McMurray test is painful.

Special Tests

Pivot shift is painful.

DIAGNOSIS

Tear of the medial and lateral meniscus, right knee with chondromalacia.

PLAN

Plan will be to proceed with arthroscopy, meniscectomy, chondroplasty and debridement. Norco will be prescribed for preoperative and postoperative pain relief. The patient will continue modified duties at work up until the time of surgery. This limits standing and walking and lifting no more than 10 pounds repetitively. She should not be required doing kneeling or squatting. She will be temporarily totally disabled in the immediate postoperative period.

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 Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:oug.JNB
D: 06/13/13
T: 06/14/13
PerezC0613Graham22724895

THE IRVINE CO./CORP. 164551

DOS: 6/13/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

STABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 69 BP: 161/83 RESP: 18 TEMP: 98.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First:_____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☑ Worse
2. What does the pain feel like? ☑ Dull ☐ Sharp ☑ Burning ☐ Throbbing ☑ Pins and Needles ☑ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see page 2 for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	(6)	(7)	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse walk, up
6. Activity or position that makes the pain less When stand the leg
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking?_____

   a. Do you need refills? ☑ Yes ☐ No
9. Do you have any allergies? ☑ Yes ☐ No

   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No

    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☑ Yes ☐ No

    If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 6/13/13

rev 11-2011

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 Perez First Consuelo DOB 3/15/52 Date of Exam: 6/13/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel (949) 720-4055 Fax: 949 720-3455

Claims Administrator CHUBB SERVICES CORP. Tel (213) 612-5400 Fax: _____

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: f/u op

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)

f/u op

all PCM
T - ō
Et - ō
M - vico carvedilol diovan pulsive
DM - ō appy cur oxphorect

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

HRRR no (m)
L chest A-ō
tear meniscus R knee

DIAGNOSES (Include ICD-9 code, if possible)

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 Rx norco
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks

WRITTEN RX REQUIRED DRSSC # 154 07973 6-13-13

WORK STATUS ☐ First Aid Case

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

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / (✓) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
(✓) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / (✓) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

TTD pert of

☐ 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 Stephen Graham M.D. Cal. Lic # _____ Date of Exam 6/13/13
Specialty: Lic G43382 Signature S Grahamm pert of
Executed at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:	YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:
☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: _____ TIME: _____ ☐ Before / After Shift	DATE: _____ TIME: _____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

THE IRVINE CO./CORP. 164551

DOS: 6/13/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

STABLISHED PATIENT UPDATED HISTORY

FOR OFFICE USE

VITALS: HT:_____ WT:_____ PULSE: 69 BP: 161/83 RESP: 18 TEMP: 98.8

JAMAR: RIGHT:_____ _____ _____ LEFT:_____ _____ _____ SETTING #: _____

INTREPRETER NAME: First:_____ Last: _____

DATE OF SURGERY: _____ DAYS SINCE SURGERY: _____

Since your last visit with the doctor

1. Do you feel: ☐ Better ☐ Same ☑ Worse
2. What does the pain feel like? ☑ Dull ☐ Sharp ☑ Burning ☐ Throbbing ☑ Pins and Needles ☑ Numbness and Tingling ☐ No pain
3. Rate the intensity of your pain today Please see page 2 for description of pain levels

Circle one:	NO PAIN									MOST PAIN
	0	1	2	3	4	5	(6)	(7)	8	9	10
	No Pain		Mild symptoms			Moderate symptoms			Severe		Debilitating

4. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☑ Constant
5. Activity or position that makes the pain worse Walk, lift
6. Activity or position that makes the pain less When I stand the leg
7. Have you kept your treatment as indicated? ☐ Yes ☐ No
8. What medications are you currently taking?_____

   a. Do you need refills? ☑ Yes ☐ No
9. Do you have any allergies? ☑ Yes ☐ No
   If yes, please explain Penicillin
10. Are you receiving therapy? ☐ Yes ☑ No
    What kind of therapy? ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic
11. Have you experienced any new symptoms? ☑ Yes ☐ No
    If yes, are these symptoms related with your injury? ☑ Yes ☐ No
12. Are you currently ☐ Off Work ☑ Modified Work ☐ Full Duty
13. Have there been any changes in your medical history? ☐ Yes ☑ No

Please explain.

Patient Signature Consuelo Perez Date 6/13/13

rev 11-2011

Encounter Addendum Notes Reason :Amended HPI
Modified By: Alipour Nima 2013.07.08 16:19:58

MEDICAL DOCUMENTATION : DO NOT DETACH

U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

Date of Service:	06-12-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	WC2013419849
Chart #:	EMR/JB

History Of Present Illness:
Preoperative Details: A pre-operative clearance examination is requested by Dr. Graham. Reason for Surgery Diagnoses: Meniscus injuryh . Meniscus arthroscopy is the surgical procedure planned. This procedure is elective. Anesthesia anticipated is general.
Pre-Operative Complaints
Complaint: Patient's complaint at this time is as follows: Knee pain. Medial joint line tenderness - Knee. Patient describes the symptom(s) as sharp. She says it is moderately severe. The frequency is intermittent. Context: pain with weight bearing. The symptoms are exacerbated by weight bearing, flexing, pivoting on leg. The symptoms are lessened by rest. Meds. Minimizing weight bearing.

Present complaint
Severity: Severity of pain is not applicable to the complaint.

Relevant History NOTES: She denies any possibility of being pregnant. Last tetanus - unknown.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.

Review Of Systems:
A complete review of systems was performed and was found to be negative unless otherwise noted below.
see 1st visit

Relevant Preop. History:
Allergies: The patient denies a history of allergies to medications . The patient states there is no history of abnormal reactions to medications or anesthetics.

Physical Examination:
Height: 60 inches. Weight: 230 lbs. BMI:45 Pulse: 71/min. BP: 159/85 mmHg. Temperature: 98.9 deg F
Respiration: 17 per min.

Psychiatric: She is alert and oriented to person, place and time . Mood and affect appear appropriate .
Eyes: The eyes are not red or injected .
HEENT: The external ear appears within normal limits . The exam of the middle and inner ears are normal . The nasal

airway is patent . The nasal septum is not deviated or perforated . The oral airway is not obstructed .
Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The patient does not display sternal retractions . There is no cyanosis or clubbing noted .
Gastrointestinal: There are no palpable abdominal masses . The abdomen is non-tender on palpation . There is no palpable abdominal guarding . There is no rebound tenderness of the abdomen . A hernia is not identified on examination. There is no evidence of organomegaly on exam . There is no ascites on abdominal exam .
Genitourinary: The external genitalia appear normal. Costovertebral angle tenderness for renal involvement is not noted .
Skin: There are no abnormal skin lesions . The skin turgor is normal . There is no evidence of abnormal bruising or petecchiae on examination .
Lymphatic: There is no palpable lymphadenopathy. There is signs of lymphedema .
Endocrine: The thyroid is non-tender on palpation . The thyroid is not enlarged .
Musculoskeletal: The thoracic spine and rib cage are within normal limits . The range of motion of the spine is within normal limits . The spine and paraspinal muscles are not tender . There is no evidence of muscle weakness .
Cardiovascular: The heart rate is normal . Heart rhythm is not irregular. Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . Peripheral pulses are intact.
Neurologic: Sensation to touch is normal . Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits .

Diagnostic Tests:
Radiology

Test Name	Findings
Chest - 2 Views (Standard)	Preliminary interpretation of these x-rays are Normal -

Medical Necessity:
Chest - 2 Views (Standard) preop
All radiology studies are sent to Radiologist for review and confirmation.

Laboratory
Internal Lab orders:

Test Name	Result	Remarks
CBC / Differential		
Urinalysis		
Comprehensive Metabolic Panel		
HCG, TOTAL, QL		
HCG, TOTAL, QL		

External Lab Orders:

CBC / Differential: Lab Code - 6399; Collection Date/Time 06-12-2013 13:40; Other -

Urinalysis: Lab Code - 5463; Collection Date/Time 06-12-2013 13:40; Other -

Comprehensive Metabolic Panel: Lab Code - 8000; Collection Date/Time 06-12-2013 13:40; Other -

HCG, TOTAL, QL : Lab Code - 8435; Collection Date/Time 06-12-2013 13:40; Other -

Medications to be Continued until Next Visit:
Clinical Decision Making Comments: continue pain meds as Rx'ed by ortho

Treatment Plan
Procedures:
An EKG was performed. m soto

Corvel Scan Date: 10/22/2013

Pre-Operative Diagnoses: v72.84 - pre-operative examination unspecified .

Other Diagnoses: Lateral Meniscus Tear (836.1)

Recommendations: All diagnostics tests ordered were reviewed on 07-12-2013 and recommendations are as follows: I have found no medical contraindications for the surgical procedures planned.

Nima . Alipour, D.O.
This has been electronically signed on 07-08-2013

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Corvel Scan Date: 10/22/2013

US HealthWorks

THE IRVINE CO./CORP. 164551

DOS: 6/12/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

WC

...o Social):_____ Date (Fecha):_____

...er):_____

...ilia):_____

1. Since your last visit, are you: ☐ improved? ☐ worse? ☑ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?

2. Since your last visit, have you developed any new complaints? ☐ Yes (*Si*) ☑ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

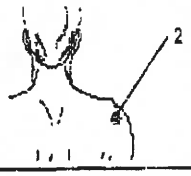
If you have not improved since your last visit, or if you have developed new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

PLEASE COMPLETE THE FOLLOWING DIAGRAM *(Por favor complete el diagrama a continuación.)*
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

SYMPTOMS (SÍNTOMAS)

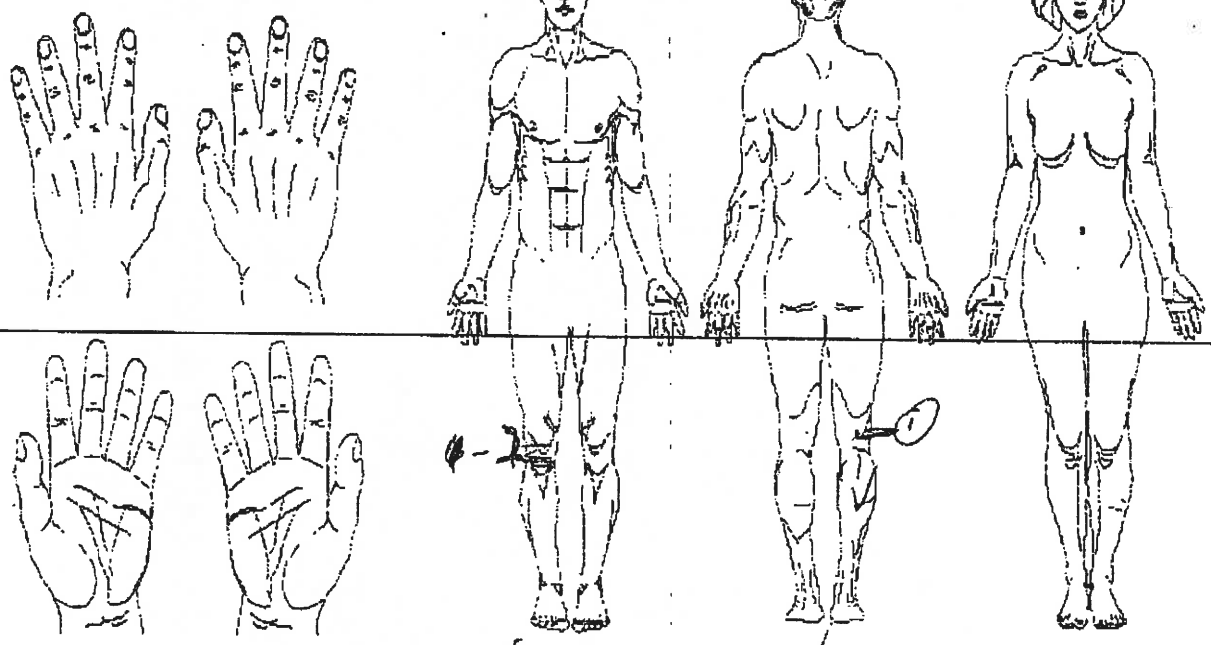
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

Example (Ejemplo)



Rate the intensity of your pain: NO PAIN — MOST PAIN
Indique la intensidad de su dolor: *SIN DOLOR* — *DOLOR INTENSO*

0 1 2 3 4 5 6 7 8 9 10



Patient Signature *(Firma del Paciente)* _____ Date *(Fecha)* _____

© US HealthWorks

Corvel Scan Date: 10/22/2013

U.S. HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Date Generated: 06-12-2013 15:35:14

NAME: Last: Perez	**First: Consuelo**	**Date of Exam: 06-12-2013**	**Case #: 032251644**
Occupation: Laundry Attendant	**DOB: 03-15-1952**	**DOI: 03-10-2013 17:00**	**Claim #: WC2013419849**
Employer: THE IRVINE CO./CORP.	**Contact: ERMA WORCESTER**	**Tel.: (949)720-4055**	**Fax: (949)720-3455**
Claims Administrator: CHUBB SERVICES CORP.		**Tel.: (213)612-5400**	**Fax:**

DIAGNOSES

Lateral Meniscus Tear (836.1)

TREATMENT

Diagnostic Tests: Radiology: Radiology tests were ordered. All radiology studies sent to Radiologist for review and confirmation.

Laboratory: Lab Tests were ordered.

Physical Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

WORK STATUS

Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull up to 10 lbs.

Patient must wear knee support.

TREATING PROVIDER

Name: **Nima . Allpour,D.O.** Lic. #: **20A11637** Signature (Original)

Specialty: **Occupational Medicine** Date of Exam: **06-12-2013**

NEXT APPOINTMENT

Next Appointment with on .

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 06-12-2013 12:05 pm **Check Out Time: 03:35 pm**

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Corvel Scan Date: 10/22/2013

U.S HealthWorks MEDICAL GROUP

UC HEALTH HISTORY / HISTORIA MÉDICA

To better assess your health condition, please provide the following information
(Para evaluar mejor su condición de salud, por favor proporcione la siguiente información)

Yes/Sí	No	PLEASE ANSWER ALL QUESTIONS / POR FAVOR CONTESTE TODAS LAS PREGUNTAS		Yes/Sí	No
		PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	**RESPIRATORY SYSTEM**		
		1. Allergies or hives — Alérgias o urticaria	42. Chronic/Recurrent Cough/Cold — Resfriado / Tos crónica o recurrente		
		2. Medications — Medicinas	43. Asthma / Wheezing — Asma o pitos (sibilancias) en el pecho		
		3. Major illnesses or injuries — Enfermedades/lesiones importantes	44. Emphysema or chronic bronchitis — Enfisema o bronquitis crónica		
		4. Hospitalizations or surgeries — Hospitalizaciones o cirugías	45. Pneumonia — Pneumonia o pulmonía		
		5. Motor vehicle accidents — Accidentes de tránsito	46. Tuberculosis — Tuberculosis		
		6. Blood transfusions — Transfusiones de sangre	47. Coughing of Blood — Tos con sangre		
		7. Worked in a hazardous environment — Trabajo en ambientes peligrosos	**GASTROINTESTINAL TRACT**	**Yes/Sí**	**No**
		8. Work-related injuries/illnesses — Accidentes/enfermedades en el trabajo	48. Frequent Indigestion or reflux — Indigestión o reflujo frecuentes		
		9. Permanent disabilities — Incapacidad permanente	49. Nausea or vomiting — Náusea o vómitos		
Yes/Sí	**No**	**FAMILY HISTORY / ANTECEDENTES FAMILIARES**	50. Vomiting of Blood — Vómitos con sangre		
		10. Blood diseases in relatives — Familiares con enfermedades de la sangre	51. Abdominal pain — Dolor abdominal		
		11. Cancer or leukemia in relatives — Familiares con cáncer o leucemia	52. Liver disease — Enfermedades del hígado		
		12. Diabetes in relatives — Familiares con diabetes	53. Change in Bowel Habits — Cambios en hábitos intestinales		
		13. Heart Disease — Familiares con enfermedades del corazón	54. Frequent Constipation/Diarrhea — Constipación o diarea frecuentes		
		14. High Blood Pressure — Familiares con presión alta	55. Blood in stools/Black stoo's — Heces negras o con sangre		
		15. Strokes in relatives — Familiares con trombosis / ataques cerebra'es	56. Hemorrhoids / Rectal Disease — Hemorroides o enfermedades del recto		
		16. Mental illnesses in relatives — Familiares con enfermedades menta'es	**GENITOURINARY TRACT**	**Yes/Sí**	**No**
Yes/Sí	**No**	**SOCIAL HISTORY / ANTECEDENTES SOCIALES**	57. Painful or difficult urination — Dificultad o dolor al orinar		
		17. Tobacco use. How much? ____ week — Uso de tabaco. ¿Cuanto? ____ semana	58. Blood in urine — Sangre en la orina		
		18. Alcohol use. How much? ____ week — Uso de alcohol. ¿Cuanto? ____ semana	59. Kidney infection/stones — Infecciones o cálculos del riñón		
		REVIEW OF SYSTEMS / REVISION DE SISTEMAS	60. Venereal Disease — Enfermedades venéreas		
Have you had or do you commonly have: / ¿Tiene usted normalmente, o ha tenido:			**MUSCULOSKELETAL**	**Yes/Sí**	**No**
Yes/Sí	**No**	**CONSTITUTIONAL**	61. Joint pain or disease — Enfermedades o dolor en las articulaciones		
		19. Recent gain or loss of weight — Ganancia o perdida de peso reciente	63. Neck or back injury — Lesiones del cuello o de la espalda		
		20. Weakness, fatigue, or appetite loss — Debilidad, fatiga o perdida de apetito	64. Foot Problems — Problemas en los pies		
		21. Fever — Fiebre	**NEUROLOGICAL**	**Yes/Sí**	**No**
Yes/Sí	**No**	**SKIN**	65. Epilepsy, Convulsions — Epilepsia, convulsiones, ataques		
		22. Skin diseases or problems — Enfermedades en la piel	66. Dizziness — Mareos o vértigo		
		23. Discoloration, pigmentation changes — Cambios de color en la piel	67. Muscle weakness or paralysis — Parálisis o debilidad muscular		
		24. Cancer/Tumors or cysts — Cáncer, tumores o quistes	68. Numbness in arms or legs — Adormecimiento de manos o pies		
Yes/Sí	**No**	**HEAD**	**PSYCHIATRIC PROBLEMS**	**Yes/Sí**	**No**
		25. Frequent or severe headaches — Dolores de cabeza frecuentes o severos	69. Depression — Depresión		
Yes/Sí	**No**	**EYES / VISION**	70. Nervousness — Nerviosismo		
		26. Eye injury, infection or pain — Lesiones, infección o dolor en los ojos	71. Mood swings — Cambios del humor o del carácter		
		27. Blurred, double or decreased vision — Visión borrosa, doble, o disminuida	72. Sleep disturbances — Trastornos del sueño		
		28. Eye itching, burning or tearing — Lagrimeo, picazón o quemazón en ojos	73. Alcoholism — Alcoholismo		
		29. Light sensitivity — Sensibilidad a la luz	74. Drug abuse treatment/rehabilitation — Rehabilitación por adicción a drogas		
Yes/Sí	**No**	**EARS, NOSE, THROAT, MOUTH**	**ENDOCRINE SYSTEM**	**Yes/Sí**	**No**
		30. Loss or decreased hearing — Pérdida o disminución de la audición	75. Increased appetite — Apetito exagerado		
		31. Ear pain, infection, discharge — Dolor, infección o secresión en oídos	76. Increased thirst — Sed exagerada		
		32. Nose / Sinus Problems — Problemas en la nariz o en senos nasales	77. Increased urination — Aumento en la frecuencia o cantidad de orina		
		33. Dental/Gum Disease — Enfermedades dentales o de las encías	78. Diabetes/High Blood Sugar — Diabetes / Azúcar en la sangre		
		34. Recurrent throat problems — Problemas de garganta recurrentes	79. Hair loss — Pérdida del cabello		
		35. Voice Change / Hoarseness — Ronquera o cambios en la voz	**BLOOD DISORDERS**	**Yes/Sí**	**No**
Yes/Sí	**No**	**CARDIOVASCULAR SYSTEM**	80. Bleeding gums — Sangramiento por las encías		
		36. Shortness of Breath — Dificultad para respirar	81. Bruising — Moretones o cardenales		
		37. Chest Pain or Pressure — Opresión o dolor en el pecho	82. Spontaneous nose bleeding — Sangramiento espontáneo por la nariz		
		38. Palpitation/Pounding Heart — Palpitaciones o saltos del corazón	83. Easy bleeding or hard to stop — Sangramiento fácil o difícil de detener		
		39. High Blood Pressure — Presión sanguínea elevada	**FOR WOMEN ONLY**	**Yes/Sí**	**No**
		40. Swelling Feet/Ankles — Hinchazón de pies o tobillos	84. Pregnant? — Embarazada?		
		41. Varicose Veins — Venas varicosas	85. Date last menstrual period? — Fecha última menstruación		
			86. Irregular Menstruation? — ¿Menstruación o períodos irregulares?		
			87. Painful Menstruation — ¿Menstruación o períodos dolorosos?		

Please write the number of any Yes answers and explain each one of them in the space below.
Por favor, escriba el número de las preguntas en las cuáles haya contestado que Sí y explique sus repuestas en este espacio.

10. #14 Medfer

PROVIDER COMMENTS

I certify that the information above is correct. (Certifico que la información arriba es correcta)

Patient Signature (Firma del Paciente): Consuelo Perez Date (Fecha):

☐ Relevant history was discussed and patient advised to follow up with personal physician
Provider Initials: _____

THE IRVINE CO./CORP. 164581
DOS: 6/12/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

THE DOCUMENTATION ABOVE.

UC HEALTH HISTORY / HISTORIA MEDICA
Confidential / Confidencial

ncident #: _____ Date: _____

ST5020A (Rev 12/2011)

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ACCESSION: EN373685M
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REPRINT

97508376 AREA/ROUTE/STOP: MAIL000
USHW-IRVINE
2362 MORSE AVE
IRVINE, CA 92614-6234

PEREZ,CONSUELO 61 F OSWALD,RICHARD H

1 0031552 EN373685M E12479 06122013 06122013 06132013 5:06AM

PACIFIC TIME

FASTING: U

FINAL

<CR> to continue

Date of Birth: 03/15/1952
Patient Phone: 714.865.1227

COMPREHENSIVE METABOLIC PANEL				EN
GLUCOSE		120 H	mg/dL	65-99
				Fasting reference interval
UREA NITROGEN (BUN)		19	mg/dL	7-25
CREATININE		0.83	mg/dL	0.50-0.99
	For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.			
eGFR NON-AFR. AMERICAN		76	mL/min/1.73m2	> OR = 60
eGFR AFRICAN AMERICAN		88	mL/min/1.73m2	> OR = 60
BUN/CREATININE RATIO		NOT APPLICABLE	(calc)	6-22
SODIUM		141	mmol/L	135-146
POTASSIUM		3.7	mmol/L	3.5-5.3
CHLORIDE		106	mmol/L	98-110
CARBON DIOXIDE		26	mmol/L	19-30

<CR> to continue

CALCIUM	9.1	mg/dL	8.6-10.4
PROTEIN, TOTAL	7.2	g/dL	6.1-8.1
ALBUMIN	4.2	g/dL	3.6-5.1
GLOBULIN	3.0	g/dL (calc)	1.9-3.7
ALBUMIN/GLOBULIN RATIO	1.4	(calc)	1.0-2.5
BILIRUBIN, TOTAL	0.5	mg/dL	0.2-1.2
ALKALINE PHOSPHATASE	52	U/L	33-130
AST	18	U/L	10-35
ALT	23	U/L	6-29

URINALYSIS, COMPLETE			EN
COLOR	YELLOW		YELLOW
The preferred specimen for urinalysis is urine			

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preserved using a Stockwell Brand Urine Preservative
Tube (yellow top, blue band) that may be obtained
from your Quest Diagnostics supplier.
Please review results with caution. Urinalysis
testing on unpreserved urine may produce alteration
of chemical constituents and deterioration of formed
elements.

APPEARANCE	CLEAR			CLEAR

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CONTINUED REPORT

REPRINT

97508376 AREA/ROUTE/STOP: MAIL000
USHW-IRVINE
2362 MORSE AVE
IRVINE, CA 92614-6234

PEREZ,CONSUELO 61 F OSWALD,RICHARD H

2 0031552 EN373685M E12479 06122013 06122013 06132013 5:06AM

PACIFIC TIME

FASTING: U

FINAL

<CR> to continue

Date of Birth: 03/15/1952
Patient Phone: 714.865.1227

URINALYSIS, COMPLETE (CONTINUED)

SPECIFIC GRAVITY	1.024			1.001-1.035
PH	7.0			5.0-8.0
GLUCOSE	NEGATIVE			NEGATIVE
BILIRUBIN	NEGATIVE			NEGATIVE
KETONES	NEGATIVE			NEGATIVE
OCCULT BLOOD	NEGATIVE			NEGATIVE
PROTEIN		TRACE		NEGATIVE
NITRITE	NEGATIVE			NEGATIVE
LEUKOCYTE ESTERASE	NEGATIVE			NEGATIVE
WBC		6-10	/HPF	< OR = 5
RBC	0-3		/HPF	< OR = 3
SQUAMOUS EPITHELIAL CELLS		10-20	/HPF	< OR = 5
BACTERIA	NONE SEEN		/HPF	NONE SEEN
HYALINE CAST	NONE SEEN		/LPF	NONE SEEN

CBC (INCLUDES DIFF/PLT) EN

WHITE BLOOD CELL COUNT	7.3	Thousand/uL	3.8-10.8
RED BLOOD CELL COUNT	4.44	Million/uL	3.80-5.10
HEMOGLOBIN	13.4	g/dL	11.7-15.5

<CR> to continue

HEMATOCRIT	40.4	%	35.0-45.0
MCV	91.0	fL	80.0-100.0
MCH	30.1	pg	27.0-33.0

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MCHC	33.1	g/dL	32.0-36.0
RDW	13.7	%	11.0-15.0
PLATELET COUNT	178	Thousand/uL	140-400
MPV	10.2	fL	7.5-11.5
ABSOLUTE NEUTROPHILS	4453	cells/uL	1500-7800
ABSOLUTE LYMPHOCYTES	2059	cells/uL	850-3900
ABSOLUTE MONOCYTES	599	cells/uL	200-950
ABSOLUTE EOSINOPHILS	168	cells/uL	15-500
ABSOLUTE BASOPHILS	22	cells/uL	0-200
NEUTROPHILS	61.0	%	
LYMPHOCYTES	28.2	%	
MONOCYTES	8.2	%	
EOSINOPHILS	2.3	%	
BASOPHILS	0.3	%	

CONTINUED REPORT

REPRINT

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97508376 AREA/ROUTE/STOP: MAIL000
USHW-IRVINE
2362 MORSE AVE
IRVINE, CA 92614-6234

PEREZ,CONSUELO 61 F OSWALD,RICHARD H

3 0031552 EN373685M E12479 06122013 06122013 06132013 5:06AM

PACIFIC
TIME
FASTING: U

FINAL

Date of Birth: 03/15/1952
Patient Phone: 714.865.1227
HCG, TOTAL, QL NEGATIVE EN

<CR> to continue

Reference Range
Non-Pregnant: Negative
Pregnant: Positive

>> END OF REPORT - PEREZ,CONSUELO EN373685M <<

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Recv'd Date: 20150630 Bill DCN: 2015182GJ000372

STEPHEN GRAHAM, M.D.
Orthopaedic Surgeon
An Independent Contractor of
U.S. HealthWorks Medical Group
2362 Morse Avenue • Irvine, CA 92614
Phone (949) 863-9103 • Fax (949) 863-1337

BIL

May 16, 2013

Chubb Services Corporation
Attention Claims Examiner
PO Box 30570
Los Angeles CA 90030-0570

RE:	**PEREZ, CONSUELO**
Claim #:	**WC2013419849**
Inc. #:	032-251644
Date of Injury:	03/10/13
Employer:	The Irvine Company/Corporation

INITIAL ORTHOPEDIC CONSULTATION

Dear Claims Adjuster:

This is the initial orthopedic consultation of Consuelo Perez. This patient is being evaluated at the request of the treating physician, Richard Oswald, D.O., and this has been authorized by the claims adjuster for Chubb Services Corporation.

The patient is being evaluated with respect to an alleged work-related injury sustained while working for The Irvine Company on 03/10/13.

A Spanish interpreter, Lucero Herrera, was used in the face-to-face time with this patient during the course of the history and physical examination.

The following is a report of my examination, findings, diagnosis, prognosis, and treatment recommendations with respect to this injury.

This report is a separate and compensable item in addition to the Evaluation and Management Code.

CHIEF COMPLAINT

Painful right knee.

HISTORY OF PRESENT INJURY

Recvd Date: 20150630 Bill DCN: 2015182GJ000372

Consuelo Perez is a 61-year-old female who presents for evaluation of her right knee. The patient's symptoms began on 03/10/13. She stated that she has had problems with knee prior to that time, which she had not reported. There is no specific injury. She noted increasing pain as she was going downstairs, but she did not twist her ankle or foot or leg in the process of doing so. Due to increasing symptoms, she presented at our U.S.HealthWorks facility in Irvine on 04/09/13. She was evaluated by Dr. Oswald. She was diagnosed as having a sprain of the knee and pain in the patellar area. She was placed on nabumetone for an anti-inflammatory effect, tramadol for pain relief as well as was provided with a hot and a cold pack as well as a hinged knee support. She was referred for physical therapy and went through about six sessions of therapy. Her condition improved to a degree, but she has been left with residuals as she continues to have painful swelling of the knee. Pain is aggravated by weightbearing, only partially relieved by rest. It gives out on her frequently and she feels unstable. She denies prior problems similar to this in the past. She has been able to return to modified duties at work, but has not been able to return to her regular job.

OCCUPATIONAL HISTORY

The patient has been working at The Irvine Company for the past four-and-a-half years. She is an uniform attendant. She will have to deliver uniforms to employees and she will have to lift them up off the conveyor belts, which are sometimes overhead. She will have to pick up and carry laundry, so bending, lifting, stooping, pushing and pulling are involved.

ACTIVITIES OF DAILY LIVING

Per the information provided by the patient, the activities of daily living are as follows:

Patient is able to:	
Dress self including shoes	Yes
Wash and dry self	Yes
Take a bath	Yes
Get on and off the toilet	Yes
Cut food	Yes
Lift a full cup to mouth	Yes
Make a meal	Yes
Write a note	
Type a message on a computer	
Use a telephone	Yes
Work outdoors on flat ground	No
Climb up 1 flight of stairs (10 steps)	Yes
Stand	Yes
Sit	Yes
Recline	Yes
Rise from a chair	Yes
Run errands	Yes
Light housework	Yes
Feel to touch	Yes

Recvd Date: 20150630 Bill DCN: 2015182GJ000372
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Open car doors	Yes
Turn faucets on and off	Yes
Get in and out of a car	Yes
Sleep	Yes
Engage in sexual activity	Yes

MEDICAL TREATMENT TO DATE

As reported in History of Present Injury.

HISTORY OF PREVIOUS INJURIES

Similar Injuries

None.

Work Injuries

None.

PAST MEDICAL HISTORY

Medical History

The patient has a history of hypertension. There is no history of MI or CVA.

Surgical History

She has had cesarean sections, appendectomy and carpal tunnel syndrome of the right wrist, which was work-related.

Allergies

PENICILLIN.

Medications

Diovan and carvedilol for hypertension, Prilosec for stomach, and tramadol for pain relief.

SOCIAL HISTORY

Habits

Alcohol

The patient denies alcohol consumption.

Recv'd Date: 20150630 Bill DCN: 2015182GJ000372
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Tobacco
The patient denies smoking tobacco.

FAMILY HISTORY

The patient's family history is significant for mother with high blood pressure and diabetes.

REVIEW OF SYSTEMS

Constitutional

The patient denies fever, weakness, fatigue or appetite loss. There has been no significant weight loss or gain.

Skin

The patient has no skin disease or problems. There are no pigmentation changes or discoloration. There are no tumors/cancer or cysts.

Head

The patient denies frequent or severe headaches.

Eyes/Vision

The patient denies eye injury, infection or pain. The patient denies blurred, double or decreased vision, eye itching, burning or tearing and light sensitivity.

Ears, Nose, Throat, Mouth

The patient denies ear pain, infection, discharge or decreased or loss of hearing. The patient denies sinus problems, recurrent throat problems, voice change or dental disease.

Cardiovascular

Positive for hypertension. The patient denies chest pain, heart palpitations, shortness of breath, swelling of the feet or ankles or varicose veins.

Respiratory

The patient denies chronic cough, asthma, emphysema or chronic bronchitis, pneumonia, tuberculosis or coughing of blood.

Gastrointestinal

Recvd Date: 20150630 Bill DCN: 2015182GJ000372
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The patient denies frequent indigestion or reflux, nausea or vomiting, vomiting of blood, or abdominal pain. The patient denies liver disease, change in bowel habits, frequent constipation or diarrhea, blood in stools or hemorrhoids/rectal disease.

Genitourinary

The patient denies painful or difficulty urination, blood in the urine, kidney infection/stones or venereal disease.

Musculoskeletal

The patient denies musculoskeletal problems with the exception of those associated with this injury.

Neurologic

The patient denies epilepsy or convulsions. The patient denies other neurologic problems with the exception of those associated with this injury.

Psychiatric

The patient denies depression, nervousness, mood swings or sleep disturbances. The patient denies alcoholism or drug abuse treatment.

Endocrine

The patient denies increased thirst, appetite or urination. The patient denies diabetes or hair loss.

Hematologic

The patient denies bleeding gums, easy bruising or spontaneous nose bleeding. The patient denies easy bleeding or bleeding that is hard to stop.

PHYSICAL EXAMINATION

General Appearance

The patient is a well-developed, well-nourished, female appearing her stated age and in no acute distress. The patient stands 5 feet 2 inches tall and weighs 229 pounds.

Vital Signs

Blood Pressure:	182/96
Pulse:	67
Respirations:	16

Recvd Date: 20150630 Bill DCN: 2015182GJ000372
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Temperature: 98.8

Examination of the Right Knee

Visual Inspection

The patient's knee shows no erythema or ecchymosis; however, there is moderate effusion present.

Palpation

Palpation reveals pain in the infrapatellar area and also along the lateral joint line more than the medial joint line.

Range of Motion

She is able to extend her knee fully. Flexion is limited to 120 degrees, normal is 135 degrees.

Special Tests

There is no instability to varus or valgus test. Lachman's test appears to be negative at this time. McMurray test is painful. Pivot shift is also painful, but negative. She is able to walk full weightbearing with a minimal limp.

DIAGNOSTIC TESTING

MRI studies of the right knee were performed at SimonMed in Irvine on 05/14/13, and were evaluated by Dr. Sarah Kao. MRI shows a radial tear of the posterior horn of the medial meniscus with mild peripheral extrusion of the medial meniscus body. There is longitudinal, vertical, oblique tear of the posterior horn of the lateral meniscus. There is a focal full-thickness chondral defect at the central portion of the medial femoral condyle measuring 8 x 14 mm. There is moderate-to-severe chondromalacia of the patella and a large joint effusion with suggestion of a 10 mm intraarticular body posterior aspect of the joint.

DIAGNOSIS

A consultation was held with the patient in which the diagnosis was explained in layman's terms. It is my opinion that the patient suffers from:

Tear of the medial and lateral meniscus, chondromalacia and possible loose body of the right knee.

CAUSATION

Recvd Date: 20150630 Bill DCN: 2015182GJ000372

In reviewing the patient's history and examination today, it appears that the patient did sustain an injury to right knee arising out of and caused by the industrial exposure of 03/10/13.

RECOMMENDATIONS

Treatment recommendations were discussed and/or communicated with the patient's treating physician. On the basis of today's evaluation and in reviewing the patient's job responsibilities, my recommendations are as follows:

The patient is given the options of a steroid injection. She wishes more definitive type of treatment. Based upon this, I think she would be a good candidate for arthroscopic surgery for meniscectomy, chondroplasty, and debridement. Authorization for surgery will be requested. Norco will be prescribed for severe pain, which she may use at nighttime, but she should not use it when she is working or driving. She should return preoperatively in preparation for surgery.

Thank you for allowing me to participate in the care of this patient and provide you with my opinion and recommendations for continued treatment. I have outlined my treatment plan above and would ask that you review.

WORK STATUS

The patient is capable of modified duties at work, which limit standing and walking to no required kneeling or squatting and limit lifting, pushing and pulling to 10 pounds.

REVIEW OF RECORDS

No additional medical records were reviewed as a part of today's evaluation.

DISCLOSURE

The conclusions and opinions expressed in this report were dictated by me and are mine, based on my personal evaluation of the patient and any records available to me.

In compliance with Labor Code §4628(b), §4628(j), §5703(a)(2) and Regulations 9795, I declare under penalty of perjury that the information in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, I believe it to be true.

I further declare under penalty of perjury that I personally performed the evaluation on the date and at the location stated on the face sheet of this report and that, except as stated herein, the evaluation was performed under, and the time spent performing the evaluation was in compliance with, the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to §5307.6 of the California Labor Code.

RE: **PEREZ, CONSUELO**
May 16, 2013
Page 8

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code §139.3 with regard to the evaluation of this patient or the preparation of this report.

Executed at Orange County, California, on _____.

Physician Signature _____ CA Lic. #: G43382

Stephen Graham, M.D.

IUSHW:SG:TDY:oug.TVS
D: 05/17/13
T: 05/18/13
PerezC0516Graham2272

cc: Richard Oswald, D.O.

Recv'd Date: 20150630 Bill DCN: 2015182GJ000372

Stephen P. Graham M.D.
Independent Contractor for U.S. HealthWorks Medical Group

THE IRVINE CO./CORP. 164551
DOS: 5/16/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, consuelo
Case # : 32-251644 Ref # : EMR/JB

INITIAL VISIT SLIP

Patient: Consuelo Perez Age: 61 Date of Birth: 3/15/52
Address: 1919 N. Sheesy Lane #37 SS 570 85 1146
[ ] Right handed [ ] Left handed Telephone. Home: Cell:
Date of Injury: 3/10/13 Employer 4
How long have you worked for this employer? Years: 4 Months 6 Date Last Worked: today
Duty: (X) Full ( ) Modified ( ) Off Occupation: Uniforms attendet
Job Description (Brief: up and down stairs (NO acute injury)
Chief Complaint: pain to (R) knee
Cause of Injury: Lot pain ~~from~~ knee; repetitive with walking and going up and down stairs
History of Similar Injuries:
Past Work Injuries: no

Past Medical Problems Blood Pressure

Allergies: Penicillin Smoker: (N) Y Drinker: (N) Y
Past Surgeries: down carpal CTS R wrist tunnel Cx spine tonsilectomy
Medications: 2 Blood Pressure / Estrace / for Pain

REVIEW OF SYSTEMS – (Check all that apply)

☐ Headache	☐ Shortness of breath	☐ Abdominal pain
☐ Blurred vision	☐ Chest Pain	☐ Bowel irregularity
☐ Ringing in ears	☐ Heart palpitations	☐ Incontinence
☐ Sore Throat	☐ Dizziness / Fainting	☐ Frequent infection
☐ Cough	☐ Fever	☐ Joint pain/swelling
☐ Shaking/Chills	☐ Night sweats	☐ Numbness/Tingling
☐ Nervousness	☐ Psychiatric Conditions	☐ Rashes
☐ Swollen glands	☐ Fatigue	☐ Weight Loss

Patient Feels: ( ) Better ( ) Worse ( ) Same
Body Measurements:
Tests Performed:

FAMILY HISTORY – (Must be observed on all new patients)

	Father	Mother	Grandparents	Siblings
Heart Disease	☐	☐	☐	☐
High blood pressure	☐	☒	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐

PHYSICAL EXAM – (Additional pages as needed)
Height: 5'4 3/4 Weight: 229 Temp 98.8 Pulse 67 BP 182/96 Resp 16
Jaman: R ___-___-___ L ___-___-___

no injury ↑ stairs ↓
PT - some 3 mos prior some pain
work - delivers uniforms lift off conveyor still sore walk + wt bear given out
pushing duty

ACTIVITIES OF DAILY LIVING (ADL'S)

(**Patient:** Please answer each question once with an X in the appropriate column. Note that these questions should be answered as they pertain to your activities of daily living based on your current injury. If the activity does not apply to you please answer N/A)

Name: Dougvelo Perez Date: 5/16/13

Are you able to:	Yes	No	N/A	If NO please explain
1. Dress yourself including shoes	✓			
2. Wash and dry yourself	✓			
3. Take a bath	✓			
4. Get on and off the toilet	✓			
6. Cut your food	✓			
7. Lift a full cup to your mouth				
8. Make a meal	✓			
9. Write a note				
10. Type a message on a computer				
11. Use a telephone	✓			
12. Work outdoors on flat ground		✓		
13. Climb up 1 flight of stairs (10 steps)	✓			
14. Stand	✓			
15. Sit	✓			
16. Recline	✓			
17. Rise from a chair	✓			
18. Run errands	✓			
19. Light housework	✓			
20. Feel what you touch	✓			
21. Open car doors	✓			
22. Turn faucets on and off	✓			
23. Get in and out of a car	✓			
24. Sleep	✓			
25. Engage in sexual activity	✓			

(rev 1-2012)

Patient Signature: _____ Date: _____

Provider Initials _____ Date _____

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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 Perez First Consuelo DOB 3/15/52 Date of Exam: 5/16/13 Case #: 32251644

Occupation Laundry Attendent SS# 570-85-1146 Date of Injury 3/10/13 Claim # WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel: (213) 612-5400 Fax: _____

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)

see intake

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

mod eff + infra pat LJL > MJL 0.120 v/v - L -
MRI AST MRI Tear MFL
a CM

DIAGNOSES (Include ICD-9 code, if possible) tear meniscus
chondromalacia > R knee

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 norco PRN, tramadol pain
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

WRITTEN RX REQUIRED

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

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to _____ hrs/day
( ) No / (✓) Limited standing or walking to _____ hrs/day
( ) No / ( ) Limited overhead work to _____ hrs/day
( ) No / ( ) Limited stooping and bending to _____ hrs/day
(✓) No / ( ) Limited kneeling or squatting to _____ hrs/day
( ) No / ( ) Limited ☑ Lift ☐ Pull ☐ Push
Up to: ☑ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ _____ lbs
( ) No climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage ☐ Other _____
( ) Must keep _____ elevated
( ) Keep wound\bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from ( ) Keyboard / ( ) _____
( ) Other _____

☐ 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 Stephen Graham M.D. Cal. Lic # Lic G43382 Date of Exam 5/16/13
Specialty: _____ Signature _____
Executed at: USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103 Pre op

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

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U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Perez First: Consuelo Date of Exam: 5/16/13 Case #: 32251644

SS#: XXX-XX-1146 Date of Birth: 3/15/52 Date of Injury: 3/10/13 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel.: (949) 720-4055 Fax: 949 720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel.: (213) 612-5400 Fax: _____

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

- ☐ improved as expected
- ☐ worsened
- ☐ improved, but slower than expected
- ☐ reached plateau and no further improvement is expected
- ☐ work status pending PR2
- ☒ not improved significantly
- ☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

836.2 TEAR MENISCUS NEC-CURREN R
733.92 CHONDROMALACIA R

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 _____

☐ Consultation / ☒ Referral ☒ Requested / ☐ Pending. Specialty SURGERY. ☐ 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.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☒ Return to work as of (Date) 5/16/13 with the restrictions indicated below. Estimated duration of modified duty is _____ days.

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

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

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.

TREATING PROVIDER

Name GRAHAM, STEPHEN, M.D. Lic. # G43382 Date of Exam 5/16/13

Specialty _____ Signature Signature on File

Issued at: **USHW of California - Irvine, 2362 Morse Avenue, Irvine, CA 92614 Tel: (949) 863-9103**

Checkin Time 2:00 PM Checkout Time 2:40 PM

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2013/05/15 17:29 12 1 /2
CSC-DAL-CV-2013-06-11-000028

SimonMed
See tomorrow Today

FINAL

SimonMed California Irvine
DIAGNOSTIC IMAGING REPORT

Patient **Perez, Consuelo** Sex F DOB 3/15/1952 Age 61 MRN 1353345
Status Outpatient
Referring Physician Nima Allpour

Accession # 6587951 - **5/14/2013** MRI LOWER EXTREMITY JT W/O CON (Right)

CLINICAL HISTORY Knee pain

COMPARISON None available

TECHNIQUE Multiplanar multisequence MR imaging of the right knee was obtained utilizing a 1 0 T MR unit in three orthogonal imaging planes utilizing standard imaging sequences without intravenous or intra-articular administration of contrast.

FINDINGS

Radial tear at the posterior horn of the medial meniscus is noted near the posterior root ligament measuring 4 mm in AP dimension with mild peripheral extrusion of the meniscal body (series 7, image 14, series 5005, image 5) Focal longitudinal vertical oblique tear of the posterior horn of the lateral meniscus is noted violating the inferior surface (series 7, image 7)

The medial collateral ligamentous complex, lateral supporting structures cruciate ligaments and extensor mechanism are intact. Patella alta is noted

There is no evidence for recent fracture or bone contusion Subchondral bone marrow edema at the peripheral aspect of the medial femoral condyle is noted, likely reactive to the meniscal tear (series 5005, image 9)

Focal full-thickness cartilage defect is noted at the central portion of the medial femoral condyle measuring 8 x 14 mm (transverse, AP, series 5005, image 9, series 4, image 16) The lateral femorotibial articular cartilage is preserved High-grade cartilage loss involves the median ridge of the patella and paramedian aspect of the lateral patellar facet (series 4, image 8) High-grade cartilage loss involves the central aspect of the trochlea (series 7, image 12)

Large joint effusion is present There is suggestion of a 10 mm intra-articular body at the posterior aspect of the joint (series 7, image 12)

The regional muscles demonstrate normal bulk and signal There is mild diffuse soft tissue edema about the knee Small popliteal cyst is noted with mild inferior leakage of fluid

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CSC-DAL-CV-2013-06-11-000054

IMPRESSION

1 Radial tear at the posterior horn of the medial meniscus near the posterior root ligament with mild peripheral extrusion of the medial meniscal body

2 Focal longitudinal vertical oblique tear of the posterior horn of the lateral meniscus, violating the inferior surface

3 Focal full-thickness chondral defect at the central portion of the medial femoral condyle measuring 8 x 14 mm

4 Moderate to severe chondromalacia patella

5 Subchondral bone marrow edema at the peripheral aspect of the medial femoral condyle, likely reactive to the meniscal tear

6 Large joint effusion with suggestion of 10 mm intra-articular body at the posterior aspect of the joint. Recommend correlation with right knee radiographs

7 Small popliteal cyst with mild inferior leakage of fluid

Note Key images submitted

Reported by Sarah Kao
Electronically signed by Sarah Kao

CC One Call Medical

Thank you for your kind referral If you require further assistance, please contact our Radiologist Hotline at
1-855-RAD-TALK / 1-855-723-8255

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE Any person who knowingly files a statement of claim containing any misrepresentation or any false incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS A patient s signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true accurate and complete In the case of a Medicare claim the patient s signature authorizes any entity to release to Medicare medical and nonmedical information including employment status and whether the person has employer group health insurance liability no fault worker s compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made See 42 CFR 411 24(a) If item 9 is completed the patient s signature authorizes release of the information to the health plan or agency shown In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge and the patient is responsible only for the deductible coinsurance and noncovered services Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services Information on the patient s sponsor should be provided in those items captioned in Insured I e items 1a 4 6 7 9 and 11

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision except as otherwise expressly permitted by Medicare or CHAMPUS regulations

For services to be considered as 'incident' to a physician s professional service 1) they must be rendered under the physician s immediate personal supervision by his/her employee 2) they must be an integral although incidental part of a covered physician's service 3) they must be of kinds commonly furnished in physician s offices and 4) the services of nonphysicians must be included on the physician s bills

For CHAMPUS claims I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government either civilian or military (refer to 5 USC 5536) For Black Lung claims I further certify that the services performed were for a Black Lung related disorder

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424 32)

NOTICE Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE CHAMPUS FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare CHAMPUS FECA and Black Lung programs Authority to collect information is in section 205(a) 1862 1872 and 1874 of the Social Security Act as amended 42 CFR 411 24(a) and 424 5(a) (6) and 44 USC 3101 41 CFR 101 et seq and 10 USC 1079 and 1086 5 USC 8101 et seq and 30 USC 901 et seq 38 USC 613 E O 9397

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made

The information may also be given to other providers of services carriers intermediaries medical review boards health plans and other organizations or Federal agencies for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program and as otherwise necessary to administer these programs For example it may be necessary to disclose information about the benefits you have used to a hospital or doctor Additional disclosures are made through routine uses for information contained in systems of records

FOR MEDICARE CLAIMS See the notice modifying system No 09 70 0501 titled Carrier Medicare Claims Record published in the Federal Register Vol 55 No 177 page 37549 Wed Sept 12 1990, or as updated and republished

FOR OWCP CLAIMS Department of Labor Privacy Act of 1974 Republication of Notice of Systems of Records Federal Register Vol 55 No 40 Wed Feb 28 1990 See ESA 5 ESA 6 ESA 12 ESA 13 ESA 30 or as updated and republished

FOR CHAMPUS CLAIMS PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law

ROUTINE USE(S) Information from claims and related documents may be given to the Dept of Veterans Affairs the Dept of Health and Human Services and/or the Dept of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA to the Dept of Justice for representation of the Secretary of Defense in civil actions to the Internal Revenue Service private collection agencies and consumer reporting agencies in connection with recoupment claims and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains Appropriate disclosures may be made to other federal state local foreign government agencies, private business entities and individual providers of care on matters relating to entitlement claims adjudication fraud, program abuse utilization review quality assurance peer review program integrity third party liability coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS

DISCLOSURES Voluntary however failure to provide information will result in delay in payment or may result in denial of claim With the one exception discussed below there are no penalties under these programs for refusing to supply information However failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs Failure to furnish any other information such as name or claim number, would delay payment of the claim Failure to provide medical information under FECA could be deemed an obstruction

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment Section 1128B of the Social Security Act and 31 USC 3801 3812 provide penalties for withholding this information

You should be aware that P L 100 503 the Computer Matching and Privacy Protection Act of 1988 permits the government to verify information by way of computer matches

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State s Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept of Health and Human Services may request

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program with the exception of authorized deductible coinsurance co payment or similar cost sharing charge

SIGNATURE OF PHYSICIAN (OR SUPPLIER) I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction

NOTICE This is to certify that the foregoing information is true accurate and complete I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless it displays a valid OMB control number The valid OMB control number for this information collection is 0938 0999 The time required to complete this information collection is estimated to average 10 minutes per response including the time to review instructions search existing data resources gather the data needed and complete and review the information collection If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to CMS Attn PRA Reports Clearance Officer 7500 Security Boulevard Baltimore Maryland 21244 1850 This address is for comments and/or suggestions only DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS

Recvd Date: 20150630 Brf7 DCN: 2015182GJ000344

U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

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

Patient Name: Last: Perez First: Consuelo MI: DOB: 03-15-1952 Date of Service: 05-10-2013 Case #: 032251644

Occupation: Laundry Attendent SS#: 570-85-1146 Date of Injury: 03-10-2013 17:00 Claim #: WC2013419849

Employer: THE IRVINE CO./CORP. Contact: ERMA WORCESTER Tel. (949)720-4055 Fax. (949)720-3455

Claims Administrator: CHUBB SERVICES CORP. Tel. (213)612-5400 Fax.

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 ( ) Information 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 (X) 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

History Of Present Illness:

Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.

The patient reports that their condition is better - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Comments: Alittle better.Still has episodes of buckling.Finished all PT visits ,which were helpful.Has MRI scheduled for 5-14-13.Ortho.appt.for 5-16-13.Would like additional PT.REQUESTES ANOTHER KNEE SUPPORT,OLD ONE GETTING WORN AND LOOSE..

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: PAIN - RIGHT KNEE. Patient describes the symptom(s) as dull. She says it is mild and moderately severe. She reports having symptoms for 61 days. The frequency is intermittent. The symptoms are exacerbated by walking. The symptoms are lessened by rest.

Associated Symptoms: The patient denies any knee pain . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient denies pain with motion of the knee . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee . Other symptoms - buckling.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work.
She denies any lost work-time as a result of this injury. She denies any other source of employment.

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 84/min. BP: 154/88 mmHg. Temperature: 98.4 deg F Respiration: 18 per min.
Severity: The severity of the pain was 5/10.
FDLMNP: 2003.

Constitutional: The patient is a well-developed, well-nourished female.

Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities .
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is not tender on the right lateral joint line . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Prior diagnostic studies were reviewed. Comments. Alittle better.Still has episodes of buckling.Finished all PT visits ,which were helpful.Has MRI scheduled for 5-14-13.Ortho.appt.for 5-16-13.Would like additional PT.REQUESTES ANOTHER KNEE SUPPORT,OLD ONE GETTING WORN AND LOOSE..

DIAGNOSES: (Include ICD-9 code, if possible)

Sprain/Strain Knee/Leg Other Right (844.8)
Pain - Knee/Patella Right (719.46)

Differential Diagnosis / Comments: Alittle better.Still has episodes of buckling.Finished all PT visits ,which were helpful.Has MRI scheduled for 5-14-13.Ortho.appt.for 5-16-13.Would like additional PT.REQUESTES ANOTHER KNEE SUPPORT,OLD ONE GETTING WORN AND LOOSE

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	( ) Start ( ) Continue (**X**) Renew	(**2**) times / week for	(**3**) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Clinical Decision Making Comments: Awaiting MRI and Ortho.referral.

Supplies Dispensed:

Item Name	Quantity	Hcpc / Cpt
Knee-Support Clsd Patella Stabilized Reinf Lg	1	L1810

Dispensed orthotics were applied and fit ensuring patient comfort, no neurovascular compromise, with capillary refill intact. Patient verbally acknowledged their understanding of use and care of the device."

Treatment Plan Comments: New knee support applied and fitted for comfort and support.PT re-ordered.Cont.modified duty.Follow-up with ortho. on 5-16-13.

Additional Treatment: An additional course of Physical Therapy has been requested. 2 times per week; for 3 week(s). Reasons for treatment include functional strength deficits and decreased pain with treatment. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.

Consult / Referral: The MRI consult is pending . The orthopedist consult is pending .

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 05-10-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull up to 10 lbs.
Patient must wear knee support.

DISCHARGE STATUS:

( ) Released from care. Return to full duty on () with no limitations or restrictions.

( ) 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 139.3.

Signature (Original)

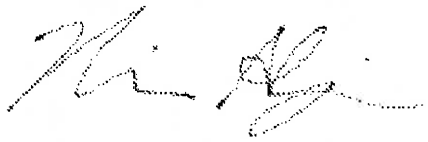
Name: **William Jason, P.A.**

Cal. Lic. #: **PA11102**

Specialty: **Occupational Medicine**

Date of Exam: **05-10-2013**

Signature (Original)



Nima Alipour D.O.

Supervising Provider

Cal. Lic. #: 20A11637

NEXT APPOINTMENT

Next Appointment with on .

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 05-10-2013 0955

Recv'd Date: 20150630 Brit DCN: 2015182GJ000344
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MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	05-10-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	WC2013419849
Chart #:	EMR/JB

Patient Status:
Since the last exam, this patient's condition has: Improved but slower than expected

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is better - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated.
Comments: Alittle better.Still has episodes of buckling.Finished all PT visits ,which were helpful.Has MRI scheduled for 5-14-13.Ortho.appt.for 5-16-13.Would like additional PT.REQUESTES ANOTHER KNEE SUPPORT,OLD ONE GETTING WORN AND LOOSE..

Knee Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: PAIN - RIGHT KNEE. Patient describes the symptom(s) as dull. She says it is mild and moderately severe. She reports having symptoms for 61 days. The frequency is intermittent. The symptoms are exacerbated by walking. The symptoms are lessened by rest.
Associated Symptoms: The patient denies any knee pain . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient denies pain with motion of the knee . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee . Other symptoms - buckling.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
Surgeries: Appendectomy 1983.

Medical History: Patient denies history of ulcers or gastritis. No history of Diabetes. Patient states no known major/recurrent illnesses/injuries.
Treatment Problems: penicillans / shortness of breath.
Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure : Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use.

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a complete review of systems obtained from the health history completed on 04-09-2013 was done and any interval changes are noted.

Current Medications at the start of Encounter:
Nabumetone 750 mg Tabs #20 . 2 everyday with food/ 2 diarias con comida, Dispense 1
Tramadol/Acet HCL 37.5/325 mg #20 . 1-2 Tablet Every Eight Hours PRN , Dispense 1 Container
Omeprazole D.R. 20mg #20 . 1 Capsule Once A day when taking etodolac for 20 Days , Dispense 1 Container
Allergies:
PENICILLINS.

Physical Examination:
Pulse: 84/min. BP: 154/88 mmHg. Temperature: 98.4 deg F Respiration: 18 per min.

On a severity scale the pain is 5 out of 10.
FDLMNP: 2003.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities .
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is not tender on the right lateral joint line . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right popliteal fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Prior diagnostic studies were reviewed.

Diagnoses
Sprain/Strain Knee/Leg Other Right (844.8)

Pain - Knee/Patella Right (719.46)

Medical Assessment: Alittle better.Still has episodes of buckling.Finished all PT visits ,which were helpful.Has MRI scheduled for 5-14-13.Ortho.appt.for 5-16-13.Would like additional PT.REQUESTES ANOTHER KNEE SUPPORT,OLD ONE GETTING WORN AND LOOSE

Treatment Plan
Last Saved By: Admin Admin 05-10-2013 10:39:04

Medications to be Continued until Next Visit:
Nabumetone 750 mg Tabs #20 2 by mouth, every day, after meals
Tramadol/Acet HCL 37.5/325 mg #20 . 1-2 Tablet Every Eight Hours not to take with tylenol, not more than 1/d
Omeprazole D.R. 20mg #20 . 1 Capsule Once A Day 20 Days
Clinical Decision Making Comments: Awaiting MRI and Ortho.referral.

Supplies:

Item Name	Quantity	Hcpc / Cpt
Knee-Support Clsd Patella Stabilized Reinf Lg	1	L1810

Dispensed orthotics were applied and fit ensuring patient comfort, no neurovascular compromise, with capillary refill intact. Patient verbally acknowledged their understanding of use and care of the device."

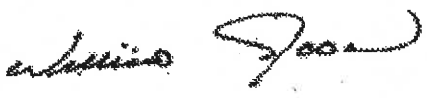
Treatment Plan Comments: New knee support applied and fitted for comfort and support.PT re-ordered.Cont.modified duty.Follow-up with ortho. on 5-16-13.

WORK STATUS:

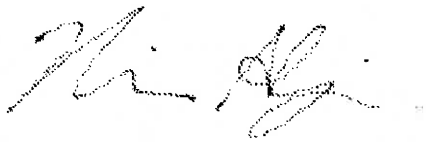
The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 05-10-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.
Work Restrictions:
Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull
up to 10 lbs.
Patient must wear knee support.

Additional Treatment: An additional course of Physical Therapy has been requested. 2 times per week; for 3 week(s). Reasons for treatment include functional strength deficits and decreased pain with treatment. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, accelerate / increase strength to 4/5 on MMT or acceptable performance on specific functional motor tests, achieve normalization of special test findings, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis, restore functional capacity to allow return to full duty.

Consult / Referral: The MRI consult is pending . The orthopedist consult is pending .



William . Jason, P.A.
This has been electronically signed on 05-10-2013



Nima Alipour D.O.
Supervising Provider

U.S. HealthWorks MEDICAL GROUP

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

THE IRVINE CO./CORP. 164551

Name (Nombre): DOS: 5/10/13 DOI: 3/10/13 DOB: 3/15/52 Date (Fecha): 5/10/13 WC

Telephone (Teléfono): Home (Ca Patient: Perez, Consuelo

Date of Injury (Fecha de Lesión): Case # : 32-251644 Ref # : EMR/JB

1. Since your last visit, are you: ☒ improved? ☐ worse? ☐ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?

2. Since your last visit, have you developed any new complaints? ☐ Yes (Si) ☒ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

If you have not improved since your last visit, or if you have developed new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

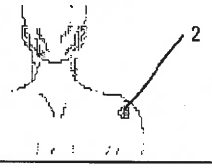
PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***

If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

SYMPTOMS (SÍNTOMAS)

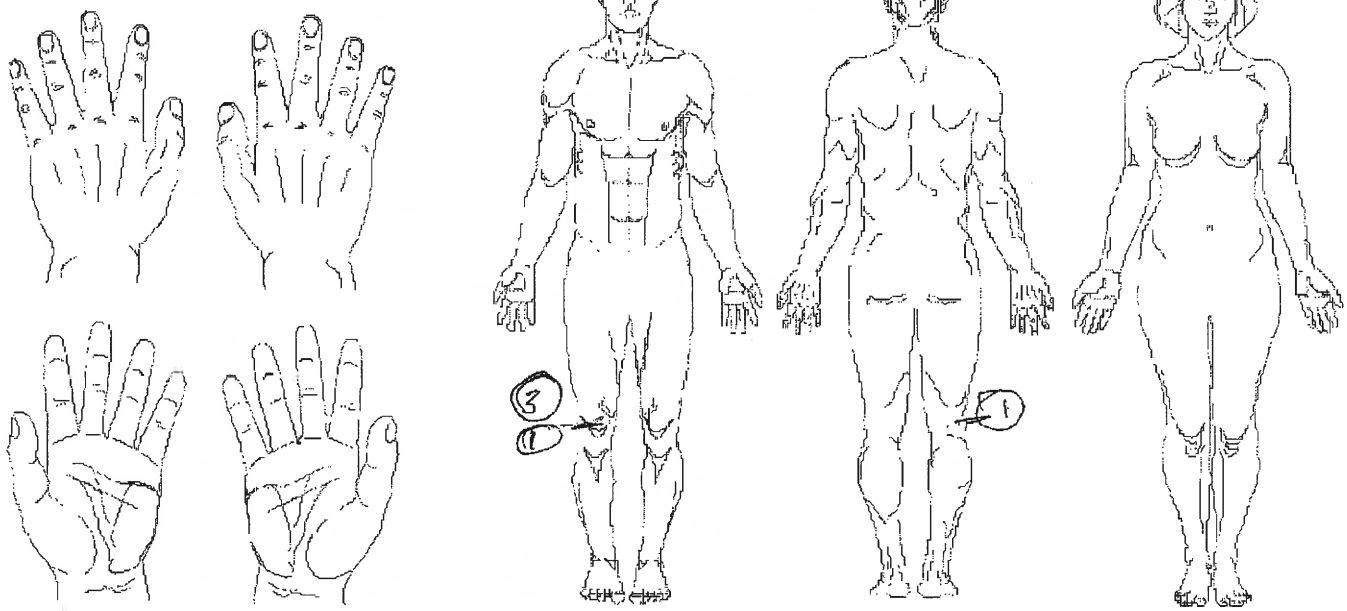
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

Example (Ejemplo)



Rate the intensity of your pain: NO PAIN / MOST PAIN
Indique la intensidad de su dolor: *SIN DOLOR* / *DOLOR INTENSO*

0 1 2 3 4 (5) 6 7 8 9 10



Patient Signature (Firma del Paciente) _____ Date (Fecha) 5/10/13

ST1011 (03/2013)

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BIL

Treatment Visit #: 5

Authorized Visit #: 6

THE IRVINE CO./CORP. 164551

DOS: 5/10/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

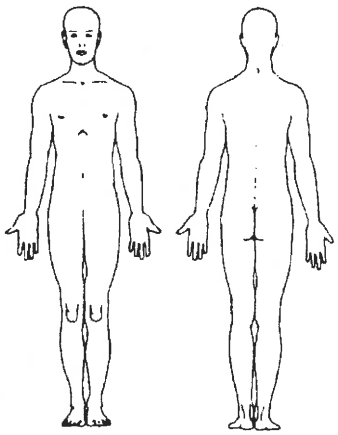
DAILY THERAPY TREATMENT NOTE

Diagnosis: (R) knee pain

Subjective: Pain level 0 1 (2) 3 4 5 6 7 8 9 10

Inj WB (R)

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☑ Electrical Stimulation: (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☑ Infrared Heat Light (R) knee
	☐ Whirlpool (3 min, °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
10	☑ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.5 w / cm² MHz to 9 sq in (area)
	☐ Iontophoresis (ml of Dexamethasone) to (area), at (milliampere-min)
	Rehabilitation:
10	☑ Myofascial Release/Soft Tissue Mobilization (R) quads
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
8	☑ Biofeedback mod to ↑ hamstring
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
27	☑ Supervised Therapeutic Exercises: (specify) Bike L15' Quads x1 Hams x1 Hip ups 4x1 Tmp Bows x3' ½ Squats x 15

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)

☐ Burn/Wound Care

☐ Other/Supplies:

☑ **Skin checked and clear following treatment**

Unigel Electrode Triode
HCPCS: A4556
Bill Code: 3186 Item# 922301

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Able to ↓ Squat.

☐ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Signature License Number

Encounter Addendum Notes Reason :Amended Referral/Consult
Modified By: Jason William 2013.05.06 07:59:06

U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

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

Patient Name: Last: Perez **First: Consuelo** **MI:** **DOB: 03-15-1952** **Date of Service: 05-03-2013** **Case #: 032251644**

Occupation: Laundry Attendent **SS#: 570-85-1146** **Date of Injury: 03-10-2013 17:00** **Claim #: WC2013419849**

Employer: THE IRVINE CO./CORP. **Contact: ERMA WORCESTER** **Tel. (949)720-4055** **Fax. (949)720-3455**

Claims Administrator: CHUBB SERVICES CORP. **Tel. (213)612-5400** **Fax.**

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 (X) Need for referral or consultation ( ) Information requested by:
( ) Change in work status ( ) Need for surgery or hospitalization ( ) Released from care (X) Request for authorization
( ) Change in treatment plan ( ) Periodic Report (45 days after last report) (X)Other: MRI and Ortho.referral.

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

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

SUBJECTIVE COMPLAINTS

History Of Present Illness:

Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is the same - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty .
Comments: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits..

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as sharp and dull. She says it is moderately severe. She reports having symptoms for buckling. The frequency is intermittent. The symptoms are exacerbated by motion. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - . The patient states there is no numbness or tingling of the knee . The patient states there is knee weakness - . The patient denies knee edema . The patient denies discoloration . The patient denies pain with motion of the knee . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee . Other symptoms - buckling.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 73/min. BP: 192/106 mmHg. Temperature: 98.4 deg F Respiration: 19 per min.
Severity: The severity of the pain was 6/10.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities .
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right patella is tender - infrapatellar. Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Neurologic: There is no asymmetry of the left quadriceps - . There is no atrophy of the left quadriceps .

Diagnostic Tests: Comments: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits..

DIAGNOSES: (Include ICD-9 code, if possible)

Pain - Knee/Patella Right (719.46)
Sprain/Strain Knee/Leg Other Right (844.8)
Blood In Stool (578.1)

Differential Diagnosis / Comments: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits.

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	( ) Start (**X**) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Medication(s) Prescribed:

Tramadol/Acet HCL 37.5/325 mg #20 . 1-2 Tablet Every Eight Hours PRN , Dispense 1 Container
Omeprazole D.R. 20mg #20 . 1 Capsule Once A day when taking etodolac for 20 Days , Dispense 1 Container

Clinical Decision Making Comments: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits..Finish PT.Minimal progress x54 days.Ortho.referal ordered.Still recommend MRI.to aid in diagnosis and treatment plan.

Treatment Plan Comments: Cont.PT.Awaiting MRI.Referral to Ortho.indicated.Rx Prilosec for blood in stools.Ultracet for pain relief.Cont.modified duty.Follow-up in 5 days.

Additional Treatment: Patient should continue Physical Therapy treatment. The patient is not responding well to Physical Therapy - .

Consult / Referral: The MRI consult is pending . The Ophthalmology consult has been cancelled 54 days,minimal progress. An orthopedist consult has been ordered 54 days,minimal progress.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 05-03-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull up to 10 lbs.
Patient must wear knee support.

DISCHARGE STATUS:

( ) Released from care. Return to full duty on () with no limitations or restrictions.

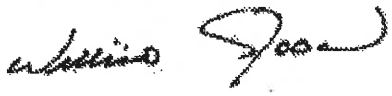
( ) Patient discharged as permanent and stationary with either impairment, work restrictions, and/or need for future medical care. A PR-4 to follow.

( ) 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 139.3.

Signature (Original)



Name: **William Jason, P.A.**

Cal. Lic. #: **PA11102**

Specialty: **Occupational Medicine**

Date of Exam: **05-03-2013**

Signature (Original)

Nima Alipour D.O.

Supervising Provider

Cal. Lic. #: 20A11637

NEXT APPOINTMENT

Next Appointment with Jason William on 05-10-2013 10:15 am.

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 05-03-2013 1013

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Encounter Addendum Notes Reason :Amended Referral/Consult
Modified By: Jason William 2013.05.06 07:59:06

MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	05-03-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	WC2013419849
Chart #:	EMR/JB

PR2 Reason: follow-up. There is a need for referral or consultation. There is a request for authorization. Other: MRI and Ortho.referral.

Patient Status:
Since the last exam, this patient's condition has: Not improved significantly

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is the same - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty .
Comments: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits..

Knee Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as sharp and dull. She says it is moderately severe. She reports having symptoms for buckling. The frequency is intermittent. The symptoms are exacerbated by motion. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - . The patient states there is no numbness or tingling of the knee . The patient states there is knee weakness - . The patient denies knee edema . The patient denies discoloration . The patient denies pain with motion of the knee . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee . Other symptoms - buckling.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
Surgeries: Appendectomy 1983.

Medical History: Patient states no known major/recurrent illnesses/injuries.
Treatment Problems: none.
Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure : Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use.

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a complete review of systems obtained from the health history completed on 04-09-2013 was done and any interval changes are noted.

Current Medications at the start of Encounter:
Nabumetone 750 mg Tabs #20 . 2 everyday with food/ 2 diarias con comida, Dispense 1
Allergies:
PENICILLINS.

Physical Examination:
Pulse: 73/min. BP: 192/106 mmHg. Temperature: 98.4 deg F Respiration: 19 per min.

On a severity scale the pain is 6 out of 10.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities .
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right patella is tender - infrapatellar. Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Neurologic: There is no asymmetry of the left quadriceps - . There is no atrophy of the left quadriceps .

Diagnoses
Pain - Knee/Patella Right (719.46)
Sprain/Strain Knee/Leg Other Right (844.8)
Blood In Stool (578.1)

Medical Assessment: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits.

Treatment Plan
Last Saved By: Admin Admin 05-03-2013 10:43:16

Prescribed Medications:
New: Tramadol/Acet HCL 37.5/325 mg #20 . 1-2 Tablet Every Eight Hours PRN , Dispense 1 Container
Omeprazole D.R. 20mg #20 . 1 Capsule Once A day when taking etodolac for 20 Days , Dispense 1 Container

Medications to be Continued until Next Visit:
Clinical Decision Making Comments: Pain continues to the right knee.Awaiting MRI approval.Noticed blood in stools twice this week.Denies abdominal pain.The knee has buckled 3-4 x this week.PT 4/6 visits..Finish PT.Minimal progress x54 days.Ortho.referal ordered.Still recommend MRI.to aid in diagnosis and treatment plan.

Treatment Plan Comments: Cont.PT.Awaiting MRI.Referral to Ortho.indicated.Rx Prilosec for blood in stools.Ultracet for pain relief.Cont.modified duty.Follow-up in 5 days.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 05-03-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.
Work Restrictions:
Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull
up to 10 lbs.
Patient must wear knee support.

Additional Treatment: Patient should continue Physical Therapy treatment. The patient is not responding well to Physical Therapy - .

Consult / Referral: The MRI consult is pending . The Ophthalmology consult has been cancelled 54 days,minimal progress. An orthopedist consult has been ordered 54 days,minimal progress.

The interpreter used was Yeli. Bahaena.

William . Jason, P.A.

This has been electronically signed on 05-06-2013

Nima Alipour D.O.
Supervising Provider

Next Appointment with Jason William on 05-10-2013 10:15 am.

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U.S. HealthWorks MEDICAL GROUP

THE IRVINE CO./CORP. 164551

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

WC

Name (Nombre): DOS: 5/03/13 DOI: 3/10/13 DOB: 3/15/52 Date (Fecha): 5/3/13

Telephone (Teléf Patient: Perez, Consuelo

Date of Injury (Fe Case # : 32-251644 Ref # : EMR/JB

1. Since your last visit, are you: ☐ improved? ☐ worse? ☒ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?

2. Since your last visit, have you developed any new complaints? ☒ Yes (*Si*) ☐ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

If you have not improved since your last visit, or if you have developed new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

lose my power

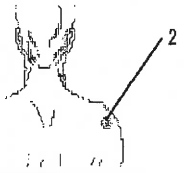
PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***

If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

SYMPTOMS (SÍNTOMAS)

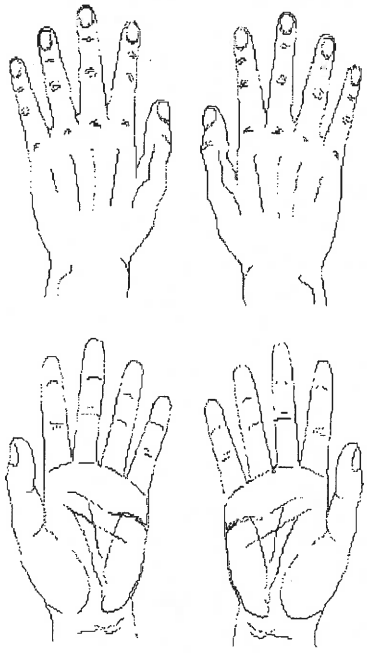
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

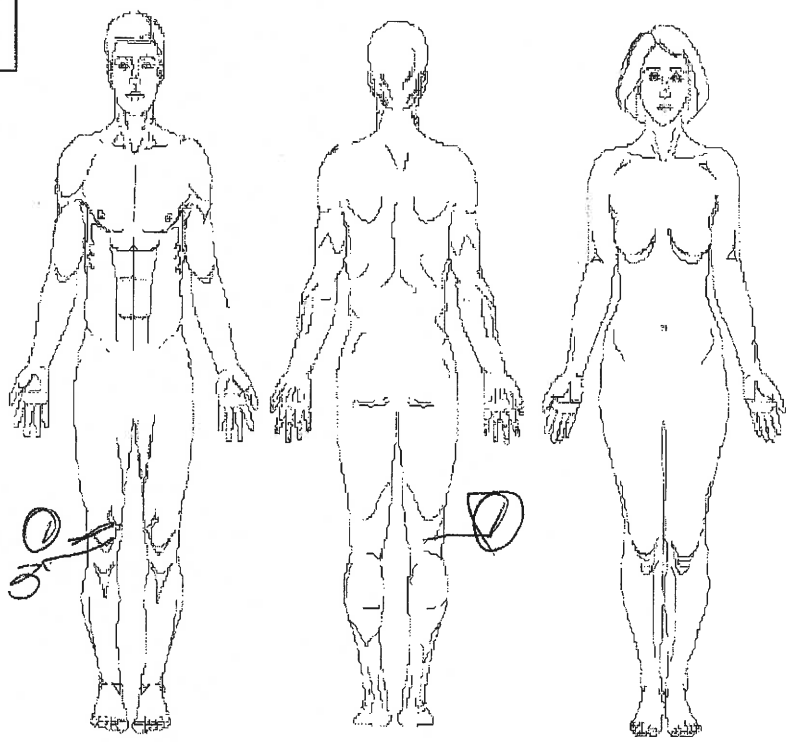
Example (Ejemplo)



Rate the intensity of your pain: NO PAIN *SIN DOLOR* — MOST PAIN *DOLOR INTENSO*

0 1 2 3 4 5 (6) 7 8 9 10





Patient Signature (*Firma del Paciente*) _____ Date (*Fecha*) 5/3/13

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IRVINE COMPANY
Since 1864

Workers' Compensation Medical Authorization Form

Date: *(this date only)* 4/9/13

Employee's Name: Consuelo Perez

Supervisor's Name: Blanca Romo

Division: Pelican Hill Resort / Laundry
(Property or Department Name)

Please provide the above mentioned Employee medical treatment as allowed by California Workers' Compensation law. All work related injury/illness medical treatments will be reimbursed by our insurance carrier:

Federal Insurance Company
P. O. Box 30570
Los Angeles CA 90030

Should you not be affiliated with **Federal Insurance Company** Workers' Compensation program, please accept this letter as authorization for industry standard Workers' Compensation medical treatments and billing procedures.

WC 7173-71-80 Irvine Company
Policy Year: 10/01/11 thru 09/30/2012

Please contact me with any questions at (949) 720-4055, fax (949) 720-3455.

Sincerely,

Erma Worcester
Sr. Workers Compensation Administrator

This form goes to the clinic with the employee

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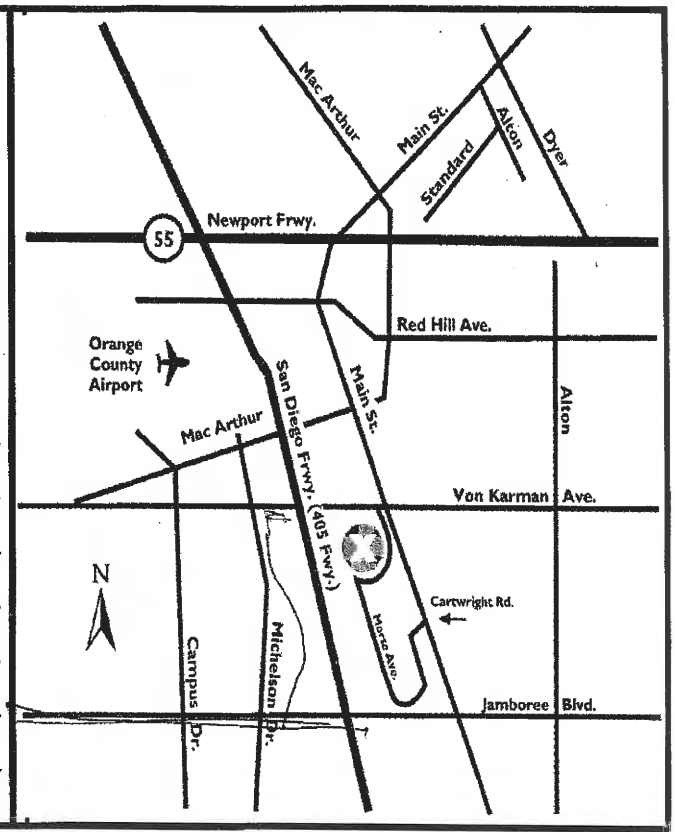
TREATMENT AUTHORIZATION

U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

We are authorizing the below listed U.S. HealthWorks location to provide services to our employees:

2362 Morse Ave
Irvine, CA 92614
PH: (949) 863-9103
FX: (949) 863-1337
Open 24 hours a day, 7 days a week!



Pelican Hill Resort #164551
EMPLOYER NAME EMPLOYER #

PRIMARY CONTACT NAME
22701 Pelican Hill Rd. S.
ADDRESS LINE 1

ADDRESS LINE 2
Newport Beach CA
CITY STATE ZIP

949-467-6838
PH PH (after HRs/Cell)

FAX

EMAIL

EMPLOYEE DETAILS

DATE: 4-9-13 TIME: 1030 AM OR (PM)

PATIENT NAME: Consuelo Perez DEPARTMENT: Laundry - Uniforms

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ☐ YES ☒ NO NAME OF TEMP AGENCY:

AUTHORIZED BY: NAME (PRINT): Patrick Brass PHONE: 949-467-6838 (24hrs)

TITLE: Security AFTER HRS / CELL PH:

SIGNATURE: Patrick Brass ( ) VERBAL

INSURANCE

INSURANCE COMPANY NAME:

CLAIMS ADDRESS:

PHONE#: EFFECTIVE DATE:

POLICY #: EXPIRATION DATE:

SERVICES

☒ INJURY: DATE OF INJURY: 3/10/13 LAST WORKED: 4/9/13

INJURED BODY PART: left knee CLAIM #:

O RETURN-TO-WORK EVALUATION

O PHYSICAL EXAM TYPE: PROTOCOL #:

O DRUG/ALCOHOL TEST. SPECIFY TYPE AND REASON/PURPOSE BELOW PROTOCOL #

TYPE:

☐ INSTANT DRUG TEST
☐ NON-DOT DRUG TEST
☐ DOT DRUG TEST
☐ NON-DOT BREATH ALCOHOL TEST
☐ DOT BREATH ALCOHOL TEST

(CIRCLE BRANCH: FMCSA FAA FTA FRA PHMSA USCG)

REASON/PURPOSE:

☐ POST-OFFER
☐ POST-ACCIDENT
☐ RETURN TO DUTY
☐ REASONABLE SUSPICION
☐ RANDOM
☐ POST-INJURY

NOTE: PICTURE ID REQUIRED FOR DRUG TESTING

Thank you for choosing U.S. HealthWorks Medical Group!

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U.S. HealthWorks MEDICAL GROUP

BIL

eatment Visit #: 4

Authorized Visit #: 6

THE IRVINE CO./CORP. 164551

DOS: 5/03/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

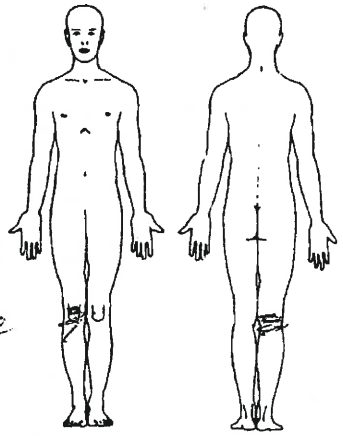
AILY THERAPY TREATMENT NOTE

Diagnosis: (R) knee sprain, patellar (R)

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee symptoms remain mod → high, esp pm/day & end range of ↓ ↑.

Objective: (i.e. **ROM, MMT, Posture, Girth, Color**)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat Light & Left Joules to (R) knee
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.0 w/cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization (R) knee/quads
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
	☐ Biofeedback
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x 8', Quad sets, ham digs, ~~Add~~ x15, knee ✓ ↑ x10.

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet

☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)

☐ Burn/Wound Care

☐ Other/Supplies:

☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Able to bike 8 mins & mod (R) knee ↑.

☒ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary

☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Steve Honda, PTA

License Number AT6225

Signature _____ License Number _____

U.S. HealthWorks MEDICAL GROUP

Treatment Visit #: 3
Authorized Visit #: 6

THE IRVINE CO./CORP. 164551
DOS: 5/01/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

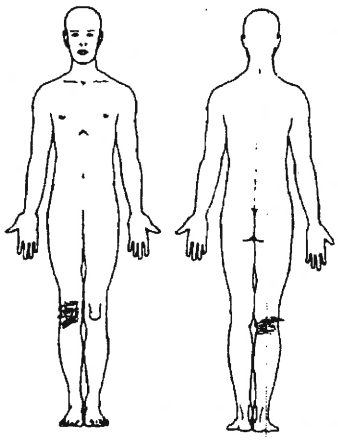
THERAPY TREATMENT NOTE

Diagnosis: (R) knee sprain patellar (R).

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

(R) knee (P) & stiffness persists esp ~~2~~ extended wt bearing during workday.

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to (R) knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat to (R) knee @ 6.0 Joules
	☐ Whirlpool (____ min, ____ °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ 1.0 w / cm² 1 MHz to (R) knee (area)
	☐ Iontophoresis (____ ml of Dexamethasone) to ____ (area), at ____ (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization (R) knee/patellar tendon
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct
8	☒ Biofeedback to (R) VMO to facil. better recruitment
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
10	☒ Supervised Therapeutic Exercises: (specify) Bike x 7', Quad sets x 15, bridges & Add x 10, knee ext x 10.

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☒ Other/Supplies: Unigel Electrode Triode HCPCS: A4556 Bill Code: 3186 Item# 922301
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)
Able to perform Bike & Bridges c mod (R) knee (P) & fatigue/weakness.
☒ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / re-evaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Steve Honda, PTA
License Number AT6225

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Provider

Treating Name: **BONNIE P.T. KATAYAMA** License #:
Practice Name: **USHW of California - Irvine** Tax ID: **954643269** NABP #:

Practice Address: **IRVINE MEDICAL CENTER** City: **Irvine** State: **CA** ZIP: **92614** Practice NPI: **1316927338**
Billing Name: **U.S. HEALTHWORKS MEDICAL GROUP, PC**
Billing Address: **P.O. BOX 50042** City: **LOS ANGELES** State: **CA** ZIP: **90074** Billing NPI: **1316927338**

Patient

Name: **Perez, Consuelo** DOB: **03/15/1952** Sex: **F** Phone:
Address: **1919 N. Sherry Ln Apt 37** City: **Santa Ana** State: **CA** ZIP: **92705**
SSN: Country:
Marital Status: Payee: **NO** Control#: **032251644**

Claim

Number: **WP75908Y4AY** DOI: **03/10/13** Client ID:
Insured's Name: **THE IRVINE CO./CORP.**

Bill

Admit Date: / / Service Start: / / Service End: / /
FS/UL Allowance: **$0.00** Discharge Status: DRG Code:
Provider Billed: **$83.01** Provider Billed Date: **05/09/13** Bill Type: **000**
Foreign Bill Control #: **032251644** DCN: **13129006004210758979**
Reprice State:

Prescribing/Referring Doctor

Name: DEA #:
Address: City: State: ZIP:

Diagnosis Code

Primary: **8448** 2: 3: 4: 5:
6 : 7: 8: 9: 10:
Adm. Diag Code:

Procedure Codes - Dates

Principal: - / / Second: - / / Third: - / /
Fourth: - / / Fifth: - / / Sixth: - / /

General Fields

General 1:
General 2:
General 3:
General 4:

Comments

Line#	Type	Code	Rev. Code	POS	TOS	Service Start	Actual Charge	DXR Nbr.	Mod	Units	FS/UC Allowance	HCPCS/ Rates
1	P	97250				05/01/13	$44.28			1	$0.00	
2	P	97110				05/01/13	$24.90			1	$0.00	
3	P	97014				05/01/13	$9.22			1	$0.00	
4	P	97026				05/01/13	$4.61			1	$0.00	

U.S. HealthWorks MEDICAL GROUP

Treatment Visit #: 2
Authorized Visit #: 6

THE IRVINE CO./CORP. 164551

DOS: 4/29/13 DOI: 3/10/13 DOB: 3/15/52 **DAILY THERAPY TREATMENT NOTE**

Patient: Perez, Consuelo

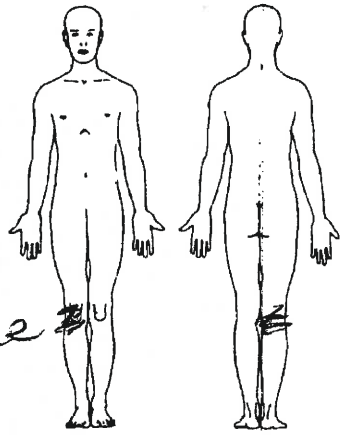
Case # : 32-251644 Ref # : EMR/JB

Diagnosis: ® knee sprain

Subjective: Pain level 0 1 2 3 4 5 6 7 8 9 10

® lat & post knee repain mod → high ® level c wt. bearing or walking uneven surfaces.

Objective: (i.e. ROM, MMT, Posture, Girth, Color)



Time	Modalities:
	☐ Vaso-comp/Edema Control:
15	☒ Electrical Stimulation: TENS to ® knee
	☐ Hot Pack or Cold Pack or Ice Massage (circle) to
8	☒ Infrared Heat Light @ 6.0 J cm² to ® knee
	☐ Whirlpool (min, °F) to
	☐ Paraffin Bath
	☐ Mechanical Traction
	☐ Other
8	☒ Ultrasound/Phonophoresis - Cont. or Pulsed 50 % @ .80 w / cm² 1 MHz to ® knee (area)
	☐ Iontophoresis (ml of Dexamethasone) to (area), at (milliampere-min)
	Rehabilitation:
10	☒ Myofascial Release/Soft Tissue Mobilization ® Quads / knee.
	☐ Joint Mobs/Manual Traction:
	☐ Orthotic/Splinting Training/Taping
	☐ FAs/ADLs/KAs/Ind. Instruct.
8	☒ Biofeedback to ® VMO to facilitate recruitment
	☐ Neuromuscular Reeducation
	☐ Gait Training/Assistive Device Training
15	☒ Supervised Therapeutic Exercises: (specify) Bike x 5', Quad sets x 10 biceps curl x 10, knee ext, HEP

☐ Established/Reviewed/Progressed Home Program ☐ See Exercise Flow Sheet (in chart) ☐ See Handout/Booklet
☐ TENS Issue & Instruction ☐ NCV Testing ☐ FCE/Return to Work PAT ☐ PePAT/PPE (see report)
☐ Burn/Wound Care
☒ Other/Supplies: Unigel Electrode Triode HCPCS: A4556 Bill Code: 3186 Item# 922301
☒ **Skin checked and clear following treatment**

Assessment: ☐ Improved functional capacity (specify below) ☐ Improving with limitations (specify below)

Unable to perform SLR 2° acute ® knee pain. able to ride bike 5 min with minimal discomfort / limitations

☒ Treatment Plan Reviewed by Supervising Therapist

Plan: ☐ progress therapeutic treatment program (specify below) ☐ perform PPE / reevaluation / D/C summary
☐ D/C from therapy: Has met goals / has reached plateau / is non compliant

Steve Honda, PTA
License Number AT6225

U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

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

Patient Name: Last: Perez **First: Consuelo** **MI:** **DOB: 03-15-1952** **Date of Service: 04-26-2013** **Case #: 032251644**

Occupation: Laundry Attendent **SS#: 570-85-1146** **Date of Injury: 03-10-2013 17:00** **Claim #: WC2013419849**

Employer: THE IRVINE CO./CORP. **Contact: ERMA WORCESTER** **Tel. (949)720-4055** **Fax. (949)720-3455**

Claims Administrator: CHUBB SERVICES CORP. **Tel. (213)612-5400** **Fax.**

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

(X) Change in patient's condition (X) Need for referral or consultation ( ) Information requested by:
( ) Change in work status ( ) Need for surgery or hospitalization ( ) Released from care (X) Request for authorization
( ) Change in treatment plan ( ) Periodic Report (45 days after last report) (X)Other: MRI request

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

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

Comments: increased pain

SUBJECTIVE COMPLAINTS

History Of Present Illness:

Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.

The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed. Patient is currently on modified duty .

Comments: First PT was yesterday.Feels worse today.Feels like joint opens up when walking..

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 47 days. The frequency is constant. The symptoms are exacerbated by motion. The symptoms are lessened by rest.

Associated Symptoms: The patient also complains of knee pain - . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient states there is edema of the knee - . The patient denies discoloration . The patient complains of pain with knee motion - . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,

She denies any lost work-time as a result of this injury. She denies any other source of employment.

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 88/min. BP: 163/74 mmHg. Temperature: 98.7 deg F Respiration: 18 per min.

Severity: The severity of the pain was 7/10.

Constitutional: The patient appears obese - .

Psychiatric: Mood and affect appear appropriate .

Respiratory: There are no apparent signs of respiratory distress .

Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Following conditions of the right knee are present: swelling - at quadriceps insertion. Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, masses, deformities and open wounds - .

Musculoskeletal: The patient has an abnormal gait - .

Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Flexion: 135/135 deg . Extension: 0/0 deg . External Rotation L `10/10 deg Internal rotation L 10/10 deg The right knee is not tender on the right medial joint line . The right knee is tender on the right lateral joint line - . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Limitations to the tested range of motion of the right knee were as listed below: Flexion: 110/135 deg. Extension: 0/0 deg. R 10/10 deg, R 10/10 deg.

Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.

Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Prior diagnostic studies were reviewed. Comments: First PT was yesterday.Feels worse today.Feels like joint opens up when walking..

DIAGNOSES: (Include ICD-9 code, if possible)

Sprain/Strain Knee/Leg Other Right (844.8)

Differential Diagnosis / Comments: First PT was yesterday.Feels worse today.Feels like joint opens up when walking.Moderate tenderness noted.

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	( ) Start (**X**) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Medication(s) Prescribed:

Nabumetone 750 mg Tabs #20 . 2 everyday with food/ 2 diarias con comida, Dispense 1

Clinical Decision Making Comments: Continue with PT.Refill rx'd Relafen.MRI of rt.knee ordered.

Treatment Plan Comments: Rx'd Relafen.Cont PT.Cont.modified duty.Follow-up in 1 week.

Additional Treatment: Patient should continue Physical Therapy treatment. The patient is not responding well to Physical Therapy - .

Consult / Referral: MRI consult has been ordered right knee."worse" x47 days from injury.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-26-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull up to 10 lbs.
Patient must wear knee support.

DISCHARGE STATUS:

( ) Released from care. Return to full duty on () with no limitations or restrictions.

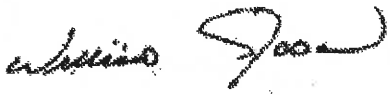
( ) Patient discharged as permanent and stationary with either impairment, work restrictions, and/or need for future medical care. A PR-4 to follow.

( ) 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 139.3.

Signature (Original)



Name: **William Jason, P.A.**

Cal. Lic. #: **PA11102**

Specialty: **Occupational Medicine**

Date of Exam: **04-26-2013**

Signature (Original)

Richard Oswald D.O.

Supervising Provider

Cal. Lic. #: 20A4382

NEXT APPOINTMENT

Next Appointment with Oswald Richard on 05-03-2013 10:00 am.

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 04-26-2013 0930

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MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	04-26-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	WC2013419849
Chart #:	EMR/JB

PR2 Reason: follow-up. The patient has had a change in condition. There is a need for referral or consultation. There is a request for authorization. Other: MRI request

Patient Status:
Since the last exam, this patient's condition has: Worsened Comments:- increased pain

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed. Patient is currently on modified duty .
Comments: First PT was yesterday.Feels worse today.Feels like joint opens up when walking..
Knee Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 47 days. The frequency is constant. The symptoms are exacerbated by motion. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient states there is edema of the knee - . The patient denies discoloration . The patient complains of pain with knee motion - . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
Surgeries: Appendectomy 1983.

Medical History: Patient denies history of ulcers or gastritis. No history of Diabetes. Patient states no known major/recurrent illnesses/injuries.

Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure : Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use.

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a complete review of systems obtained from the health history completed on 04-09-2013 was done and any interval changes are noted.

Current Medications at the start of Encounter:
Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle
Allergies:
PENICILLINS.

Physical Examination:
Pulse: 88/min. BP: 163/74 mmHg. Temperature: 98.7 deg F Respiration: 18 per min.

On a severity scale the pain is 7 out of 10.

Constitutional: The patient appears obese - .
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Following conditions of the right knee are present: swelling - at quadriceps insertion. Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, masses, deformities and open wounds - .
Musculoskeletal: The patient has an abnormal gait - .
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Flexion: 135/135 deg . Extension: 0/0 deg . External Rotation L `10/10 deg Internal rotation L 10/10 deg The right knee is not tender on the right medial joint line . The right knee is tender on the right lateral joint line - . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Limitations to the tested range of motion of the right knee were as listed below: Flexion: 110/135 deg. Extension: 0/0 deg. R 10/10 deg, R 10/10 deg.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Prior diagnostic studies were reviewed.

Diagnoses
Sprain/Strain Knee/Leg Other Right (844.8)

Medical Assessment: First PT was yesterday.Feels worse today.Feels like joint opens up when walking.Moderate tenderness noted.

Treatment Plan
Last Saved By: Admin Admin 04-26-2013 10:07:49

Prescribed Medications:
New: Nabumetone 750 mg Tabs #20 . 2 everyday with food/ 2 diarias con comida, Dispense 1

Medications Completed or Stopped:
Tramadol/Acet HCL 37.5/325 mg #20 . (04-26-2013)
Medications to be Continued until Next Visit:
Clinical Decision Making Comments: Continue with PT.Refill rx'd Relafen.MRI of rt.knee ordered.

Treatment Plan Comments: Rx'd Relafen.Cont PT.Cont.modified duty.Follow-up in 1 week.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-26-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.
Work Restrictions:
Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull
up to 10 lbs.
Patient must wear knee support.

Additional Treatment: Patient should continue Physical Therapy treatment. The patient is not responding well to Physical Therapy - .

Consult / Referral: MRI consult has been ordered right knee."worse" x47 days from injury.

The interpreter used was Mary Soto.

William . Jason, P.A.
This has been electronically signed on 04-26-2013

Richard Oswald D.O.
Supervising Provider

Next Appointment with Oswald Richard on 05-03-2013 10:00 am.

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U.S. HealthWorks

THE IRVINE CO./CORP. 164551

DOS: 4/26/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

WC

Seguro Social): 570-85-1146 Date (Fecha): 4/26/13

Celular): 714-865-1827

Compañía):

1. Since your last visit, are you: ☐ improved? ☐ worse? ☒ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?

2. Since your last visit, have you developed any new complaints? ☑ Yes (Si) ☐ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

If you have not improved since your last visit, or if you have developed new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

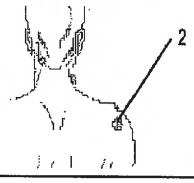
PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***

If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

SYMPTOMS (SÍNTOMAS)

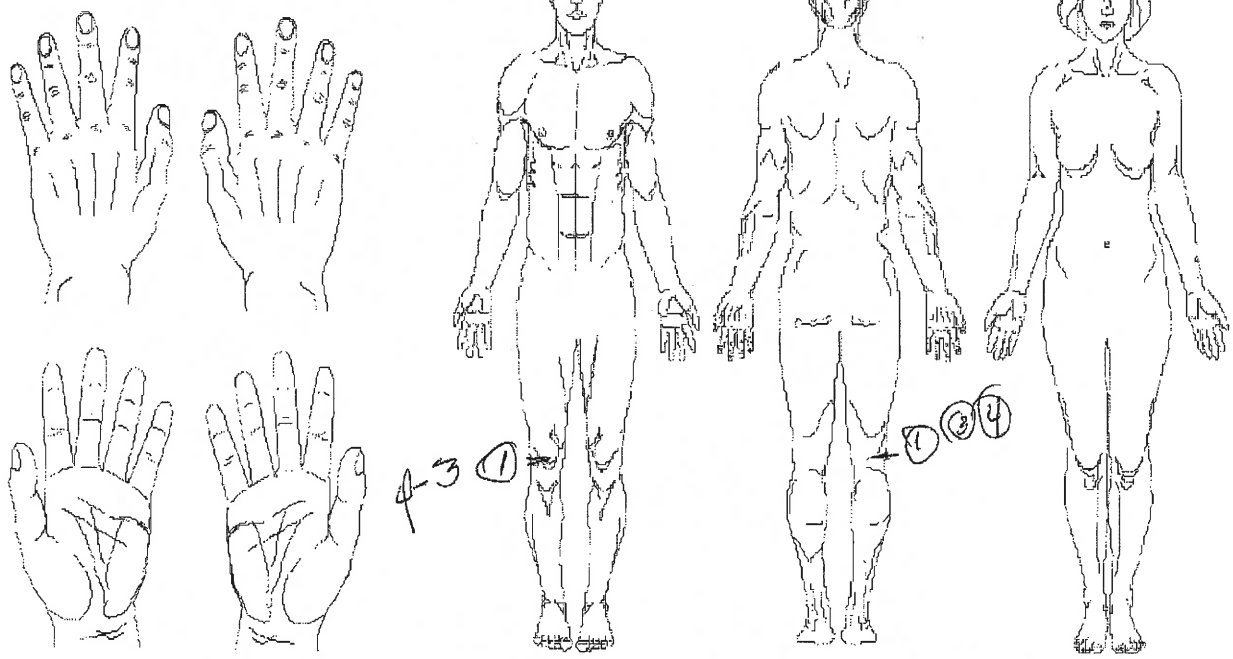
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

Example (Ejemplo)



Rate the intensity of your pain: NO PAIN — MOST PAIN
Indique la intensidad de su dolor: *SIN DOLOR* — *DOLOR INTENSO*

0 1 2 3 4 5 6 (7) 8 9 10



Patient Signature *(Firma del Paciente)* Consuelo Perez Date *(Fecha)* 4/26/13

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IRVINE COMPANY

Since 1864

Workers' Compensation Medical Authorization Form

Date: *(this date only)* 4/9/13

Employee's Name: Consuelo Perez

Supervisor's Name: Blanca Romo

Division: Pelican Hill Resort / Laundry
(Property or Department Name)

Please provide the above mentioned Employee medical treatment as allowed by California Workers' Compensation law. All work related injury/illness medical treatments will be reimbursed by our insurance carrier:

Federal Insurance Company
P. O. Box 30570
Los Angeles CA 90030

Should you not be affiliated with **Federal Insurance Company** Workers' Compensation program, please accept this letter as authorization for industry standard Workers' Compensation medical treatments and billing procedures.

WC 7173-71-80 Irvine Company
Policy Year: 10/01/11 thru 09/30/2012

Please contact me with any questions at (949) 720-4055, fax (949) 720-3455.

Sincerely,

Erma Worcester
Sr. Workers Compensation Administrator

This form goes to the clinic with the employee

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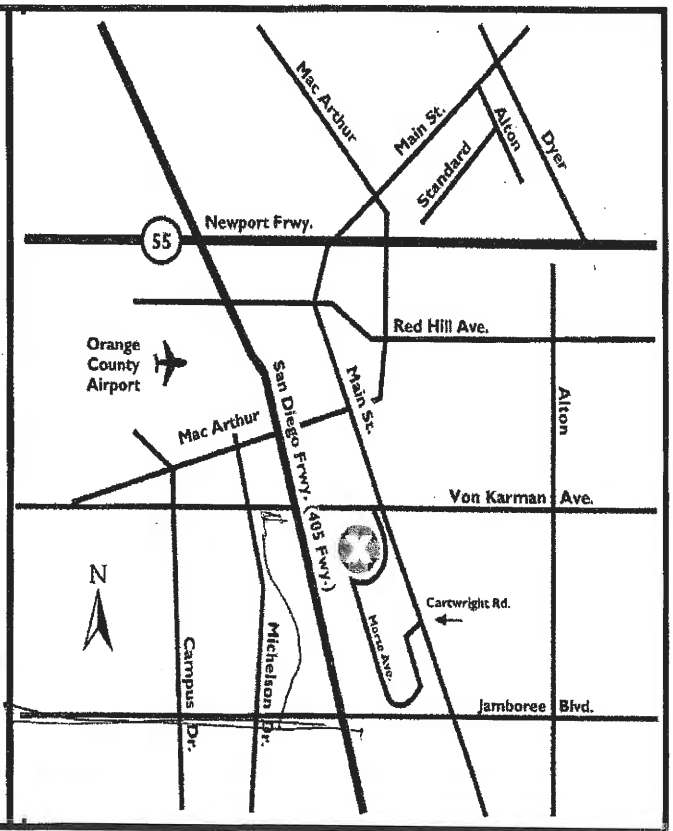
TREATMENT AUTHORIZATION

U.S. HealthWorks™ MEDICAL GROUP
The Right Care, Right Away

We are authorizing the below listed U.S. HealthWorks location to provide services to our employees:

2362 Morse Ave
Irvine, CA 92614
PH: (949) 863-9103
FX: (949) 863-1337
Open 24 hours a day, 7 days a week!



Pelican Hill Resort #164551
EMPLOYER NAME / EMPLOYER #

PRIMARY CONTACT NAME 22701 Pelican Hill Rd S.
ADDRESS LINE 1

ADDRESS LINE 2 Newport Beach CA
CITY 949-467-6838 STATE ZIP

PH / PH (after HRs/Cell)

FAX

EMAIL

EMPLOYEE DETAILS

DATE: 4-9-13 TIME: 1030 AM OR (PM)

PATIENT NAME: Consuelo Perez DEPARTMENT: Laundry - Uniforms

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ☐ YES ☒ NO NAME OF TEMP AGENCY:

AUTHORIZED BY: NAME (PRINT): Patrick Brass PHONE: 949-467-6838 (24hrs)

TITLE: Security AFTER HRS / CELL PH:

SIGNATURE: Patrick Brass ( ) VERBAL

INSURANCE

INSURANCE COMPANY NAME:

CLAIMS ADDRESS:

PHONE#: EFFECTIVE DATE:

POLICY #: EXPIRATION DATE:

SERVICES

☒ INJURY: DATE OF INJURY: 3/10/13 LAST WORKED: 4/9/13

INJURED BODY PART: left knee CLAIM #:

O RETURN-TO-WORK EVALUATION

O PHYSICAL EXAM TYPE: PROTOCOL #:

O DRUG/ALCOHOL TEST. SPECIFY TYPE AND REASON/PURPOSE BELOW PROTOCOL #

TYPE:

- ☐ INSTANT DRUG TEST
- ☐ NON-DOT DRUG TEST
- ☐ DOT DRUG TEST
- ☐ NON-DOT BREATH ALCOHOL TEST
- ☐ DOT BREATH ALCOHOL TEST

(CIRCLE BRANCH: FMCSA FAA FTA FRA PHMSA USCG)

REASON/PURPOSE:

- ☐ POST-OFFER
- ☐ POST-ACCIDENT
- ☐ RETURN TO DUTY
- ☐ REASONABLE SUSPICION
- ☐ RANDOM
- ☐ POST-INJURY

NOTE: PICTURE ID REQUIRED FOR DRUG TESTING

Thank you for choosing U.S. HealthWorks Medical Group!

U.S. HealthWorks MEDICAL GROUP

REHABILITATION
Page 3

EVALUATION / RE EVALUATION

THE IRVINE CO./CORP. 164551

Name: _____ DOS: 4/25/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

SUBJECTIVE: _____ Case # : 32-251644 Ref # : EMR/JB

Sx DI

ASSESSMENT: 1. Antalgic gait (R) knee (L).
2. ↓ ROM (R) knee
3. ↓ (R) LE strength
4. ? Inflammation (R) knee
5. Decreased gait E ↓ LOS (L)
6. s/p TKR

GOALS

STG	LTG		TIME FRAME
☐	☑	Increase strength (R) LE to 5/5	2-4 wks
☐	☐	Increase AROM (R) knee	1-3
☐	☑	Restore prior function, including Sports & activity	4
☑	☑	Independent with strengthening home exercise program for continued carryover of functional gains made during skilled therapy.	1-4
☐	☐	Pt able to lift ____ # floor to knuckle and ____ # knuckle to shoulder to	
☑	☐	Open to ½	1-3
☐	☐	# ROM & activity	1-3 wks
☑	☐	↓ inflammation / effusion	1-3 wks

Frequency: 3 Estimated Length of Treatment: 4

Therapy assessment, goals and treatment plan have been discussed with patient and patient is in agreement. ☑ Yes ☐ No

- ☑ Strengthening
- ☑ Stretching
- ☑ Stabilization
- ☑ A/AA/PROM
- ☑ Neuromuscular re-ed
- ☐ Gait training
- ☐ Aquatics
- ☐ ADL training
- ☐ Paraffin
- ☐ Post Injury PAT
- ☐ Postural education/exercise
- ☑ Body mechanics/Joint protection training
- ☑ Joint mobilizations
- ☑ Soft tissue mobilization
- ☑ Home exercise program
- ☐ Tape/brace support
- ☐ Symptom management
- ☐ Work conditioning
- ☐ Splinting/Orthotic training
- ☐ Balance/Proprioceptive training
- ☑ Heat
- ☑ Ice
- ☐ Traction
- ☑ US/Phono
- ☐ Iontophoresis
- ☑ E-Stim
- ☑ SEMG Biofeedback
- ☐ Whirlpool
- ☐ TENS issue & instruction
- ☐ VASO-Compression
- ☑ Patient Education
- ☑ Continue with therapy

☐ Recommend Discharge
☑ Reusable Electrodes dispensed
☐ Other/Supplies Dispensed: _____

HCPCS: A9273
CHT100NK
BLUE VINYL COLPAC, NECK C
*ONTOUR, 23"

HCPCS: A4556
NPP40222B
BODYMED SELF-ADHERING ELE
*CTRODES, FABRIC BACK, REU

☐ Follow up with Physician
☐ Iontophoresis Electrod...

Today's Treatment:
Time: Drill

____ ☐ Patient education regarding nature of their injury.
10 ☑ Home exercises as per handouts/log.
____ ☐ Supine knee ext / 1 x10
____ ☐ Adduction DF / PF x10
Ankle circles x10
Bridges x5

10 ☐ Supine ...
____ ☐ Prone / prone ...
____ ☐ _____
5 ☑ Supine (L) quads (R) knee
10 / LOS (L) SLR and (R) knee
15 / ES to (R) knee

HCPCS: E0190
DMI158
BLUE ORTHO BED WEDGE, 8" X 20" X 24"

☑ Treatment Plan Discussed/Reviewed with PTA

Signature: _____

Lic #: _____

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U.S. HealthWorks MEDICAL GROUP

EVALUATION / RE-

THE IRVINE CO./CORP. 164551
DOS: 4/25/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB -

Name: _____

		AROM		PROM		STRENGTH	
LEVEL	MOTION	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
L1/2/3	Hip Flex. (0-120)	100	100			4	4-
L5/S1-2	Hip Ext. (0-30)	0	0			4	4
L4/5-S1	Hip Abd. (0-45)	45	45			4	4
L4/5-S1	Hip Add. (0-30)	0	0			4	4
L4/5-S1	Hip Int. Rot. (0-45)	-	-			-	-
L3/4/5-S1	Hip Ext. Rot. (0-45)	-	-			-	-
L2/3/4	Knee Ext. (0)	0	3c		10	4	3+
L5/S1/S2	Knee Flex (0-135)	120	120		100	4	3+
L4/5	Ankle DF (0-20)	5	5			5	5
S1/2	Ankle PL (0-50)	45	45			5	5
L5/S1	Ankle Ev. (0-15)	5	5			5	5
L5	Ankle Inv. (0-35)	35	35			5	5
L4/5/S1	EHL					5	
	Abdominals						

Gait: Normal/Antalgic R L Uses (R)

Posture: Standing: Slow (R) Knee Flex (R) Sitting: _____

Neurological:
Sensation: Intact
Reflexes: _____
Patellar (L4) (L) 1+ (R) NT
Achilles (S1) (L) 1+ (R) 1+
Babinski/Clonus (C7) (L) C (R) C
Dural Signs: C
Other: _____

Lumbar Spine Active Range of Motion	
Flexion	100%
Extension	
L Side Flexion	
R Side Flexion	
L Rotation	
R Rotation	↓

Special Tests:

	(R)	(L)
MCL	2+	2+
LCL	1+	1+
ACL	1+	1+

Palpation/Structural Alignment/Atrophy/Edema:
Tenderness c patellar mvt
↓ patellar mobility
2+ effusion (R) knee
Heat felt in (R) knee

Functional Mobility:
Sit to Stand: Able
Heel/Toe Walk: unable/unable
Squat: able 1/4
Balance: NT.

Other: _____

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U.S. HealthWorks MEDICAL GROUP

BIL

REHABILITATION EVALUATION

THE IRVINE CO./CORP. 164551
DOS: 4/25/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Date of Surgery: _____ Next MD visit: _____
Referred by: OSMed.
Diagnosis: Strain @ knee 844.8
ICD 9#: Pituitary gland 719.46

Injury Mechanism: Pt reports lifting stairs repetitively causing Rt knee (P).

P.M.H./Past Surgeries: No surgeries @ knee bilat
heart C, HTN @, CAC, DM2

Medications: unknown meds for HTN, tramadol, ibuprofen
Allergies: penicillin
Diagnostic Tests: X-rays?
Previous TX: knee brace,
Social/Leisure Activities:

Occupation/Work Status: Laundry attendant
Work Requirements: standing, walking, stairs
Symptoms-C/O: Pain surrounding Rt patella and posterior knee (P). Pt also reports pain is "inside."

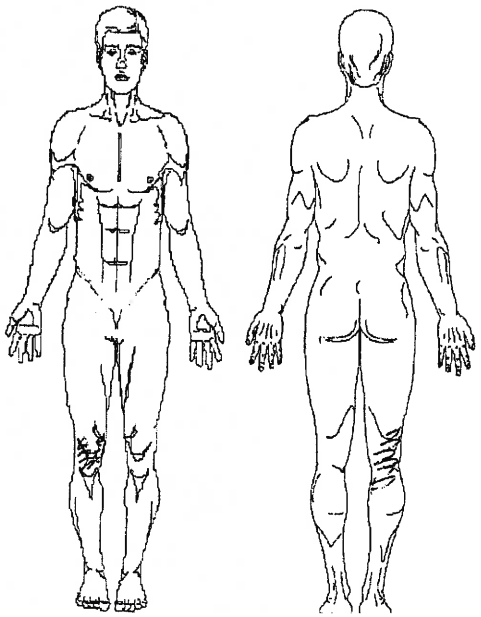
Increase Symptoms: WB, change of position
Decrease Symptoms: NWB

Pain: Current: 8/10 Worst: 9/10 Best: 7/10
✓ same ___ better ___ worse

24 hour pain cycle:
am: noon: pm: night time:

Other/Special Questions: Able to sleep sx

Patient Goals: Less pain in @ knee



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U.S. HealthWorks MEDICAL GROUP

BIL

REHABILITATION EVALUATION

THE IRVINE CO./CORP. 164551
DOS: 4/25/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Date of Surgery: _____ Next MD visit: _____
Referred by: Ortho.
Diagnosis: Strain (R) knee 844.8
ICD 9#: patellar pain 719.46

Injury Mechanism: Pt reports climbing stairs repetitively causing pain (R) knee (R).

P.M.H./Past Surgeries: No previous (R) knee injury
heart C, HTN (R), CAC, Brace

Medications: unknown meds for HTN, tramadol, naproxen
Allergies: penicillin
Diagnostic Tests: X-rays?
Previous TX: knee brace,
Social/Leisure Activities:

Occupation/Work Status: Laundry attendant
Work Requirements: standing, walking, stairs
Symptoms-C/O: Pain surrounding the patella and posterior knee (R). Pt also reports pain is "inside."

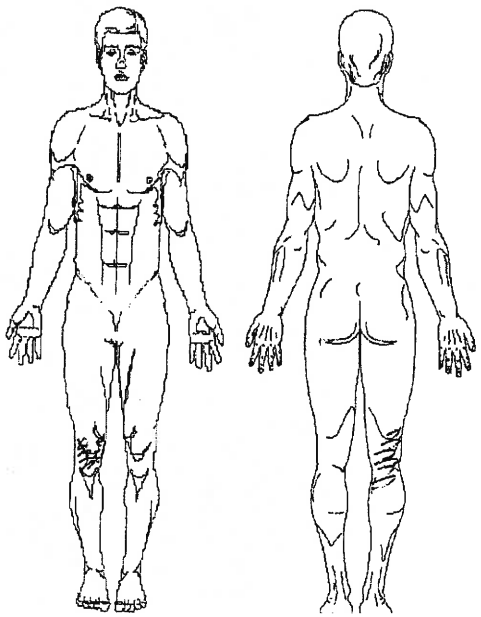
Increase Symptoms: WB, change of position
Decrease Symptoms: NWB

Pain: Current: 8/10 Worst: 9/10 Best: 7/10
✓ same ___ better ___ worse

24 hour pain cycle:
am: noon: pm: night time:

Other/Special Questions: Able to sleep at

Patient Goals: Pain in (R) knee



U.S. HealthWorks MEDICAL GROUP

EVALUATION / RE-

THE IRVINE CO./CORP. 164551
DOS: 4/25/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Name: _____

		AROM		PROM		STRENGTH	
LEVEL	MOTION	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT
L1/2/3	Hip Flex. (0-120)	120	120			4	4
L5/S1-2	Hip Ext. (0-30)	0	0			4	4
L4/5-S1	Hip Abd. (0-45)	45	45			4	4
L4/5-S1	Hip Add. (0-30)	0	0			4	4
L4/5-S1	Hip Int. Rot. (0-45)	-	-			-	-
L3/4/5-S1	Hip Ext. Rot. (0-45)	-	-			-	-
L2/3/4	Knee Ext. (0)	0	30		10	4	3+
L5/S1/S2	Knee Flex (0-135)	120	90		100	4	3+
L4/5	Ankle DF (0-20)	5	5			5	5
S1/2	Ankle PL (0-50)	45	45			5	5
L5/S1	Ankle Ev. (0-15)	5	5			5	5
L5	Ankle Inv. (0-35)	35	35			5	5
L4/5/S1	EHL					5	
	Abdominals					3	

Gait: Normal/Antalgic R L Uses (R)

Posture: Standing: Genu Valgum (B) Knee (R) J

Sitting: _____

Neurological:

Sensation: Intact

Reflexes: _____

Patellar (L4) (L) 1+ (R) NT

Achilles (S1) (L) 1+ (R) 1+

Babinski/Clonus (C7) (L) C (R) C

Dural Signs: C

Other: _____

Lumbar Spine Active Range of Motion	
Flexion	100%
Extension	
L Side Flexion	
R Side Flexion	
L Rotation	
R Rotation	

Special Tests:

	(R)	(L)
MCL	2+	2+
LCL	1+	1+
ACL	1+	1+

Palpation/Structural Alignment/Atrophy/Edema:

Tenderness to patellar mob
↓ patellar mobility.
2+ effusion @ knee
Heat felt in (R) knee

Functional Mobility:

Sit to Stand: Able

Heel/Toe Walk: unable / unable

Squat: able 1/4

Balance: NT.

Other: _____

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U.S. HealthWorks MEDICAL GROUP

EVALUATION / RE EVALUATION

THE IRVINE CO./CORP. 164551

Name: _____ DOS: 4/25/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

SUBJECTIVE: _____ Case # : 32-251644 Ref # : EMR/JB

Sx DI

ASSESSMENT: 1. Mild sx gr. tendonitis (R) knee (P).
2. sx (R) knee
3. ↓ (R) LE strength
4. ↑ inflammation (R) knee
5. antalgic gait ↓ LE (R)
6. w/ HEP

GOALS

STG	LTG		TIME FRAME
☐	☑	Increase strength (R) LE to 5/5	2-4 wks
☐	☑	Increase AROM (R) knee	1-3
☐	☑	Restore prior function, including ADLs + functional activities	4
☐	☑	Independent with strengthening home exercise program for continued carryover of functional gains made during skilled therapy.	1-4
☐	☐	Pt able to lift ____ # floor to knuckle and ____ # knuckle to shoulder to _____	
☐	☐	Open to ½	1-3
☐	☐	↑ ROM & strength	1-3
☐	☐	↓ inflammation / effusion	1-3

Frequency: 3 Estimated Length of Treatment: 4

Therapy assessment, goals and treatment plan have been discussed with patient and patient is in agreement. ☑ Yes ☐ No

- ☑ Strengthening
- ☑ Stretching
- ☑ Stabilization
- ☑ A/AA/PROM
- ☑ Neuromuscular re-ed
- ☐ Gait training
- ☐ Aquatics
- ☐ ADL training
- ☐ Paraffin
- ☐ Post Injury PAT
- ☐ Postural education/exercise
- ☑ Body mechanics/Joint protection training
- ☑ Joint mobilizations
- ☑ Soft tissue mobilization
- ☑ Home exercise program
- ☐ Tape/brace support
- ☐ Symptom management
- ☐ Work conditioning
- ☐ Splinting/Orthotic training
- ☐ Balance/Proprioceptive training
- ☑ Heat
- ☑ Ice
- ☐ Traction
- ☑ US/Phono
- ☐ Iontophoresis
- ☑ E-Stim
- ☐ SEMG Biofeedback
- ☐ Whirlpool
- ☐ TENS issue & instruction
- ☐ VASO-Compression
- ☑ Patient Education
- ☑ Continue with therapy

☐ Recommend Discharge
☑ Reusable Electrodes dispensed
☐ Other/Supplies Dispensed: _____

HCPCS: A9273
CHT100NK
BLUE VINYL COLPAC, NECK C
ONTOUR, 23"

☐ Follow up with Physician
☐ Iontophoresis Electrod...

HCPCS: A4556
NPP40222B
BODYMED SELF-ADHERING ELE
CTRODES, FABRIC BACK, REU

Today's Treatment:
Time: Drill

____ ☐ Patient education regarding nature of their injury.
10 ☑ Home exercises as per handouts/log.
____ ☐ Supine knee ext 1 x10
____ ☐ Add'n ADD/PF x10
Add'n clamshells x10
Bridges x10

10 ☑ Stretches
____ ☐ Physical Modal...
____ ☐ _____
5 ☑ Light (C) Lyn (R) knee
10 / LAQ C. SAQ (and (R) knee
15 / E15 to (R) knee

HCPCS: E0190
DMI158
BLUE ORTHO BED WEDGE, 8" X 20" X 24"

☑ Treatment Plan Discussed/Reviewed with PTA
Signature: _____

Lic #: _____

CA4104 (REV. 8/09)

Recvd Date: 20150630 Bin: DCN: 2015182GJ000343

U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

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

Patient Name: Last: Perez	First: Consuelo	MI:	DOB: 03-15-1952	Date of Service: 04-19-2013	Case #: 032251644
Occupation: Laundry Attendent	SS#: 570-85-1146		Date of Injury: 03-10-2013 17:00	Claim #: WC2013419849	
Employer: THE IRVINE CO./CORP.	Contact: ERMA WORCESTER		Tel. (949)720-4055	Fax. (949)720-3455	
Claims Administrator: CHUBB SERVICES CORP.			Tel. (213)612-5400	Fax.	

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 ( ) Information 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

History Of Present Illness:

Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.

The patient reports that their condition is better - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty .

Comments: Alittle better.Ran out of medication.Still awaiting PT approval.Hinged knee brace is concomfortable to sides of knee..

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain - rt.knee. Patient describes the symptom(s) as dull. She reports having symptoms for 40 days. The frequency is intermittent. The symptoms are exacerbated by walking/motion. The symptoms are lessened by rest.

Associated Symptoms: The patient denies any knee pain . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient complains of pain with knee motion - . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work.
She denies any lost work-time as a result of this injury. She denies any other source of employment.

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 70/min. BP: 173/83 mmHg. Temperature: 98.8 deg F Respiration: 17 per min.
Severity: The severity of the pain was 6/10.

Constitutional: The patient appears obese - .

Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .

Musculoskeletal:

Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.

Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is not tender on the right lateral joint line . The right patella does not have subluxation . The right patella is not tender . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.

Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.

Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Prior diagnostic studies were reviewed. Comments: Alittle better.Ran out of medication.Still awaiting PT approval.Hinged knee brace is concomfortable to sides of knee..

DIAGNOSES: (Include ICD-9 code, if possible)

Sprain/Strain Knee/Leg Other Right (844.8)

Differential Diagnosis / Comments: Alittle better.Ran out of medication.Still awaiting PT approval.Hinged knee brace is concomfortable to sides of knee.Tenderness to medial joint line.

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel (X) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Medication(s) Prescribed:

Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle
Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet at bedtime PRN severe pain, Dispense 1 Container

Clinical Decision Making Comments: Continue with conservative care.Awaiting PT approval.

Supplies Dispensed:

Item Name	Quantity	Hcpc / Cpt
Knee-Support Clsd Patella Stabilized Reinf Xlg	1	L1810

Dispensed orthotics were applied and fit ensuring patient comfort, no neurovascular compromise, with capillary refill

Recvd Date: 20150630 Bill DCN: 2015182GJ000343

intact. Patient verbally acknowledged their understanding of use and care of the device."

Treatment Plan Comments: Stabilizer knee support applied and fitted for comfort.RX Relafen for pain and inflamation.Rx Ultracet for moderate pain.Cont.modified duty.Follow-up in 1 week.

Additional Treatment: The patient has not started Physical Therapy.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-19-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.

Limited standing or walking

No kneeling or squatting.

Limited Lift, Limited Push and Limited Pull up to 10 lbs.

Patient must wear knee support.

DISCHARGE STATUS:

( ) Released from care. Return to full duty on () with no limitations or restrictions.

( ) 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 139.3.

Signature (Original)

Name: **William Jason, P.A.**

Cal. Lic. #: **PA11102**

Specialty: **Occupational Medicine**

Date of Exam: **04-19-2013**

Signature (Original)

Alan Nayes M.D.

Supervising Provider

Cal. Lic. #: C41136

NEXT APPOINTMENT

Next Appointment with Oswald Richard on 04-26-2013 10:00 am.

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 04-19-2013 0945

Recvd Date: 20150630 Bill DCN: 2015182GJ000343
D:\Documents\Electronic Templates\Originals\2015\Bill 182GJ000343-Original.rtf

MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	04-19-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	WC2013419849
Chart #:	EMR/JB

Patient Status:
Since the last exam, this patient's condition has:

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is better - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty .
Comments: Alittle better.Ran out of medication.Still awaiting PT approval.Hinged knee brace is concomfortable to sides of knee..

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain - rt.knee. Patient describes the symptom(s) as dull. She reports having symptoms for 40 days. The frequency is intermittent. The symptoms are exacerbated by walking/motion. The symptoms are lessened by rest.

Associated Symptoms: The patient denies any knee pain . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient complains of pain with knee motion - . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
Surgeries: Appendectomy 1983.

Medical History: Patient denies history of ulcers or gastritis. No history of Diabetes. Patient states no known major/recurrent illnesses/injuries.
Treatment Problems: none.
Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure : Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use.

Review Of Systems:

A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a complete review of systems obtained from the health history completed on 04-09-2013 was done and any interval changes are noted.

Current Medications at the start of Encounter:
Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion. Dispense 1 Bottle
Tramadol HCL 50mg Tabs #20 . 1-2 every 4 hours as needed for pain/ 1 o 2 cada 4 horas mientras sea necesario para el dolor. Dispense 1
Allergies:
PENICILLINS.

Physical Examination:
Pulse: 70/min. BP: 173/83 mmHg. Temperature: 98.8 deg F Respiration: 17 per min.

On a severity scale the pain is 6 out of 10.

Constitutional: The patient appears obese - .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Musculoskeletal:
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is not tender on the right lateral joint line . The right patella does not have subluxation . The right patella is not tender . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Prior diagnostic studies were reviewed.

Diagnoses
Sprain/Strain Knee/Leg Other Right (844.8)

Medical Assessment: Alittle better.Ran out of medication.Still awaiting PT approval.Hinged knee brace is

concomfortable to sides of knee.Tenderness to medial joint line.

Treatment Plan
Last Saved By: Admin Admin 04-19-2013 10:08:53

Prescribed Medications:
New: Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle
Tramadol/Acet HCL 37.5/325 mg #20 . 1 Tablet at bedtime PRN severe pain, Dispense 1 Container

Medications to be Continued until Next Visit:
Clinical Decision Making Comments: Continue with conservative care.Awaiting PT approval.

Supplies:

Item Name	Quantity	Hcpc / Cpt
Knee-Support Clsd Patella Stabilized Reinf Xlg	1	L1810

Dispensed orthotics were applied and fit ensuring patient comfort, no neurovascular compromise, with capillary refill intact. Patient verbally acknowledged their understanding of use and care of the device."

Treatment Plan Comments: Stabilizer knee support applied and fitted for comfort.RX Relafen for pain and inflamation.Rx Ultracet for moderate pain.Cont.modified duty.Follow-up in 1 week.

WORK STATUS:
The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-19-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.
Work Restrictions:
Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
Limited Lift, Limited Push and Limited Pull
up to 10 lbs.
Patient must wear knee support.

Additional Treatment: The patient has not started Physical Therapy.

William . Jason, P.A.
This has been electronically signed on 04-19-2013

Alan Nayes M.D.
Supervising Provider

Next Appointment with Oswald Richard on 04-26-2013 10:00 am.

Recvd Date: 20150630 Bill DCN: 2015182GJ000343

U.S. HealthWorks
THE IRVINE CO./CORP.

164551

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

DOS: 4/19/13 DOI: 3/10/13 DOB: 3/15/52
Patient: Perez, Consuelo
Case # : 32-251644 Ref # : EMR/JB

Seguro Social): 570-85-1146 Date (Fecha): 4/19/13 WC
Celular): 714-865-1227
Compañía):

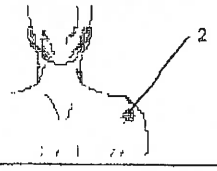
1. Since your last visit, are you: ☑ improved? ☐ worse? ☐ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?
2. Since your last visit, have you developed any new complaints? ☐ Yes (Si) ☑ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

If you have not improved since your last visit, or if you have developec new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

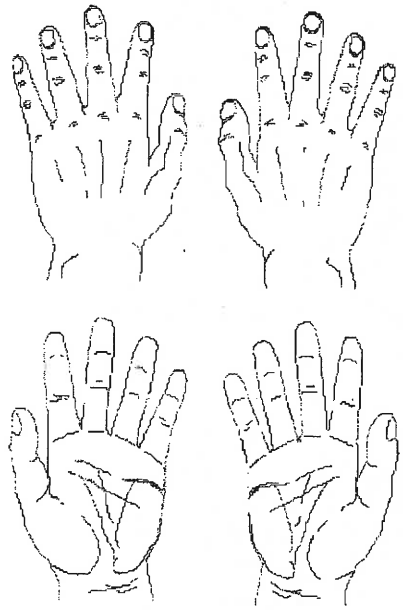
PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

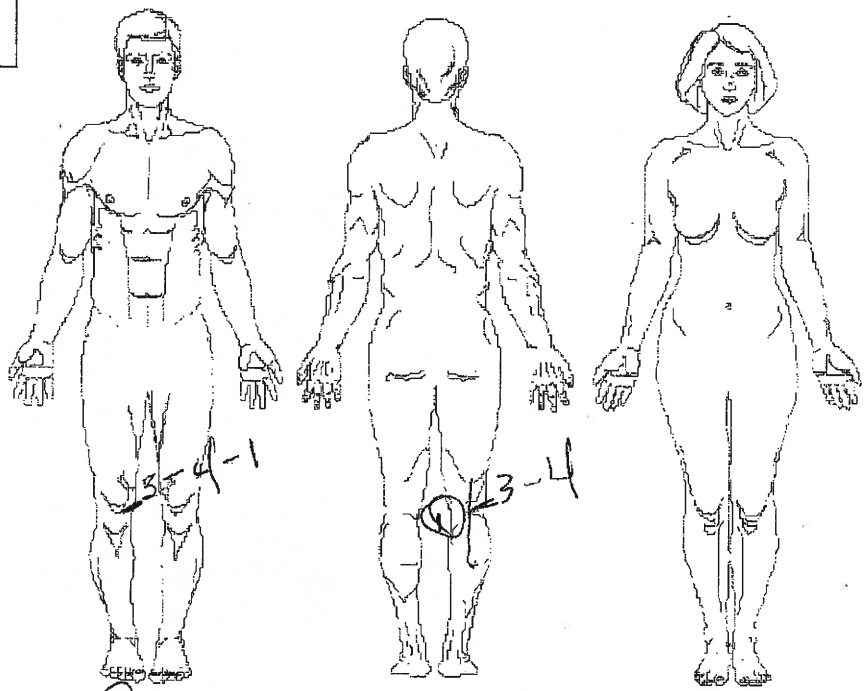
SYMPTOMS (SÍNTOMAS)
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

Example (Ejemplo)



Rate the intensity of your pain: / Indique la intensidad de su dolor:
NO PAIN *SIN DOLOR* — MOST PAIN *DOLOR INTENSO*
0 1 2 3 4 5 6 7 8 9 10





Patient Signature *(Firma del Paciente)* Consuelo Perez Date *(Fecha)* 4/19/13

ST1011 (11/2009)

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2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103

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

Patient Name: Last: Perez **First: Consuelo** **MI:** **DOB: 03-15-1952** **Date of Service: 04-12-2013** **Case #: 032251644**

Occupation: Laundry Attendent **SS#: 570-85-1146** **Date of Injury: 03-10-2013 17:00** **Claim #:**

Employer: THE IRVINE CO./CORP. **Contact: ERMA WORCESTER** **Tel. (949)720-4055** **Fax. (949)720-3455**

Claims Administrator: CHUBB SERVICES CORP. **Tel. (213)612-5400** **Fax.**

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 ( ) Information 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 (X) not improved significantly
( ) worsened ( ) reached plateau and no further improvement is expected ( ) been determined to be non-work related

SUBJECTIVE COMPLAINTS

History Of Present Illness:

Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is the same - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty .
Comments: I still have the pain I havent started the thrapy.

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 33. The frequency is intermittent. The symptoms are exacerbated by standing. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient denies pain with motion of the knee . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 63/min. BP: 134/72 mmHg. Temperature: 9835 deg F Respiration: 16 per min.
Severity: The severity of the pain was 8/10.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .

Skin: Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .

Musculoskeletal: The patient has an abnormal gait - . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.

Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is tender on the right lateral joint line - . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.

Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.

Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the right quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests: Comments: I still have the pain I havent started the thrapy.

DIAGNOSES: (Include ICD-9 code, if possible)

Pain - Knee/Patella Right (719.46)
Sprain/Strain Knee/Leg Other Right (844.8)

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	(**X**) Start ( ) Continue ( ) Renew	(**3**) times / week for	(**2**) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Supplies Dispensed:

Item Name	Quantity	Hcpc / Cpt
Heat-Moist Heat Pad - Custom Touch 14"X14"	1	E0215

Treatment Plan Comments: Pain level the same Has to star5t pt

Additional Treatment: Patient is referred to Physical Therapy for evaluation and treatment. 3 times per week; for 2 week(s). Reasons for treatment include decreased pain with treatment. Goals for treatment include restore functional capacity to allow return to full duty.

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-12-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.

Limited standing or walking

No kneeling or squatting.

hinged knee support.

DISCHARGE STATUS:

( ) Released from care. Return to full duty on () with no limitations or restrictions.

( ) 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 139.3.

Signature (Original)

Name: **Richard Oswald, D.O.**

Cal. Lic. #: **20A4382**

Specialty: **Occupational Medicine**

Date of Exam: **04-12-2013**

NEXT APPOINTMENT

Next Appointment with 00 Injury-Private-Physicals, Division on 04-19-2013 10:00 am.

Executed at: **US HealthWorks 2362 Morse Avenue, Irvine CA 92614 Ph:949 863-9103**

Check In Time: 04-12-2013 11:00

MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	04-12-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	
Chart #:	EMR/JB

Patient Status:
Since the last exam, this patient's condition has: Not improved significantly

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 03-10-2013 17:00.
The patient reports that their condition is the same - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty .
Comments: I still have the pain I havent started the thrapy.
Knee Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: pain - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 33. The frequency is intermittent. The symptoms are exacerbated by standing. The symptoms are lessened by rest.
Associated Symptoms: The patient also complains of knee pain - . The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient denies pain with motion of the knee . The patient states there is no foot and ankle pain . The patient states there is no restriction to knee motion . The patient denies any locking or clicking of the affected knee .

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment.
Surgeries: Appendectomy 1983.

Medical History: Patient denies history of ulcers or gastritis. No history of Diabetes. Patient states no known major/recurrent illnesses/injuries.

Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure : Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use.

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a

complete review of systems obtained from the health history completed on 04-09-2013 was done and any interval changes are noted.

Current Medications at the start of Encounter:
Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle
Tramadol HCL 50mg Tabs #20 . 1-2 every 4 hours as needed for pain/ 1 o 2 cada 4 horas mientras sea necesario para el dolor, Dispense 1
Allergies:
PENICILLINS.

Physical Examination:
Pulse: 63/min. BP: 134/72 mmHg. Temperature: 9835 deg F Respiration: 16 per min.

On a severity scale the pain is 8 out of 10.

Constitutional: The patient is a well-developed, well-nourished female.
Psychiatric: Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Musculoskeletal: The patient has an abnormal gait - . Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is tender on the right lateral joint line - . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Exam of the following RLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the right knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the right quadriceps . There is no atrophy of the right quadriceps .

Diagnoses
Pain - Knee/Patella Right (719.46)
Sprain/Strain Knee/Leg Other Right (844.8)

Treatment Plan
Last Saved By: Admin Admin 04-12-2013 11:41:56

Medications to be Continued until Next Visit:

Supplies:

Item Name	Quantity	Hcpc / Cpt
Heat-Moist Heat Pad - Custom Touch 14"X14"	1	E0215

Treatment Plan Comments: Pain level the same Has to star5t pt

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-12-2013. Expected Maximum Medical Improvement (MMI) date 04-26-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.
hinged knee support.

Additional Treatment: Patient is referred to Physical Therapy for evaluation and treatment. 3 times per week; for 2 week(s). Reasons for treatment include decreased pain with treatment. Goals for treatment include restore functional capacity to allow return to full duty.

RH Oswald, DO

Richard . Oswald, D.O.

This has been electronically signed on 04-12-2013

Next Appointment with 00 Injury-Private-Physicals, Division on 04-19-2013 10:00 am.

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IRVINE COMPANY

Since 1864

Workers' Compensation Medical Authorization Form

Date: *(this date only)* 4/9/13

Employee's Name: Consuelo Perez

Supervisor's Name: Blanca Romo

Division: Pelican Hill Resort / Laundry
(Property or Department Name)

Please provide the above mentioned Employee medical treatment as allowed by California Workers' Compensation law. All work related injury/illness medical treatments will be reimbursed by our insurance carrier:

Federal Insurance Company
P. O. Box 30570
Los Angeles CA 90030

Should you not be affiliated with **Federal Insurance Company** Workers' Compensation program, please accept this letter as authorization for industry standard Workers' Compensation medical treatments and billing procedures.

WC 7173-71-80 Irvine Company
Policy Year: 10/01/11 thru 09/30/2012

Please contact me with any questions at (949) 720-4055, fax (949) 720-3455.

Sincerely,

Erma Worcester
Sr. Workers Compensation Administrator

This form goes to the clinic with the employee

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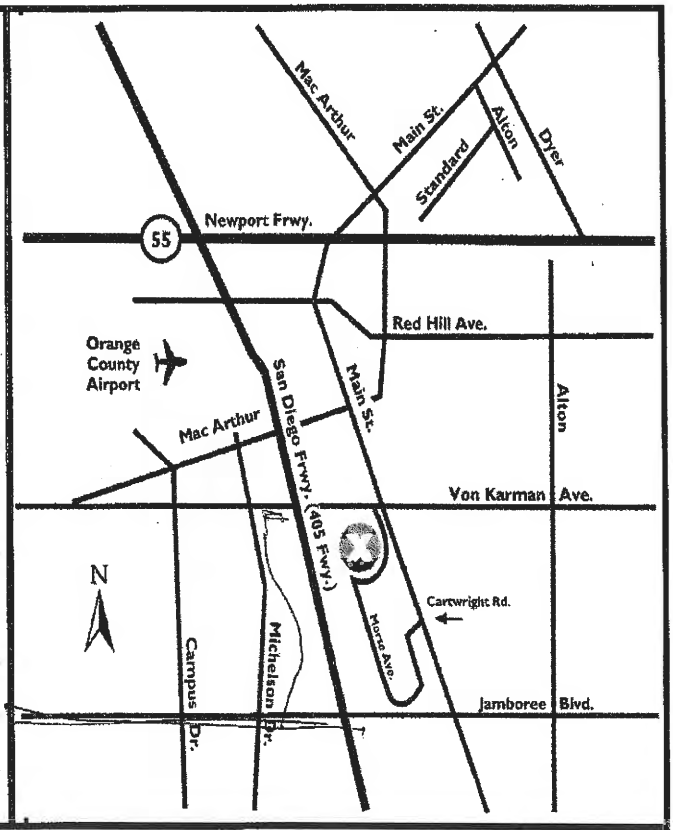
TREATMENT AUTHORIZATION

U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

We are authorizing the below listed U.S. HealthWorks location to provide services to our employees:

2362 Morse Ave
Irvine, CA 92614
PH: (949) 863-9103
FX: (949) 863-1337
Open 24 hours a day, 7 days a week!



Pelican Hill Resort #164551
EMPLOYER NAME EMPLOYER #

PRIMARY CONTACT NAME 22701 Pelican Hill Rd S.
ADDRESS LINE 1

ADDRESS LINE 2 Newport Beach CA
CITY 949-467-6838 STATE ZIP

PH PH (after HRs/Cell)

FAX

EMAIL

EMPLOYEE DETAILS

DATE: 4-9-13 TIME: 1030 AM OR (PM)

PATIENT NAME: Consuelo Perez DEPARTMENT: Laundry - Uniforms

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ☐ YES ☒ NO NAME OF TEMP AGENCY:

AUTHORIZED BY: NAME (PRINT): Patrick Brass PHONE: 949-467-6838 (24hrs)

TITLE: Security AFTER HRS / CELL PH:

SIGNATURE: Patrick Brass ( ) VERBAL

INSURANCE

INSURANCE COMPANY NAME:

CLAIMS ADDRESS:

PHONE#: EFFECTIVE DATE:

POLICY #: EXPIRATION DATE:

SERVICES

☒ INJURY: DATE OF INJURY: 3/10/13 LAST WORKED: 4/9/13

INJURED BODY PART: left knee CLAIM #:

○ RETURN-TO-WORK EVALUATION

○ PHYSICAL EXAM TYPE: PROTOCOL #:

○ DRUG/ALCOHOL TEST. SPECIFY TYPE AND REASON/PURPOSE BELOW PROTOCOL #

TYPE:

- ☐ INSTANT DRUG TEST
- ☐ NON-DOT DRUG TEST
- ☐ DOT DRUG TEST
- ☐ NON-DOT BREATH ALCOHOL TEST
- ☐ DOT BREATH ALCOHOL TEST

(CIRCLE BRANCH: FMCSA FAA FTA FRA PHMSA USCG)

REASON/PURPOSE:

- ☐ POST-OFFER
- ☐ POST-ACCIDENT
- ☐ RETURN TO DUTY
- ☐ REASONABLE SUSPICION
- ☐ RANDOM
- ☐ POST-INJURY

NOTE: PICTURE ID REQUIRED FOR DRUG TESTING

Thank you for choosing U.S. HealthWorks Medical Group!

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U.S. HealthWorks MEDICAL GROUP

THE IRVINE CO./CORP.

164551

DOS: 4/12/13 DOI: 3/10/13 DOB: 3/15/52

Patient: Perez, Consuelo

Case # : 32-251644 Ref # : EMR/JB

ESTABLISHED PATIENT STATEMENT
DECLARACIÓN DEL PACIENTE

WC

eguro Social): 570-85-1146 Date (Fecha): 4/12/13

elular): 714 865-1227

ıpañía):

1. Since your last visit, are you: ☐ improved? ☐ worse? ☒ unchanged?
   ¿Desde su última visita, se ha usted mejorado? empeorado? mantenido sin cambios?

2. Since your last visit, have you developed any new complaints? ☐ Yes *(Sí)* ☒ No
   ¿Desde su última visita, ha usted presentado nuevos síntomas o dolencias?

If you have not improved since your last visit, or if you have developed new problems, please explain in the space below.
(Si no ha mejorado desde su última visita, o si ha presentado nuevos síntomas o dolencias, por favor explique en el espacio a continuación.)

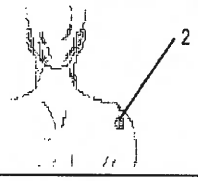
APR 12 AM 10:54

PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, indique el tipo de síntoma y marque en las figuras la zona del cuerpo en donde los siente.

SYMPTOMS (SÍNTOMAS)

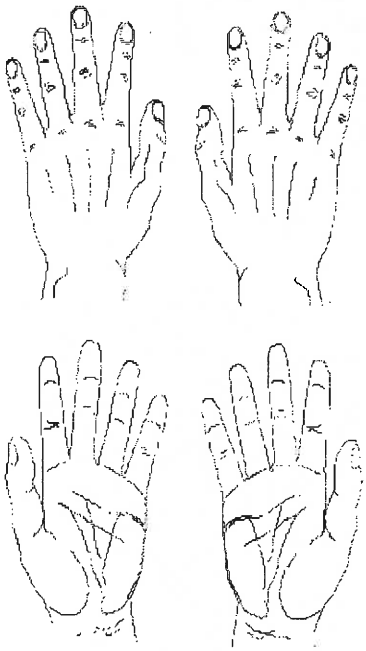
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

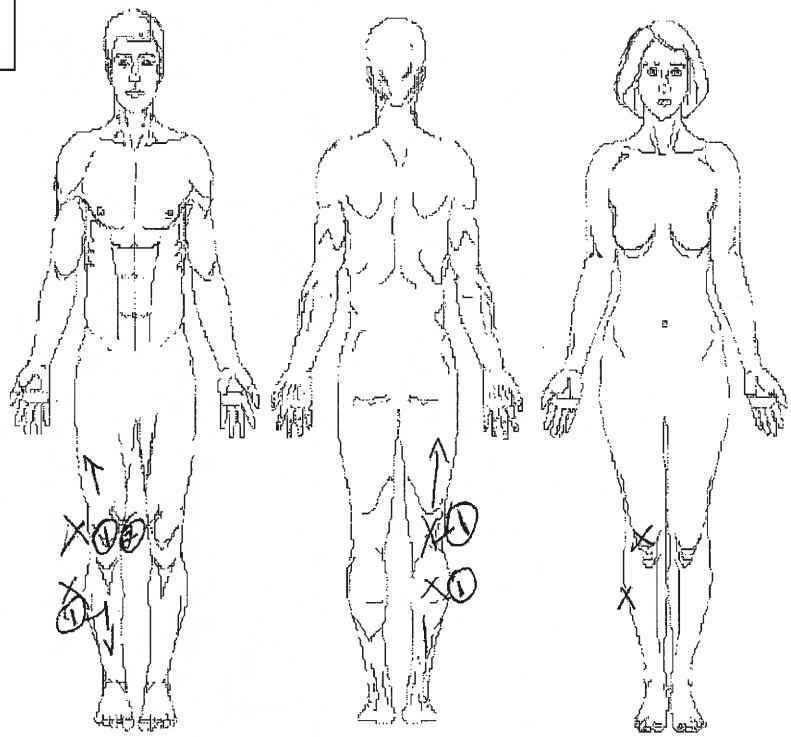
Example (Ejemplo)



Rate the intensity of your pain: NO PAIN — MOST PAIN
Indique la intensidad de su dolor: *SIN DOLOR* — *DOLOR INTENSO*

0 1 2 3 4 5 6 7 (8) 9 10





Patient Signature *(Firma del Paciente)* Consuelo Perez Date *(Fecha)* 4/12/13

© US HealthWorks

U.S. HealthWorks
2362 Morse Avenue, Irvine CA 92614
Ph: 949 863-9103
Case #: 032251644

DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's worker's compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. **INSURER NAME AND ADDRESS** CHUBB SERVICES CORP. PO BOX 30570 LOS ANGELES CA 90030 - 0570 Claim #:				PLEASE DO NOT USE THIS COLUMN
2. **EMPLOYER NAME** THE IRVINE CO./CORP.				Case No.
3. **Address** No. and Street 550 NEWPORT CENTER DR.	**City** NEWPORT BEACH	**Zip** 92660 - 0000		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) Consuelo Perez		6. **Sex** Female	7. **Date of Birth:** 03-15-1952	Age
8. **Address: No. and Street** 1919 N. Sherry Ln Apt 37	**City:** Santa Ana	**Zip:** 92705	9. **Telephone Number** (714)865-1227	Hazard
10. **Occupation** (Specific Job Title) Laundry Attendent			11. **Social Security Number** 570-85-1146	Disease
12. **Injured at: No. and Street** 550 NEWPORT CENTER DR.		**City:** NEWPORT BEACH	**County:**	Hospitalization
13. **Date and hour of injury or onset of illness**		Mo. Day. Yr./ Hour 03-10-2013 /17:00	14. **Date last worked** Mo. Day Yr. 04-09-2013	Occupation
15. **Date and hour of first examination or treatment**		Mo. Day. Yr./ Hour 04-09-2013/11:55 pm	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 if 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.)

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

History Of Present Illness:

Dominant hand is right.

Knee Complaints / Symptoms

Complaint: Patient's complaint at this time is as follows: pain and stiffness - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 30 days. The frequency is constant. Context: Gradually worsening pain and stiffness to right knee. The employee relates to repetitive climbing of an unsteady step ladder to reach for uniforms on overhead shelves which cause her to pivot in order to maintain balance on the step ladder. The symptoms are exacerbated by weight bearing activities. The symptoms are lessened by limiting standing and walking.

Associated Symptoms: The patient also complains of knee pain - 2+ tender all aspects of right knee including patella with crepitus and limited range of motion. The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient

Recvd Date: 20150630 Bill DCN: 2015182GJ000342

denies discoloration . The patient complains of pain with knee motion - . The patient states there is no foot and ankle pain . The patient complains of restricted motion of the knee - . The patient admits to locking or clicking of the affected knee - .

Present complaint

Severity: On severity scale, the pain is 8 out of 10.

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

A. A Physical Exam was performed. Any pertinent findings are noted as follows:

Physical Examination:

Height: 65 inches. Weight: 221 lbs. BMI:37 Pulse: 77/min. BP: 165/105 mmHg. Temperature: 98.4 deg F Respiration: 18 per min.

FDLMNP: 1993.

Constitutional: The patient appears obese - .

Psychiatric: She is alert and oriented to person, place and time . Mood and affect appear appropriate .

Respiratory: There are no apparent signs of respiratory distress .

Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .

Lymphatic: There are no signs of lymphedema on the left lower extremity . There are no signs of inguino/crural lymphadenopathy on the left lower extremity . There are no signs of lymphedema on the right lower extremity . There are no signs of inguino/crural lymphadenopathy on the right lower extremity .

Musculoskeletal: The patient has an abnormal gait - Limping favoring right leg.

Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament - . Cruciate function of the left knee is intact with negative anterior and posterior drawer sign. - . There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.

Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is tender on the right lateral joint line - . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right poplital fossa is nontender - . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. There is a positive patellofemoral grind test for retropatellar pathology. - . Limitations to the tested range of motion of the right knee were as listed below: Flexion: 40/135 deg. Extension: 0/0 deg. R 5/10 deg, R 5/10 deg. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.

Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.

Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

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

Diagnostic Tests:

Radiology:

Test Name	Findings
Knee Right 3 Views	Preliminary interpretation of these x-rays are Normal -

Medical Necessity:

Knee Right 3 Views Inability to flex knee to 90 degrees. (ACOEM p 331)

Severe pain on motion. (ACOEM p 331)

All radiology studies are sent to Radiologist for review and confirmation.

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

ICD9 Code

Sprain/Strain Knee/Leg Other Right (844.8)

Pain - Knee/Patella Right (719.46)

Record Date: 20150630 Brief DCN: 2015182GJ000342

Differential Diagnosis / Comments: Moderate severity right knee strain-sprain. Gradual progress expected with conservative care. No barriers to care identified. Employee is motivated to recovered.

The finding and diagnosis are consistent with patient's account of injury or onset of illness.

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

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

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

Cryotherapy performed over right knee for 20min.

Supplies:

Item Name	Quantity	Hcpc / Cpt
Cold-Hot/Cold Pack 9-1/2" x 4-1/2" Reusable	1	A9273
Knee-Support Hinged Buttress Univ Xlg	1	L1810

Dispensed orthotics were applied and fit ensuring patient comfort, no neurovascular compromise, with capillary refill intact. Patient verbally acknowledged their understanding of use and care of the device."

Treatment Plan Comments: Conservative care initiated with prescription of antiinflammatory med and narcotic pain med prescription. Knee support and ice pack dispensed. Physical therapy authorization requested. Expected treatment time is 4 weeks. Next appt is 04/12/13.

Medication(s) Prescribed:

Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle

Tramadol HCL 50mg Tabs #20 . 1-2 every 4 hours as needed for pain/ 1 o 2 cada 4 horas mientras sea necesario para el dolor, Dispense 1

Clinical Decision Making Comments: Right knee injury consistent with mechanism of injury and clinical findings including mild to moderated degenerative changes to right knee on preliminary review of xrays. Plan is for close follow up care to assess progress and modify treatment as indicated.

Additional Treatment: Patient is referred to Physical Therapy for evaluation and treatment 3 times per week; for 2 week(s). Reasons for treatment include decreased / impaired functional mobility / capacity, decreased joint range of motion, provocation of pain with functional mobility ROM, improved ROM with treatment and decreased pain with treatment. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis and restore functional capacity to allow return to full duty.

Patient Education:

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

24. If further treatment required, specify treatment plan/estimate duration.

25. If hospitalized as Inpatient, give hospital name and location.	Date Admitted :	Estimated stay
26. WORK STATUS - Is patient able to perform usual work? () Yes (X)No		
Return to work with restrictions as of : 04-10-2013	Specify restrictions: Restrictions for return to modified work as follows: no climbing. Limited standing or walking No kneeling or squatting. hinged knee support.	

Doctor's Signature		CA License #:	20A4382
Name and Degree	RH Oswald, MD		

Received Date: 20150630 Bill DCN: 2015182GJ000342

	Richard Oswald D.O.		
	Supervising Physician	IRS Number	95-4643269
Address	2362 Morse Avenue, Irvine CA 92614	Telephone Number	949 863-9103

FORM 5021 (rev. 4) 1992

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

Recvd Date: 20150630 Bill DCN: 2015182GJ000342

MEDICAL DOCUMENTATION : DO NOT DETACH
New Patient Narrative

U.S. HealthWorks
2362 Morse Avenue
Irvine CA 92614
Ph: 949 863-9103

Date of Service:	04-09-2013
Patient Name:	Perez, Consuelo
Patient Account Number:	032251644
Date Of Injury:	03-10-2013 17:00
Date Of Birth:	03-15-1952
Employer Name:	THE IRVINE CO./CORP.
Claim #:	
Chart #:	EMR/JB

History Of Present Illness:
Knee Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: pain and stiffness - right knee. Patient describes the symptom(s) as dull. She says it is moderately severe. She reports having symptoms for 30 days. The frequency is constant. Context: Gradually worsening pain and stiffness to right knee. The employee relates to repetitive climbing of an unsteady step ladder to reach for uniforms on overhead shelves which cause her to pivot in order to maintain balance on the step ladder. The symptoms are exacerbated by weight bearing activities. The symptoms are lessened by limiting standing and walking.
Associated Symptoms: The patient also complains of knee pain - 2+ tender all aspects of right knee including patella with crepitus and limited range of motion. The patient states there is no numbness or tingling of the knee . The patient states there is no knee weakness . The patient denies knee edema . The patient denies discoloration . The patient complains of pain with knee motion - . The patient states there is no foot and ankle pain . The patient complains of restricted motion of the knee - . The patient admits to locking or clicking of the affected knee - .

Present complaint
Severity: On severity scale, the pain is 8 out of 10.

Occupational history: Length of employment is reported as 2 to 5 years. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, climbing and overhead work,
She denies any lost work-time as a result of this injury. She denies any other source of employment. Patient denies any prior treatment for this injury.

Chemical Exposure: No chemical or toxic exposure was reported.

Surgeries: Appendectomy 1983.

Medical History:
Dominant hand is right. Patient denies history of ulcers or gastritis. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. Patient states no known major/recurrent illnesses/injuries.
Tetanus History:
Last tetanus - unknown.

Family History: High Blood Pressure : Mother.
Social History: Alcohol or Tobacco use: She does not use tobacco. Denies alcohol use. Patient does not participate

in any sports or does not have any hobbies.

Review Of Systems:
A complete review of systems was performed and was found to be negative unless otherwise noted below.

Current Medications at the start of Encounter:
No known current medication.
Allergies:
PENICILLINS.

Patient Report Of Injury
Injury Details: Patient states injury or condition was caused at work. Date: 04-09-2013. Time: 22:30.

Physical Examination:
Height: 65 inches. Weight: 221 lbs. BMI:37 Pulse: 77/min. BP: 185/105 mmHg. Temperature: 98.4 deg F
Respiration: 18 per min.
FDLMNP: 1993.

Constitutional: The patient appears obese - .
Psychiatric: She is alert and oriented to person, place and time . Mood and affect appear appropriate .
Respiratory: There are no apparent signs of respiratory distress .
Skin: Examination of the left knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - . Examination of the right knee reveals no evidence of the following conditions: erythema, ecchymosis, scars, swelling, masses, deformities and open wounds - .
Lymphatic: There are no signs of lymphedema on the left lower extremity . There are no signs of inguino/crural lymphadenopathy on the left lower extremity . There are no signs of lymphedema on the right lower extremity . There are no signs of inguino/crural lymphadenopathy on the right lower extremity .
Musculoskeletal: The patient has an abnormal gait - Limping favoring right leg.
Left knee examined for comparison. The left knee is not tender on the left medial joint line . The left knee is not tender on the left lateral joint line . The left patella does not have subluxation - . The left patella is not tender - . There is no joint effusion present in the knee. The popliteal fossa is nontender . Exam of the following LLE areas was normal: foot, ankle, lower leg, thigh and hip . Abduction/adduction stress testing is negative for integrity of the collateral ligament - . Cruciate function of the left knee is intact with negative anterior and posterior drawer sign. - . There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. McMurray test is negative for meniscal tears. There is a negative patellofemoral grind test for retropatellar pathology. Range of motion of the left knee is normal per AMA guidelines. There is 5/5 muscle strength on strength testing of the left lower extremities in extension and flexion.
Right knee affected/injured. The right knee is tender on the right medial joint line - . The right knee is tender on the right lateral joint line - . The right patella does not have subluxation . The right patella is tender - . There is no joint effusion present in the knee . The right popltal fossa is nontender - . Abduction/adduction stress testing is negative for integrity of the collateral ligament. Cruciate function of the right knee is intact with negative anterior and posterior drawer sign. There is a negative apprehension test for patellar dislocation/subluxation. Bulge/ballottement testing is negative for joint effusion. There is a positive patellofemoral grind test for retropatellar pathology. - . Limitations to the tested range of motion of the right knee were as listed below: Flexion: 40/135 deg. Extension: 0/0 deg. R 5/10 deg, R 5/10 deg. There is 5/5 muscle strength on strength testing of the right lower extremities in extension and flexion.
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the left and capillary refill time is normal on the left. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ on the right and capillary refill time is normal on the right.
Neurologic: Left patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the left lower extremities. Right patellar and achilles deep tendon reflexes are 2/4. Sensation is intact to light touch and pinprick in all dermatomes of the right lower extremities. There is no asymmetry of the left quadriceps - . There is no asymmetry of the right quadriceps . There is no atrophy of the left quadriceps . There is no atrophy of the right quadriceps .

Diagnostic Tests:
Radiology

Test Name	Findings
Knee Right 3 Views	Preliminary interpretation of these x-rays are Normal -

Medical Necessity:
Knee Right 3 Views Inability to flex knee to 90 degrees. (ACOEM p 331)
Severe pain on motion. (ACOEM p 331)
All radiology studies are sent to Radiologist for review and confirmation.

Diagnoses
Sprain/Strain Knee/Leg Other Right (844.8)
Pain - Knee/Patella Right (719.46)

Medical Assessment: Moderate severity right knee strain-sprain. Gradual progress expected with conservative care. No barriers to care identified. Employee is motivated to recovered.
Physician Comments: According to the patient, the present injury/illness was not caused by a single specific event - Exam findings are consistent with the patient's statement.

Treatment Plan
Last Saved By: Nathan Lehrfeld 04-10-2013 01:31:53

Cryotherapy performed over right knee for 20min.

Prescribed Medications:
New: Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion, Dispense 1 Bottle
Tramadol HCL 50mg Tabs #20 . 1-2 every 4 hours as needed for pain/ 1 o 2 cada 4 horas mientras sea necesario para el dolor, Dispense 1
Current Medications at Close of Encounter:
Nabumetone 750 mg Tabs #20 . 1 tablet twice a day with food for inflammation/un tableta dos veces al dia con comida para inflamacion. Dispense 1 Bottle
Tramadol HCL 50mg Tabs #20 . 1-2 every 4 hours as needed for pain/ 1 o 2 cada 4 horas mientras sea necesario para el dolor, Dispense 1
Medications Completed or Stopped:
Clinical Decision Making Comments: Right knee injury consistent with mechanism of injury and clinical findings including mild to moderated degenerative changes to right knee on preliminary review of xrays. Plan is for close follow up care to assess progress and modify treatment as indicated.

Supplies:

Item Name	Quantity	Hcpc / Cpt
Cold-Hot/Cold Pack 9-1/2" x 4-1/2" Reusable	1	A9273
Knee-Support Hinged Buttress Univ Xlg	1	L1810

Dispensed orthotics were applied and fit ensuring patient comfort, no neurovascular compromise, with capillary refill intact. Patient verbally acknowledged their understanding of use and care of the device."

Treatment Plan Comments: Conservative care initiated with prescription of antiinflammatory med and narcotic pain med prescription. Knee support and ice pack dispensed. Physical therapy authorization requested. Expected treatment time is 4 weeks. Next appt is 04/12/13.

Record Date: 20150630 Brit DCN: 2015182GJ000342

WORK STATUS:

The finding and diagnosis are consistent with patient's account of injury or onset of illness. Return to work with restrictions as of 04-10-2013.

Work Restrictions:

Restrictions for return to modified work as follows: no climbing.
Limited standing or walking
No kneeling or squatting.

hinged knee support.

Patient Education:

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

Employer Contact:

Detailed voice message was left with 04/10/13, 0130 hrs, Erma Worcester. The following items were discussed: causation, diagnosis, prognosis, RTW, treatment plan.

Additional Treatment: Patient is referred to Physical Therapy for evaluation and treatment 3 times per week; for 2 week(s). Reasons for treatment include decreased / impaired functional mobility / capacity, decreased joint range of motion, provocation of pain with functional mobility ROM, improved ROM with treatment and decreased pain with treatment. Goals for treatment include accelerate / increase functional ROM within 80 - 90% of AMA guides, decrease pain to 2/10, or less, with proper body mechanics / posture, expedite / advance expected functional capacity / status to 80 - 90% of normal, facilitate independence in a progressive home exercise program with functional emphasis and restore functional capacity to allow return to full duty.

The interpreter used was Ray Grijalva.

Ray . Grijalva, P.A.
This has been electronically signed on 04-10-2013

Richard Oswald D.O.
Supervising Provider

Next Appointment with Oswald Richard on 04-12-2013 11:00 am.

U.S. HealthWorks MEDICAL GROUP

HX1

PATIENT INFORMATION / HEALTH HISTORY

PATIENT DETAILS

Employer (Patrón): _____ Date (Fecha): 04/09/13 SSN: 570-85-1146

First Name (Nombre): Manuela Middle Initial (Inicial): _____ Last Name (Apellido): Perez

Address (Domicilio): 1818 N Sherry Ln #37 City (Ciudad): Santa Ana State (Estado): Ca Zip (C. Postal): 92705

Telephone # (Teléfono): Home (Casa): _____ Work (Trabajo): _____ Cell (Celular): 714-865-1227

Best number to reach you (Mejor número para localizarle): _____ Email (Correo Electrónico): CIPE782034@Roadrunner.com

Date of Birth (Nacimiento): 03/15/52 Sex (Sexo): F Marital Status (Estado Civil): Divorce

INJURY DETAILS

Date of Injury (Fecha de lesión): 3/10/13 Time (Hora): 5:PM Date last worked (Ultimo día que trabajó): 4/9/13

Occupation (Ocupación): Uniforms Attendant Employer Telephone (Teléfono del Patrón): _____

Address where injury occurred (Domicilio donde ocurrió la lesión): Adddress (Domicilio): 22701 Pelliam Hill Road South

City (Ciudad): Newport East State (Estado): Ca Zip (C. Postal): 92657 County (Condado): _____

Was your problem caused by something that happened at work? (¿Fue su problema causado por algo sucedido en su trabajo? ☑ Yes (Si) ☐ Nc

Injury was reported to (Lesion fue reportada a): Security Date (Fecha): 04/9/13 Time (Hora): 10:30

Have you been treated at U.S. HealthWorks before? (Alguna vez ha sido tratado en U.S. HealthWorks?): ☐ Yes (Si) ☑ No When? (Cuándo?): _____

In case of emergency contact (En caso de emergencia llamar a): Jaime Zamora Tel: 714-543-6534

Please describe below how your present injury/illness occurred. (Por favor, describa a continuación cómo ocurrió su actual lesión ó enfermedad.) subí y bajé escalera y no tenía support

---

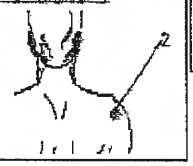
PLEASE COMPLETE THE FOLLOWING DIAGRAM *(Por favor complete el diagrama a continuación.)*

If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
(Si siente algunos de los síntomas listados a continuación, marque la zona del cuerpo en donde los siente en las figuras e indique el tipo de síntoma.

Symptoms (Síntomas)

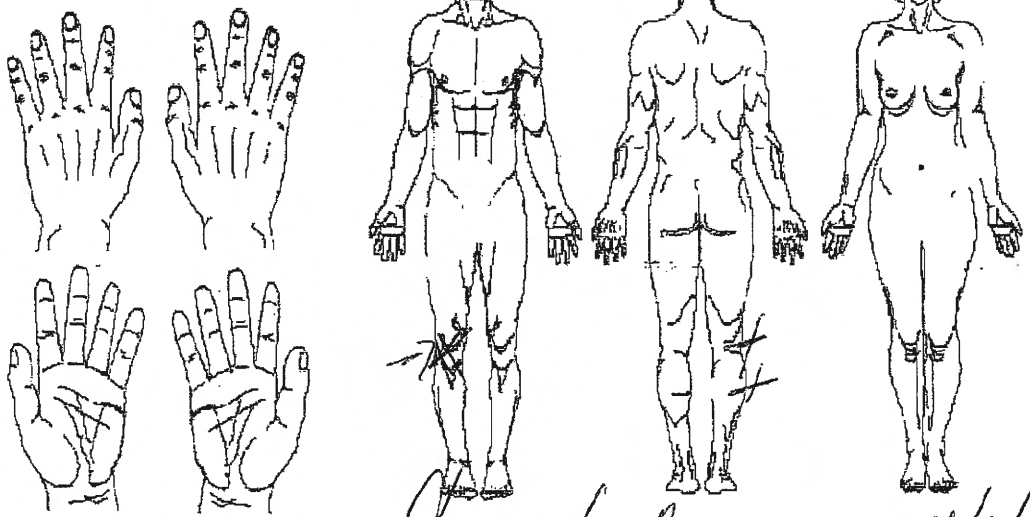
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Pinchazos)

Example (Ejemplo)



Rate the intensity of your pain: NO PAIN / SIN DOLOR — MOST PAIN / DOLOR INTENSO

0 1 2 3 4 5 6 7 8 9 10



Patient Signature (Firma del Paciente) Manuela Perez Date (Fecha) 4/9/13

U.S. HealthWorks MEDICAL GROUP

HX2

WC HEALTH HISTORY / HISTORIA MEDICA
Confidential / Confidencial

To better assess your health condition, please provide the following information (Para evaluar mejor su salud, por favor proporcione la siguiente información)

PERSONAL HISTORY / ANTECEDENTES PERSONALES			**EXPLAIN / EXPLIQUE**
☑ Yes (Sí) ☐ No	1. Allergies or hives	Alergias o urticaria	Penicillin
☑ Yes (Sí) ☐ No	2. Current Medications with dosage	Medicinas que toma actualmente	2. for Blood pressure
	Current Medications (name only)	Otras Medicinas	
☐ Yes (Sí) ☑ No	2a. Major recurrent illnesses or injuries Enfermedades/lesiones recurrentes importantes		
☐ Yes (Sí) ☑ No	3. Motor vehicle accidents with injury	Accidentes de tránsito con lesiones	
☐ Yes (Sí) ☑ No	4. Blood / Plasma transfusions	Transfusiones de sangre / plasma	
☐ Yes (Sí) ☑ No	5. Permanent disabilities	Incapacidad permanente	
☐ Yes (Sí) ☑ No	6. Worked in a hazardous environment	Trabajo en ambientes peligrosos	
☐ Yes (Sí) ☑ No	7. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo	
☑ Yes (Sí) ☐ No	8. Hospitalizations or surgeries	Hospitalizaciones o cirugías	Appendectomy 1983
FAMILY HISTORY / ANTECEDENTES FAMILIARES			**EXPLAIN / EXPLIQUE**
☑ Yes (Sí) ☐ No	10. Blood diseases in relatives	Enfermedad de la sangre en familiares	
☐ Yes (Sí) ☑ No	11. Cancer / Leukemia in relatives	Cáncer / leucemia en familiares	
☐ Yes (Sí) ☑ No	12. Diabetes in relatives	Diabetes en familiares	
☐ Yes (Sí) ☑ No	13. Heart disease in relatives	Enfermedades del corazón en familiares	
☑ Yes (Sí) ☐ No	14. High blood pressure in relatives	Presión alta en familiares	HTN - mother
☐ Yes (Sí) ☑ No	15. Strokes in relatives	Familiares con trombosis / ataques cerebrales	
☐ Yes (Sí) ☑ No	16. Mental illnesses in relatives	Enfermedades mentales en familiares	
☐ Yes (Sí) ☑ No	17. Other diseases	Otras enfermedades	
☐ Yes (Sí) ☑ No	18. Other diseases	Otras enfermedades	
SOCIAL HISTORY / ANTECEDENTES SOCIALES			
☐ Yes (Sí) ☑ No	19. Tobacco use (Uso de tabaco)?		How much (Cuanto? _____ day (día)
☐ Yes (Sí) ☑ No	20. Alcohol use (Uso de alcohol)?		How much (Cuanto? _____ week (semana)
REVIEW OF SYSTEMS / REVISIÓN DE SISTEMAS			
CONSTITUTIONAL / CONSTITUCIONAL			**EXPLAIN / EXPLIQUE**
☐ Yes (Sí) ☑ No	21. Recent gain or loss of weight	Ganancia o pérdida de peso reciente	
☐ Yes (Sí) ☑ No	22. Weakness or appetite loss	Debilidad, o pérdida de apetito	
☐ Yes (Sí) ☑ No	23. Fever	Fiebre	
☐ Yes (Sí) ☑ No	24. Fatigue or lethargy	Fatiga o letargia	
☐ Yes (Sí) ☑ No	Constitutional comments	Comentarios del sistema constitucional	
SKIN / PIEL			**EXPLAIN / EXPLIQUE**
☐ Yes (Sí) ☑ No	25. Skin diseases or problems	Enfermedades en la piel	
☐ Yes (Sí) ☑ No	26. Discoloration, pigmentation changes	Cambios de color en la piel	
☐ Yes (Sí) ☑ No	27. Cancer, tumors or cysts	Cáncer, tumores o quistes	
☐ Yes (Sí) ☑ No	Skin comments	Comentarios con respecto a la piel	
HEAD / CABEZA			**EXPLAIN / EXPLIQUE**
☐ Yes (Sí) ☑ No	28. Frequent or severe headaches	Dolor de cabeza frecuentes o severos	
☐ Yes (Sí) ☑ No	29. Prior head injury or trauma	Lesión o trauma previo en la cabeza	
☐ Yes (Sí) ☑ No	Head comments	Comentarios con respecto a la cabeza	
EYES / VISION / OJOS / VISIÓN			**EXPLAIN / EXPLIQUE**
☐ Yes (Sí) ☑ No	30. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos	
☐ Yes (Sí) ☑ No	31. Blurred, double or weak vision	Visión borrosa, doble, o débil	
☐ Yes (Sí) ☑ No	32. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos	
☐ Yes (Sí) ☑ No	33. Light sensitivity	Sensibilidad a la luz	
☐ Yes (Sí) ☑ No	Eyes / Vision comments	Comentarios con respecto a la vista y los ojos	
EARS / NOSE / THROAT / MOUTH / OÍDOS / NARIZ / GARGANTA / BOCA			**EXPLAIN / EXPLIQUE**
☐ Yes (Sí) ☑ No	34. Loss or decreased hearing	Pérdida o disminución de la audición	
☐ Yes (Sí) ☑ No	35. Ear pain, infection, discharge	Dolor, infección o secresión en oídos	
☐ Yes (Sí) ☑ No	36. Nasal or sinus diseases, conditions or infections Enfermedades o infecciones de la nariz o senos nasales		
☐ Yes (Sí) ☑ No	37. Allergic rhinitis, sneezing or chronic post-nasal drip Rinitis alérgica, estornudos o secreción posterior nasal crónica		
☐ Yes (Sí) ☑ No	Ears, Nose, Throat, Mouth comments Comentarios con respecto a los oídos / nariz / garganta y boca		

CARDIOVASCULAR SYSTEM	SISTEMA CARDIOVASCULAR	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☐ No	40. Heart disease, vascular disease or high+ cholesterol Enfermedad cardíaca, enfermedad vascular o colesterol alto	
☐ Yes (Sí) ☒ No	41. Shortness of Breath	Dificultad para respirar
☐ Yes (Sí) ☒ No	42. Chest Pain or Pressure	Opresión o dolor en el pecho
☐ Yes (Sí) ☒ No	43. PalpitationsPounding Heart	Palpitaciones o saltos del corazón
☐ Yes (Sí) ☒ No	44. High Blood Pressure	Presión sanguínea elevada
☐ Yes (Sí) ☒ No	45. Swelling Feet/Ankles	Hinchazón de pies o tobillos
☐ Yes (Sí) ☒ No	46. Varicose Veins	Venas varicosas
☐ Yes (Sí) ☒ No	Cardiovascular comments	Comentarios del sistema cardiovascular

RESPIRATORY SYSTEM	SISTEMA RESPIRATORIO	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	46. Chronic/Recurrent Cough/Cold	Resfriado / tos crónica o recurrente
☐ Yes (Sí) ☒ No	47. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho
☐ Yes (Sí) ☒ No	48. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica
☐ Yes (Sí) ☒ No	49. Pneumonia	Pneumonía o pulmonía
☐ Yes (Sí) ☒ No	50. Tuberculosis	Tuberculosis
☐ Yes (Sí) ☒ No	51. Coughing of Blood	Tos con sangre
☐ Yes (Sí) ☒ No	Respiratory comments	Comentarios del sistema respiratorio

GASTROINTESTINAL TRACT	TRACTO GASTROINTESTINAL	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	52. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes
☐ Yes (Sí) ☒ No	53. Nausea or vomiting	Náusea o vómitos
☐ Yes (Sí) ☒ No	54. Vomiting of blood	Vómitos con sangre
☐ Yes (Sí) ☒ No	55 Abdominal pain	Dolor abdominal
☐ Yes (Sí) ☒ No	56. Liver disease	Enfermedades del hígado
☐ Yes (Sí) ☒ No	57. Change in Bowel Habits	Cambios en hábitos intestinales
☐ Yes (Sí) ☒ No	58. Frequent Constipation/Diarrhea	Constipación o diarea frecuentes
☐ Yes (Sí) ☒ No	59. Blood in stools/Black stools	Heces negras o con sangre
☐ Yes (Sí) ☒ No	60. Hemorrhoids/ Rectal Disease	Hemorroides/ Enfermedades del recto
☐ Yes (Sí) ☒ No	61. Ulcer Disease	Úlceras digestivas
☐ Yes (Sí) ☒ No	62. Colitis, diverticulitis or other colon disorders Colitis, diverticulitis u otras enfermedades del colon	
☐ Yes (Sí) ☒ No	Gastrointestinal comments	Comentarios del sistema gastrointestinal

GENITOURINARY TRACT	TRACTO GENITOURINARIO	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	63. Blood in urine	Sangre en la orina
☐ Yes (Sí) ☒ No	64. Kidney infection/stones	Infecciones o cálculos del riñón
☐ Yes (Sí) ☒ No	65. Painful or difficult urination	Dificultad o dolor al orinar
☐ Yes (Sí) ☒ No	66. Venereal Disease	Enfermedades venéreas
☐ Yes (Sí) ☒ No	67. Recurrent urinary tract infections	Infecciones urinarias recurrentes
☐ Yes (Sí) ☒ No	Genitourinary comments	Comentarios del sistema genitourinario

MUSCULOSKELETAL SYSTEM	SISTEMA MUSCULOESQUELÉTICO	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	68. Joint pain or disease	Enfermedades o dolor en las articulaciones
☐ Yes (Sí) ☒ No	69. Neck injury or pain	Lesiones o dolor en el cuello
☐ Yes (Sí) ☒ No	70. Back injury or pain	Lesiones o dolor en la espalda
☐ Yes (Sí) ☒ No	71. Muscle diseases, aches or pain	Enfermedades o dolores musculares
☐ Yes (Sí) ☒ No	72. Fractures/ Broken bones	Fracturas / Huesos rotos
☐ Yes (Sí) ☒ No	73. Foot Problems	Problemas en los pies
☐ Yes (Sí) ☒ No	Musculoskeletal comments	Comentarios del sistema musculoesquelético

NEUROLOGICAL SYSTEM	SISTEMA NEUROLÓGICO	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	74. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques
☐ Yes (Sí) ☒ No	75. Dizziness	Mareos o vértigo
☐ Yes (Sí) ☒ No	76. Muscle weakness or paralysis	Parálisis o debilidad muscular
☐ Yes (Sí) ☒ No	77. Numbness in arms or legs	Adormecimiento de manos o pies
☐ Yes (Sí) ☒ No	Neurological comments	Comentarios del sistema neurológico

PSYCHIATRIC PROBLEMS	PROBLEMAS PSIQUIÁTRICOS	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	78. Depression	Depresión
☐ Yes (Sí) ☒ No	79. Nervousness	Nerviosismo
☐ Yes (Sí) ☒ No	80. Mood swings	Cambios del humor o del carácter
☐ Yes (Sí) ☒ No	81. Sleep disturbances	Trastornos del sueño
☐ Yes (Sí) ☒ No	82. Alcoholism	Alcoholismo
☐ Yes (Sí) ☒ No	83. Drug abuse rehabilitation	Rehabilitación por adicción a drogas
☐ Yes (Sí) ☒ No	Psychiatric comments	Comentarios siquiátricos

ENDOCRINE SYSTEM	SISTEMA ENDOCRINO	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	84. Increased appetite — Apetito exagerado	
☐ Yes (Sí) ☒ No	85. Increased thirst — Sed exagerada	
☐ Yes (Sí) ☒ No	86. Increased urination — Aumento en la frecuencia o cantidad de orina	
☐ Yes (Sí) ☒ No	87. Diabetes/High Blood Sugar — Diabetes / Azúcar en la sangre	
☐ Yes (Sí) ☒ No	88. Hair loss — Pérdida del cabello	
☐ Yes (Sí) ☒ No	89. Cold or heat intolerace — Intolerancia al frío o al calor	
☐ Yes (Sí) ☒ No	90. Thyroid disease — Enfermedad de la tiroides	
☐ Yes (Sí) ☒ No	91. Osteoporosis — Osteoporosis	
☐ Yes (Sí) ☒ No	Endocrine comments — Comentarios del sistema endocrino	

BLOOD DISORDERS/CANCER	ENFERMEDADES DE LA SANGRE/CÁNCER	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	92. Bleeding gums — Sangramiento por las encías	
☐ Yes (Sí) ☒ No	93. Bruising — Moretones o cardenales	
☐ Yes (Sí) ☒ No	94. Spontaneous nose bleeding — Sangramiento espontáneo por la nariz	
☐ Yes (Sí) ☒ No	95. Easy bleeding or hard to stop — Sangramiento fácil o difícil de detener	
☐ Yes (Sí) ☒ No	96. Anemia — Anemia	
☐ Yes (Sí) ☒ No	97. History of cancer — Historia o antecedentes de cáncer	
☐ Yes (Sí) ☒ No	Blood disorders/Cancer comments — Comentarios de la sangre y cáncer	

FOR WOMEN ONLY	PARA MUJERES SOLAMENTE	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	98. Are you pregnant? — ¿Esta usted embarazada?	
☐ Yes (Sí) ☒ No	99. Date last menstrual period? Fecha última menstruación:_____	
☐ Yes (Sí) ☒ No	100. Irregular Menstruation? — ¿Menstruación o períodos irregulares?	
☐ Yes (Sí) ☒ No	101. Painful Menstruation? — ¿Menstruación o períodos dolorosos?	
☐ Yes (Sí) ☒ No	102. Vaginal discharge or pain — ¿Secreción o dolor vaginal?	
☐ Yes (Sí) ☒ No	Gynecological comments — Comentarios de sistema ginecológico	

FOR MEN ONLY	PARA HOMBRES SOLAMENTE	EXPLAIN / EXPLIQUE
☐ Yes (Sí) ☒ No	103. History of prostate disorders or disease Historia o antecedentes de enfermedad o desórdenes de la próstata	
☐ Yes (Sí) ☒ No	104. Genital pain, masses or other disorders Dolor genital, masas u otros desórdenes genitales	
☐ Yes (Sí) ☒ No	Urological comments — Comentarios del sistema urológico	

Please describe here any other diseases or health problems not described above.
(Por favor describa aquí cualquier otra enfermedad o problema de salud no descrito arriba)

I hereby certify that the information provided above is correct. (Certifico que la información escrita arriba es correcta)

Patient Signature (Firma del Paciente): [signature] **Date (Fecha):** 04/09/13

PROVIDER COMMENTS

Reviewed
R. Gutierrez PA
for
R. Orlando, DO
[signature], P.A. 4/10/13

☐ Relevant history was discussed and patient advised to follow up with personal physician

For use in place of ST1012A

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