JAMES H. BOND, MD

Orthopedic Surgeon
State-Appointed Qualified Medical Examiner
2011 West 11th Street, #333 Tracy CA 95376
Phone: (123) 456-7890
Fax: (123) 456-7891
www.jamesbondmd.net

June 5, 2012

RE:	JANE DOE
SS#:	987-65-4321
DOB:	April 12, 1953
DOI:	September 4, 2009
Employer:	Landscape Development, Inc.
Occupation:	Landscape Maintenance Worker
Insurance:	O'Gara Insurance
Claim #:	222 USS 9988
WCAB #:	DEA 422 URD

REVIEW OF RECORDS

Records approximately 30 pages were received. It took a total of 2.5 hours to review these records. A summary of the records follows.

09/14/09, Doctor's First Report of Occupational Injury or Illness, Doogie Howser, MD. Ms. Doe had an injury on 09/04/09 as she used power shears and trimmers. She complains of neck stiffness and cervical tenderness. She has tenderness at the acromioclavicular joint. Diagnoses: 1) Cervical sprain with degenerative joint disease. 2) Right shoulder sprain/strain. 3) Right wrist/forearm sprain/strain. Physical therapy and medications are prescribed. She is placed on modified work.

11/04/09, Initial Orthopedic Consultation, Apollo Zeus, MD. Ms. Doe complains of right trapezius pain. Assessment: The patient sustained an industrial neck and right trapezius injury. She has a cervical and right trapezius sprain/strain, and multilevel degenerative disc disease of the cervical spine. Her symptoms are most consistent with a cervical nerve root irritation. MRI of the cervical spine is recommended to rule out herniated disc. Tylenol is dispensed. Continue with modified work.

11/23/09, MRI of the Cervical Spine, Harrison Plaza Imaging Center, Rubeus Hagrid, MD. Impression: 1) Reversal of the normal lordotic curvature compatible with muscle spasm. 2) Mild degenerative disc disease at C4-C5, C5-C6, and C6-C7. 3) At C4-C5 and C5-C6, there are small disc bulges which flatten the thecal sac. 4) At C5-C6 and C6-C7,

there is mild right neural foraminal narrowing secondary to mild degenerative changes in the uncovertebral joints.

12/16/09, Repeat Orthopedic Consultation, Apollo Zeus, MD. The patient is much improved since the last evaluation. She is doing well and will continue on conservative treatment. She will remain on modified work with restrictions of limited overhead work and limited lifting, pushing, and pulling up to 25 pounds.

02/01/10, EMG of the Right Upper Extremity, Peter Pan, MD. Impression: Abnormal study. The right median and sensory study reveals evidence of a moderate carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory and motor components. The electromyography finding of increased polyphasics in the C5-C6 and C6-C7 innervated muscles with normal paraspinals is suggestive of chronic cervical radiculopathy.

03/30/10, New Patient Consultation, Severus Snape, MD. Diagnosis: Right cervical radiculopathy secondary to disc bulge at C6-C7. Cervical epidural steroid injection and a 15-day trial of non-steroidal anti-inflammatory medication are recommended. Prescriptions for Celebrex and physical therapy are given.

04/20/10, Operative Report, Azkaban Surgery Center, Sirius Black, MD. Procedure: CESI [cervical epidural steroid injection].

This concludes the review of submitted records.

DISCLOSURE

I declare under penalty of perjury that to the best of my knowledge and belief, there has been no violation of Labor Code Section 139.3 and that the information contained 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 received from others. As to that information, I declare under penalty of perjury that the information accurately described the information provided to me and except as noted herein, that I believe it to be true.

I declare that I personally reviewed the records. They were placed in organized, collated and/or excerpted for transcription by eData Services.

This declaration is signed on the ___ day of _____ 2012, in the San Joaquin, California.

_____

James H. Bond, M.D.

JHB:eData

O'Gara Insurance

88th Fuente Osmena Culver, CA 45678
Phone: (999) 999-9999 Fax: (999) 999-9991

May 5, 2010

James H Bond, MD
2011 West 11th Street, #333
Tracy, CA 95376

Employer:	Landscape Development, Inc.
Employee:	Jane Doe
Date of Loss:	September 4, 2009
Claim Number:	222 USS 9988
WCAB Number:	DEA 422 URD

Dear Dr. Bond,

Arrangements have been made for you to examine the above noted employee, **Jane Doe, as a** Qualified Medical Examiner on:

DATE: June 9, 2010
TIME: 2:30 pm

Enclosed are copies of the medical records from our file. The employee has been instructed to obtain all x-rays, CT scans and MRI files and bring them to this examination.

Please examine the injured worker and provide your opinion on the following:

1. The current diagnosis and prognosis.
2. Need for and duration of further medical treatment. If you feel treatment is necessary, please contact us immediately.
3. Anticipated return to work date for both modified and regular duty.
4. Extent of permanent disability and any permanent physical restrictions resulting from this injury.
5. The date the injured worker can be considered to have obtained maximum medical improvement.

Should you have any questions, please call me. Please submit the enclosed Request for Summary Rating Determination (DEU Form 101) along with your medical report to the Disability Evaluation Unit address as given on the form. Also enclosed is a copy of the medical file for the above-named claimant.

Sincerely,

Caleb Gabriel
(999) 999-9999 Ext 111
CGabriel@ogara.com
Workers' Compensation Unit

Return to the Record Review

JAMES BOND, M.D., F.A.A.D.E.P.

Orthopedic Surgeon

2011 West 11th Street, #333 Tracy, California 95376
Phone: (123) 456-7890 Fax: (123) 456-7891

PATIENT INFORMATION SHEET

Date of Injury 9/4/09
Body Parts Injured Neck, (R) shoulder, arm

Patient Information
Name Jane Doe SS# 987-65-4321
Address 4th floor Unit 123 City Montreal State CA Zip 12345
Phone (606) 555-5555 Cell (123) 123-7234
Birth Date 4/12/53 Age 57 Sex F

Referring Physician Information
Dr Name
Address City State Zip
Phone Fax

Employer Information
Employer Name Landscape Dev.'t Inc.
Address 2nd floor Unit 12 City Quenhill State CA Zip 12345
Phone (888)888-8888 Fax (444)444-4444

Insurance Information
Carrier O'Cara Insurance Adjuster Caleb Gabriel
Address 88 Furth Osnena City Culver State CA Zip 45278
Phone (999) 999-9999 Fax (999) 999-9991
Claim Number 222 US59 988 WCAB Number DEA 422 UND

Attorney Information
Name
Address City State Zip
Phone Fax

Azkaban Surgery Center

OPERATIVE REPORT

PATIENT: Doe, Jane **D.O.S:** 04/20/10
D.O.B.: 04/12/53 **SEX:** Female

SURGEON: Sirius Black, MD **REFERRING PHYSICIAN:** Dr

HISTORY: Ms. Jane Doe is a 57 year old female who come sin complaining of occipital neck pain with pain radiating to the right arm, not extending to the fingers This has gone on for several months now, growing in intensity, not associated with headaches. Patient is on a variety of different medications but nothing of significance. She has a history of hypertension Surgery wise she has had a Caesarian section. Review of systems is also positive for her being a pack a day smoker for greater than 40 years, and she also drinks daily.

ALLERGIES: Codeine. **CURRENT MEDICATIONS:** Amlodipine for blood pressure.

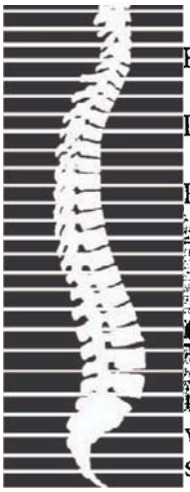
PHYSICAL EXAMINATION: She clinically presents as a well developed female 5 ft, 5 inches, 183 lbs. with occipital neck pain with pain radiating to the right shoulder extending to the forearm. There is no evidence of muscle weakness or muscle wasting. Her MRI shows a questionable disk at C4-5 and 5-6.

PROCEDURE: CESI.

DESCRIPTION OF PROCEDURE: Patient consented to the risks and benefits of the cervical epidural steroid injection. Transferred to the fluoroscopic suite. Placed prone on the fluoroscopic table. The cervical area was prepped and draped. At 7-1, a skin wheal was made using a 1% Polycaine solution. Then, taking an 18 gauge, Tuohy needle, it was inserted down the loss of resistance in the epidural space. The epidural space was delineated with 1 cc of 300 Omnipaque. Kenalog 80 mg, Decadron 10 mg were injected There were no complications. Patient tolerated the procedure well.

Signature:
Sirius Black, MD

REPORT OF EXAM-WORKMAN'S COMP



Patient Name: **DOE, Jane** Date: March 30, 2010

DOI: 9-8-09 CLM#: Referring MD:

Height: 5'5" Weight: 185 BP: 126/80 Pulse: 80

NEW PATIENT CONSULTATION

CURRENT COMPLAINTS:
The patient comes in today with complaints of neck pain and right scapula pain radiating into the right tricep and ulnar forearm for approximately six months. She was injured at work on September 8, 2009 when she was trimming bushes off a fence with gas powered shears. She denies any history of neck pain or right arm pain prior to this injury.

Conservative treatment includes six sessions of physical therapy, two visits to the chiropractor and medication management all of which has given her some pain relief. She has been off work since 3-8-10.

Pain score (0-10): neck pain 0/10, right scapula and arm pain 2/10

PAST MEDICAL HISTORY:
Skin cancer and arthritis

PREVIOUS OPERATIONS:
C-section, surgery for kidney stones and removal of skin cancer three years ago. She also broke her clavicle in the 1960's

CURRENT MEDICATIONS:
Amlodipine and Aspirin

ALLERGIES:
Codeine

ON EXAM:
Insp/Palp: WD, WN female, NAD, A&O x 3
ROM: cervical: flexion – full, extension – full, right – 80 percent, left – full
ROM UE – full
DTR's: absent right tricep, ½ + right bicep, trace right brachioradialis, trace left tricep, ½+ right bicep, trace right brachioradialis, Hoffman's sign is absent
Sensory: diminished pin right bicep and radial forearm
Motor: seems to be 5/5 in both upper extremities
Other: negative Romberg's sign, no pronator drift

continued on page 2

Patient Name: **DOE, Jane** Date: March 30, 2010

X-RAYS REVIEWED:
Cervical MRI scan dated 11-23-09 lateral views show mild reversal of normal lordosis. There are multi level degenerative changes at C4-5, more severe at C5-6 and slightly less at C6-7. There is no listhesis. The canal however appears to be capacious. The cord has normal signal. On the axial views at C4-5 there is broad based bulging and mild foraminal stenosis. At C5-6 there is more prominent bulging and again at least some mild bilateral foraminal stenosis, right probably greater than left. At C6-7 there is a broad based diffuse bulge more prominent to the right which causes right greater than left foraminal stenosis of at least a moderate to perhaps severe degree.

DIAGNOSIS:
Right cervical radiculopathy secondary to disc bulge C6-7

TREATMENT PLAN:
Recommend cervical epidural steroid injection and 15 day trial of non-steroidal anti-inflammatory medication, Rx given for Celebrex 200 mg one po bid and more physical therapy to include cervical traction as well as range of motion exercises.

Return to office: 6 weeks

WORK STATUS:
To be addressed by the patients primary treating physician.

I declare under penalty of perjury that the information contained in this report and it's attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I 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, that I believe it to be true. I have not violated Labor Code 139.3. Dated 3-30-10 (

SevSnape.md
SEVERUS SNAPE, M.D.

Date: 3-30-10

2/1/2010

Peter Pan, M.D.

Diplomate, American Board of _____

Patient: DOE, Jane **DOB:** 4/12/1953 **ID#:**
SEX: Female **Ref. Phys:**

Chief Complaint:
Patient is a 56 year old Female who presents with neck pain radiating to the right upper extremity with tingling and numbness in the hand .

EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Right	Abd Poll Brev	Median	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Reduced	Inc	
Right	1stDorInt	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	FlexCarRad	Median	C6-7	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	ExtCarRad	Radial	C6-7	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	BrachioRad	Radial	C5-6	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	Supraspinatus	SupraScap	C5-6	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Nml	Nml	2+	Reduced	Inc	
Right	C5 Parasp	Rami	C5	Nml	Nml	Nml			0			
Right	C6 Parasp	Rami	C6	Nml	Nml	Nml			0			
Right	C7 Parasp	Rami	C7	Nml	Nml	Nml			0			
Right	C8 Parasp	Rami	C8	Nml	Nml	Nml			0			
Right	T1 Parasp	Rami	T1	Nml	Nml	Nml			0			

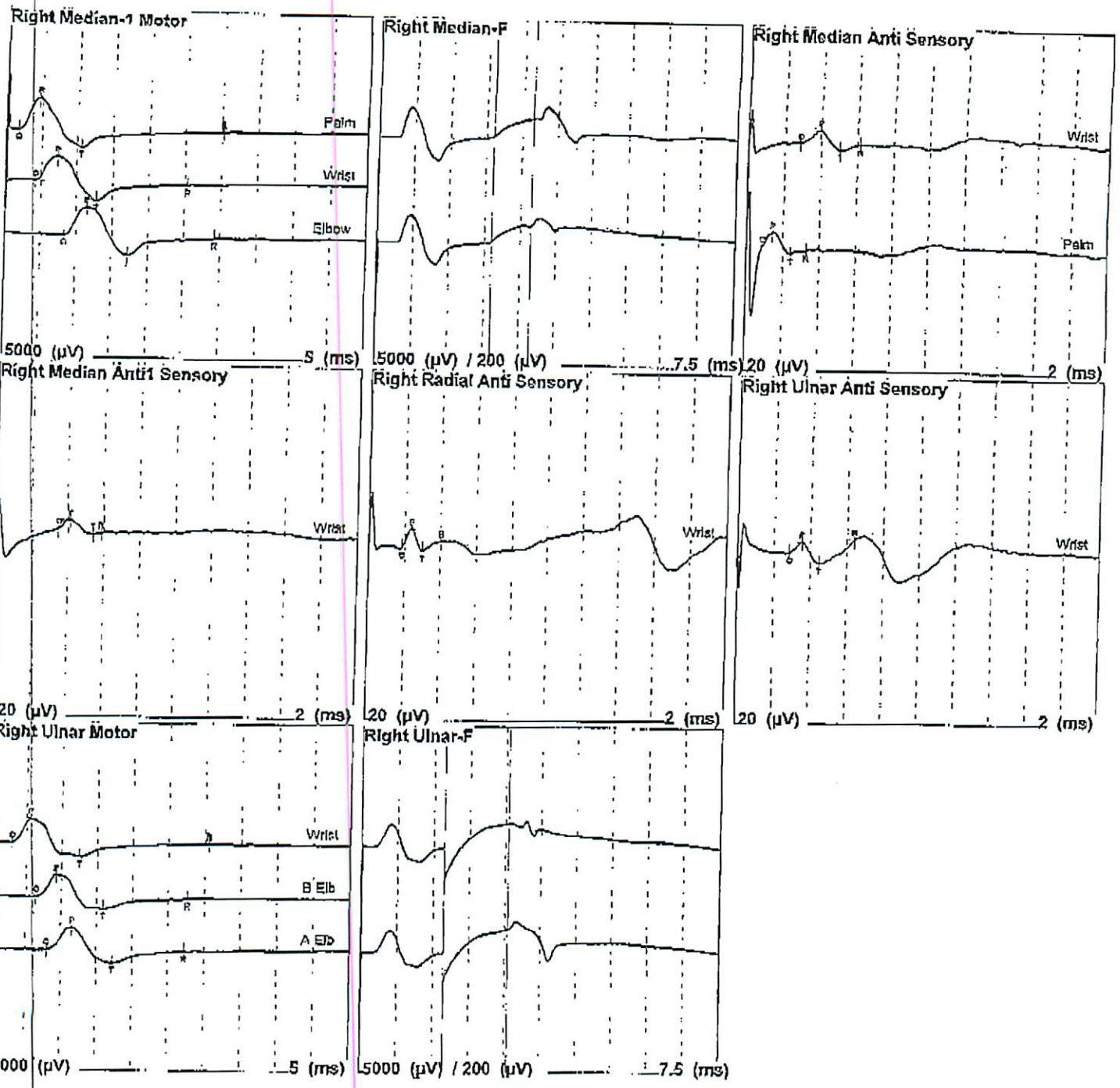
Motor Nerves

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm Amp (mV)	Neg Dur (ms)	Segment Name	Delta-O (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Median-1 (ABD)											
Palm		1.80		8.90		6.02	Palm-Wrist	-2.50	9	36.00	
Wrist		4.30		7.04		6.02	Wrist-Elbow	-4.06	21	51.72	
Elbow		8.36		7.86		6.48					
Right Ulnar (ADM)											
Wrist		2.97	<4.2	6.67	>3.0	5.70	B Elb-Wrist	3.36	21	62.50	>53.0
B Elb		6.33		6.04		6.17	B Elb-A Elb	-1.72	12	69.77	>53.0
A Elb		8.05		6.33		6.17					

Sensory Nerves

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm Amp (µV)	Segment Name	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Median Anti (2nd Digit)										
Wrist		3.97	<3.6	24.04	>10.0	Wrist-2nd Digit	3.97	14	35.26	>39.0
Palm		1.47		24.72		Palm-Wrist	-2.50	7	28.00	>48.0
Right Median AntI1 (3rd Digit)										
Wrist		4.13		17.03		Wrist-3rd Digit	4.13	14	33.90	
Right Radial Anti (Base 1st Dig)										
Wrist		2.41	<2.7	25.48		Wrist-Base 1st Dig	2.41	10	41.49	

Patient: DOE, Jane Test Date: 2/1/2010 p. 3



Right Ulnar Anti (5th Digit)										
Wrist	3.53	<3.7	24.82	>15.0	Wrist-5th Digit	3.53	14	39.66	>50.0	

FWave/HReflex

NR	Lat1 (ms)	Lat2 (ms)	Delta (ms)	Amp (µV)
Right Median-F (APB)				
	32.23	0.00	32.23	
Right Ulnar-F (ADM)				
	30.55	0.00	30.55	

Summary and Findings:

The right median motor nerve revealed prolonged distal latency, normal amplitude and normal conduction velocity.
The right ulnar motor nerve revealed normal distal latency, normal amplitude and normal conduction velocity.
The right median and ulnar F-wave latencies were normal.
The right median antidromic sensory nerve to D2 and D3 revealed prolonged distal latency, normal amplitude and decreased conduction velocity.
The right radial and ulnar sensory nerves revealed normal distal latency, normal amplitude and normal conduction velocity.
Needle examination was performed with a monopolar disposable needle electrode on the muscles indicated above. The C5-6,6-7 innervated muscles show increased polyphasics with reduced recruitment pattern.
The cervical paraspinals show normal insertional activity.

Impression:

Abnormal Study.
The right median and sensory study reveals evidence of a moderate carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory and motor components.
EMG findings of increased polyphasics in the C5-6,6-7 innervated muscles with normal paraspinals is suggestive of chronic Cervical radiculopathy.
In view of patients clinical history corelation with a cervical MRI is required.

ppan

Peter Pan, M.D.

Apollo Zeus, M.D.
Orthopedics

December 16, 2009

O'Gara Insurance
ATTN: Caleb Gabriel
88th Fuente Osmena
Culver, CA 45678

Employee:	**DOE, Jane**
Employer:	Landscape Development, Inc.
Date of Injury:	09/08/09
Date of Examination:	12/16/09
Case No:	
Chart No:	
Claim No:	

REPEAT ORTHOPEDIC CONSULTATION

Dear Claims Examiner:

I saw Jane Doe at the U.S. Healthway Clinic on December 16, 2009 in repeat orthopedic consultation regarding her work-related neck and right trapezius injury on referral from and with the approval of the insurance company.

The following is a report of my examination, findings, diagnosis, prognosis, work status and treatment recommendations with respect to this injury.

This report is a separate and compensable item in addition to the evaluation and management code.

Available medical records and radiological studies were reviewed today.

IDENTIFICATION AND CURRENT EMPLOYMENT STATUS

The patient is a 56-year-old right handed white female landscaper employed by Landscape Development, Inc. The patient had worked for this employer for eleven years at the time of this injury.

CHIEF COMPLAINT

The patient's chief complaint is pain in her right trapezius. She previously had pain in the right side of her neck and right trapezius radiating to her right upper extremity.

HISTORY OF INJURY

The patient states she began experiencing pain in the right side of her neck and right trapezius radiating to her right hand at work on September 8, 2009, while using power shears.

The patient was initially seen by Dr. D. Howser in this clinic on September 14, 2009. The patient was felt to have a cervical sprain with degenerative disc disease, right shoulder sprain/strain and a right wrist and forearm sprain/strain. The patient has been treated with extra-strength Tylenol and physical therapy.

The patient reports the treatment has provided significant improvement. She is no longer experiencing radiation of pain to her right upper extremity.

I previously evaluated the patient on November 4, 2009. I felt she had a cervical and right trapezius sprain/strain with evidence of a cervical nerve root irritation. I recommended an MRI scan of the cervical spine.

The MRI scan has been performed. It shows degenerative disc disease at C4-5, C5-6 and C6-7 with small disc bulges at C4-5 and C5-6 and mild degenerative arthritis of the uncovertebral joints at C5-C and C6-7 causing mild right foraminal narrowing. There is no evidence of herniated disc.

The patient was referred for repeat orthopedic consultations.

PRESENT COMPLAINTS

The patient states she is much improved since the last evaluation.

The patient complains of pain in the right side of her neck and right trapezius. The pain is described as an intermittent, mild, dull pain. The pain is aggravated by overhead activities and by heavy lifting, pushing and pulling. The pain is alleviated by rest and medications. The pain is also alleviated when the patient flexes her neck to the left.

The patient reports the following associated signs and symptoms: None at this time.

The patient denies prior injury to the neck, right trapezius, or right upper extremity.

PAST MEDICAL HISTORY (as of December 16, 2009)

Medical History:	The patient has hypertension and a history of skin cancer.
Surgical History:	The patient has a history of tonsillectomy, c-section, and excision of skin cancer.
Current Medications:	The patient is taking over-the-counter Tylenol for this injury.
Allergies:	NKDA.

SOCIAL HISTORY (as of December 16, 2009)

Marital Status:	Single.
Current Employment:	The patient is employed as a landscaper by Landscape Development, Inc.
Tobacco:	The patient smokes one pack of cigarettes each day for the past forty-five years.
Alcohol:	The patient reports moderate alcohol use.

FAMILY HISTORY (as of December 16, 2009)

Family history is significant for blood disease, cancer, diabetes, heart disease, hypertension, and stroke.

REVIEW OF SYSTEMS (as of December 16, 2009)

A comprehensive review of systems was performed and documented in the chart. The review of systems is significant for hypertension, frequent indigestion, hair loss and easy bruising.

PHYSICAL EXAMINATION

General Appearance

The patient is a pleasant, cooperative moderately obese white female. The patient is in no apparent distress.

Spine and Neurological Examination

There is no clinical deformity of the spine. Skin color and temperature are within normal limits over the cervical, thoracic and lumbar spine.

There is no tenderness to palpation of the cervical spine at the midline. There is no cervical paraspinous muscle tenderness. There is no cervical paraspinous muscle spasm. There is no trapezius tenderness. There is no trapezius spasm. There is no tenderness to palpation of the thoracic spine at the midline. There is no thoracic paraspinous muscle tenderness. There is no thoracic paraspinous muscle spasm. There is no tenderness to palpation of the lumbar spine at the midline. There is no lumbar paraspinous tenderness. There is no lumbar paraspinous muscle spasm. There is no sciatic notch tenderness and no sacroiliac tenderness.

Demonstrated range of motion of the neck is within normal limits, with flexion 45 degrees, extension 45 degrees, right lateral bending 45 degrees, left lateral bending 45 degrees, right rotation 90 degrees, left rotation 90 degrees. The patient reports no pain with neck motion.

Deep tendon reflexes are 2+ bilaterally in the upper extremities. Knee reflexes and ankle reflexes are 2+ bilaterally.

Sensation is reported as within normal limits in the upper extremities bilaterally.

Motor strength is 5/5 in shoulder abductors, grip strength, hand intrinsics, and thumb extensors bilaterally.

Right Shoulder Examination:

There is no clinical deformity of the right shoulder. There is no swelling of the right shoulder. Skin color and temperature are within normal limits over the right shoulder.

There is no right trapezius tenderness or spasm. There is no tenderness to palpation of the anterior or posterior joint line of the right shoulder. There is no tenderness to palpation of the anterior border of the right acromion. There is no tenderness to palpation of the right acromioclavicular joint. There is no tenderness to palpation of the right humeral head. There is no tenderness to palpation of the right biceps tendon sheath. There is no palpable biceps tendon defect. There is no other tenderness to palpation of the right shoulder.

Demonstrated range of motion of the right shoulder is within normal limits with flexion 180 degrees, extension 50 degrees, abduction 180 degrees, internal rotation 90 degrees, external rotation 90 degrees. The patient reports no pain with right shoulder motion. There is no crepitus with right shoulder motion. There is no instability of the right shoulder. Right shoulder abductor strength is 5/5. Impingement sign is negative.

Left Shoulder Examination:

There is no clinical deformity of the left shoulder. There is no swelling of the left shoulder. Skin color and temperature are within normal limits over the left shoulder.

There is no left trapezius tenderness or spasm. There is no tenderness to palpation of the anterior or posterior joint line of the left shoulder. There is no tenderness to palpation of the anterior border of the left acromion. There is no tenderness to palpation of the left acromioclavicular joint. There is no tenderness to palpation of the left humeral head. There is no tenderness to palpation of the left biceps tendon sheath. There is no palpable biceps tendon defect. There is no other tenderness to palpation of the left shoulder.

Demonstrated range of motion of the left shoulder is within normal limits, with flexion 180 degrees, extension 50 degrees, abduction 180 degrees, internal rotation 90 degrees, external rotation 90 degrees. The patient reports no pain with left shoulder motion. There is no crepitus with left shoulder motion. There is no instability of the left shoulder. Left shoulder abductor strength is 5/5. Impingement sign is negative.

Right Elbow Examination

There is no clinical deformity of the right elbow. There is no swelling of the right elbow. Skin color and temperature are within normal limits over the right elbow.

There is no tenderness to palpation of the right medial epicondyle. There is no tenderness to palpation of the right lateral epicondyle. There is no tenderness to palpation of the right radial head. There is no tenderness to palpation of the right olecranon. There is no other tenderness to palpation of the right elbow.

Demonstrated range of motion of the right elbow is within normal limits with flexion and extension 0 to 135 degrees, pronation 90 degrees, supination 90 degrees. The patient reports no pain with motion of the right elbow. There is no crepitus with motion of the right elbow. There is no ligamentous laxity of the right elbow. The patient reports no pain with stress of the ligaments of the right elbow.

The patient reports no pain in the right elbow with resisted extension of the right wrist. There is no pain in the right elbow with resisted flexion of the right wrist. There is no pain in the right elbow with power gripping.

There is no clinical deformity of the right arm or forearm. There is no swelling of the right arm or forearm. Skin color and temperature are within normal limits over the right arm and forearm. There is no tenderness to palpation of the right arm or forearm.

Left Elbow Examination

There is no clinical deformity of the left elbow. There is no swelling of the left elbow. Skin color and temperature are within normal limits over the left elbow.

There is no tenderness to palpation of the left medial epicondyle. There is no tenderness to palpation of the left lateral epicondyle. There is no tenderness to palpation of the left radial head. There is no tenderness to palpation of the left olecranon. There is no other tenderness to palpation of the left elbow.

Demonstrated range of motion of the left elbow is within normal limits with flexion and extension 0 to 135 degrees, pronation 90 degrees, supination 90 degrees. The patient reports no pain with motion of the left elbow. There is no crepitus with motion of the left elbow. There is no ligamentous laxity of the left elbow. The patient reports no pain with stress of the ligaments of the left elbow.

The patient reports no pain in the left elbow with resisted extension of the wrist. There is no pain in the left elbow with resisted flexion of the left wrist. There is no pain in the left elbow with power gripping.

There is no clinical deformity of the left arm or forearm. There is no swelling of the left arm or forearm. Skin color and temperature are within normal limits over the left arm and forearm. There is no tenderness to palpation of the left arm or forearm.

Right Hand and Wrist Examination

There is no clinical deformity of the right wrist or hand. There is no swelling of the right wrist or hand. There is no thenar or hypothenar atrophy. Skin color and temperature are within normal limits over the right wrist and hand. There are no soft tissue masses on the right wrist or hand.

There is no tenderness to palpation of the right wrist or hand. There is full motion of the right wrist with volar flexion 70 degrees, extension 50 degrees, radial flexion 30 degrees, and ulnar flexion 45 degrees. There is no pain with motion of the right wrist. There is no crepitus with motion of the right wrist. There is no ligamentous laxity of the right wrist. There is no pain with stress of the ligaments of the right wrist.

There is full motion of all digits of the right hand without pain. Flexion brings the tip of the thumb to the 5th metacarpal head. The thumb extends to a straight line. Flexion brings the tip of the fingers to the distal palmar crease. Extension brings the fingers to a straight line. There is no triggering of any of the digits of the right hand.

Sensation is reported as within normal limits in all digits of the right hand. Right hand grip strength is 5/5. Hand intrinsics and thumb extensors are 5/5 in strength on the right.

Left Hand and Wrist Examination

There is no clinical deformity of the left wrist or hand. There is no swelling of the left wrist or hand. There is no thenar or hypothenar atrophy. Skin color and temperature are within normal limits over the left wrist and hand. There are no soft tissue masses on the left wrist or hand.

There is no tenderness to palpation of the left wrist or hand. There is full motion of the left wrist with volar flexion 70 degrees, extension 50 degrees, radial flexion 30 degrees and ulnar flexion 45 degrees. There is no pain with motion of the left wrist. There is no crepitus with motion of the left wrist. There is no ligamentous laxity of the left wrist. There is no pain with stress of the ligaments of the left wrist.

There is full motion of all digits of the left hand. Flexion brings the tip of the thumb to the 5th metacarpal head. The thumb extends to a straight line. Flexion brings the tips of the fingers to the distal palmar crease. Extension brings the fingers to a straight line. There is no triggering of any digits of the left hand.

Sensation is reported as within normal limits in all digits of the left hand. Left hand grip strength is 5/5. Hand intrinsics and thumb extensors are 5/5 in strength on the left.

DIAGNOSTIC STUDIES

MRI: An MRI scan of the cervical spine was performed at Modesto Advanced Imaging Center on November 23, 2009. I have reviewed the films and a radiologists report by R. Bier, M.D. There is reversal of the lordosis. There is mild degenerate disc disease at C4-5, C5-6, and C6-7 with small bulges of the C4-5 and C5-6 disc which flatten the thecal sac, but which do not compromise the nerve roots. There is mild degenerative arthritis of the uncovertebral joints at C5-6 and C6-7 resulting in mild right neural foraminal narrowing.

X-rays: X-rays of the right shoulder taken in this clinic on September 14, 2009 are unremarkable.

X-rays of the cervical spine taken in this clinic on September 14, 2009 show multilevel degenerative disc disease with moderate disc space narrowing at C4-5, C5-6 and C6-7. There is some loss of the normal lordosis. There is no evidence of fracture or other acute bony abnormality.

EMG/NCS: None.

Other: None.

ASSESSMENT

The patient has sustained an industrial neck and right trapezius injury. The patient has a cervical and right trapezius sprain/strain.

The patient has multilevel degenerative disc disease of the cervical spine. Her symptoms are most consistent with a cervical nerve root irritation. This would explain both the trapezius pain and the

radiation of pain to the right upper extremity as well as the fact that the patient's symptoms are relieved by left lateral flexion of the neck. The MRI scan confirms multilevel degenerative disc disease with mild foraminal narrowing on the right at C5-6 and C6-7 which would explain the trapezius pain and the radiation of pain to the right upper extremity.

Treatment options include, but are not limited to the following:

1. Continued conservative treatment with medications and observation.

2. Additional physical therapy.

3. Additional diagnostic studies, specifically EMG's and nerve conduction studies of the right upper extremity to rule out cervical radiculopathy or peripheral neuropathy.

The patient is doing well. I do not feel she requires any additional diagnostic studies at this time. There is no indication for surgical intervention or epidural steroid injection at this time.

I feel the patient should continue conservative treatment.

A consultation was held with the patient. The nature of the problem, treatment options, risks, and prognosis were discussed with the patient in layman's terms.

RECOMMENDATIONS

My findings and treatment recommendations have been discussed with the patient and discussed with or communicated to the referring physician. I have recommended continued conservative treatment.

PLAN

After discussion of treatment options, the patient has agreed to my recommendations.

Medications:	Extra-strength Tylenol.
Physical Therapy:	None at this time.
Other Treatment:	None at this time.

Work Status:	The patient will continue modified work duties (if available) with restrictions of limited overhead work, 25 lbs. weight limit, 25 lbs. pushing and pulling limit.
Follow-up Appointment:	No further orthopedic appointments have been scheduled as only a one-time consultation was requested and approved. I will be happy to see the patient again anytime it is felt to be necessary.

The patient will return for follow-up with on December 21, 2009 as scheduled.

Thank you very much for allowing me to re-evaluate this patient.

DISCLOSURE STATEMENT

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Sincerely,

Apollo Zeus, md

Apollo Zeus, M.D.

Apollo Zeus, M.D.
Orthopedics

November 4, 2009

O'Gara Insurance
ATTN: Caleb Gabriel
88th Fuente Osmena
Culver, CA 45678

Employee:	**DOE, Jane**
Employer:	Landscape Development, Inc.
Date of Injury:	09/08/09
Date of Examination:	11/04/09
Case No:	
Chart No:	
Claim No:	

INITIAL ORTHOPEDIC CONSULTATION

Dear Claims Examiner:

I saw Jane Doe at the U.S. Healthway Clinic on November 4, 2009 in orthopedic consultation regarding her work-related neck and right trapezius injury on referral from and with the approval of the insurance company.

The following is a report of my examination, findings, diagnosis, prognosis, work status and treatment recommendations with respect to this injury.

This report is a separate and compensable item in addition to the evaluation and management code.

Available medical records and radiological studies were reviewed today.

IDENTIFICATION AND CURRENT EMPLOYMENT STATUS

The patient is a 56-year-old right handed white female landscaper employed by Landscape Development, Inc. The patient had worked for this employer for eleven years at the time of this injury.

CHIEF COMPLAINT

The patient's chief complaint is pain in her right trapezius. She previously had pain in the right side of her neck and right trapezius radiating to her right upper extremity.

HISTORY OF INJURY

The patient states she began experiencing pain in the right side of her neck and right trapezius radiating to her right hand at work on September 8, 2009, while using power shears.

The patient was initially seen by Dr. D. Howser in this clinic on September 14, 2009. The patient was felt to have a cervical sprain with degenerative disc disease, right shoulder sprain/strain and a right wrist and forearm sprain/strain. The patient has been treated with extra-strength Tylenol and physical therapy.

The patient reports the treatment has provided significant improvement. She is no longer experiencing radiation of pain to her right upper extremity.

An MRI scan has not been performed.

The patient was referred for orthopedic consultation.

PRESENT COMPLAINTS

The patient complains of right trapezius pain. The pain is described as an intermittent, moderate, dull pain. The pain is aggravated by overhead activities and by heavy lifting, pushing and pulling. The pain is alleviated by rest and medications. The pain is also alleviated when the patient flexes her neck to the left.

The patient reports the following associated signs and symptoms: None at this time.

The patient denies prior injury to the neck, right trapezius, or right upper extremity.

PAST MEDICAL HISTORY (as of November 4, 2009)

Medical History:	The patient has hypertension and a history of skin cancer.
Surgical History:	The patient has a history of tonsillectomy, c-section, and excision of skin cancer.
Current Medications:	The patient is taking over-the-counter Tylenol for this injury.
Allergies:	NKDA.

SOCIAL HISTORY (as of November 4, 2009)

Marital Status:	Single.
Current Employment:	The patient is employed as a landscaper by Landscape Development, Inc.
Tobacco:	The patient smokes one pack of cigarettes each day for the past forty-five years.
Alcohol:	The patient reports moderate alcohol use.

FAMILY HISTORY (as of November 4, 2009)

Family history is significant for blood disease, cancer, diabetes, heart disease, hypertension, and stroke.

REVIEW OF SYSTEMS (as of November 4, 2009)

A comprehensive review of systems was performed and documented in the chart. The review of systems is significant for hypertension, frequent indigestion, hair loss and easy bruising.

PHYSICAL EXAMINATION

General Appearance

The patient is a pleasant, cooperative moderately obese white female. The patient is in no apparent distress.

Spine and Neurological Examination

There is no clinical deformity of the spine. Skin color and temperature are within normal limits over the cervical, thoracic and lumbar spine.

There is no tenderness to palpation of the cervical spine at the midline. There is no cervical paraspinous muscle tenderness. There is no cervical paraspinous muscle spasm. There is no trapezius tenderness. There is no trapezius spasm. There is no tenderness to palpation of the thoracic spine at the midline. There is no thoracic paraspinous muscle tenderness. There is no thoracic paraspinous muscle spasm. There is no tenderness to palpation of the lumbar spine at the midline. There is no lumbar paraspinous tenderness. There is no lumbar paraspinous muscle spasm. There is no sciatic notch tenderness and no sacroiliac tenderness.

Demonstrated range of motion of the neck is within normal limits, with flexion 45 degrees, extension 45 degrees, right lateral bending 45 degrees, left lateral bending 45 degrees, right rotation 90 degrees, left rotation 90 degrees. The patient reports no pain with neck motion.

Deep tendon reflexes are 2+ bilaterally in the upper extremities. Knee reflexes and ankle reflexes are 2+ bilaterally.

Sensation is reported as within normal limits in the upper extremities bilaterally.

Motor strength is 5/5 in shoulder abductors, grip strength, hand intrinsics, and thumb extensors bilaterally.

Right Shoulder Examination:

There is no clinical deformity of the right shoulder. There is no swelling of the right shoulder. Skin color and temperature are within normal limits over the right shoulder.

There is no right trapezius tenderness or spasm. There is no tenderness to palpation of the anterior or posterior joint line of the right shoulder. There is no tenderness to palpation of the anterior border of the right acromion. There is no tenderness to palpation of the right acromioclavicular joint. There is no tenderness to palpation of the right humeral head. There is no tenderness to palpation of the right biceps tendon sheath. There is no palpable biceps tendon defect. There is no other tenderness to palpation of the right shoulder.

Demonstrated range of motion of the right shoulder is within normal limits with flexion 180 degrees, extension 50 degrees, abduction 180 degrees, internal rotation 90 degrees, external rotation 90 degrees. The patient reports no pain with right shoulder motion. There is no crepitus with right shoulder motion. There is no instability of the right shoulder. Right shoulder abductor strength is 5/5. Impingement sign is negative.

Left Shoulder Examination:

There is no clinical deformity of the left shoulder. There is no swelling of the left shoulder. Skin color and temperature are within normal limits over the left shoulder.

There is no left trapezius tenderness or spasm. There is no tenderness to palpation of the anterior or posterior joint line of the left shoulder. There is no tenderness to palpation of the anterior border of the left acromion. There is no tenderness to palpation of the left acromioclavicular joint. There is no tenderness to palpation of the left humeral head. There is no tenderness to palpation of the left biceps tendon sheath. There is no palpable biceps tendon defect. There is no other tenderness to palpation of the left shoulder.

Demonstrated range of motion of the left shoulder is within normal limits, with flexion 180 degrees, extension 50 degrees, abduction 180 degrees, internal rotation 90 degrees, external rotation 90 degrees. The patient reports no pain with left shoulder motion. There is no crepitus with left shoulder motion. There is no instability of the left shoulder. Left shoulder abductor strength is 5/5. Impingement sign is negative.

Right Elbow Examination

There is no clinical deformity of the right elbow. There is no swelling of the right elbow. Skin color and temperature are within normal limits over the right elbow.

There is no tenderness to palpation of the right medial epicondyle. There is no tenderness to palpation of the right lateral epicondyle. There is no tenderness to palpation of the right radial head. There is no tenderness to palpation of the right olecranon. There is no other tenderness to palpation of the right elbow.

Demonstrated range of motion of the right elbow is within normal limits with flexion and extension 0 to 135 degrees, pronation 90 degrees, supination 90 degrees. The patient reports no pain with motion of the right elbow. There is no crepitus with motion of the right elbow. There is no ligamentous laxity of the right elbow. The patient reports no pain with stress of the ligaments of the right elbow.

The patient reports no pain in the right elbow with resisted extension of the right wrist. There is no pain in the right elbow with resisted flexion of the right wrist. There is no pain in the right elbow with power gripping.

There is no clinical deformity of the right arm or forearm. There is no swelling of the right arm or forearm. Skin color and temperature are within normal limits over the right arm and forearm. There is no tenderness to palpation of the right arm or forearm.

Left Elbow Examination

There is no clinical deformity of the left elbow. There is no swelling of the left elbow. Skin color and temperature are within normal limits over the left elbow.

There is no tenderness to palpation of the left medial epicondyle. There is no tenderness to palpation of the left lateral epicondyle. There is no tenderness to palpation of the left radial head. There is no tenderness to palpation of the left olecranon. There is no other tenderness to palpation of the left elbow.

Demonstrated range of motion of the left elbow is within normal limits with flexion and extension 0 to 135 degrees, pronation 90 degrees, supination 90 degrees. The patient reports no pain with motion of the left elbow. There is no crepitus with motion of the left elbow. There is no ligamentous laxity of the left elbow. The patient reports no pain with stress of the ligaments of the left elbow.

The patient reports no pain in the left elbow with resisted extension of the wrist. There is no pain in the left elbow with resisted flexion of the left wrist. There is no pain in the left elbow with power gripping.

There is no clinical deformity of the left arm or forearm. There is no swelling of the left arm or forearm. Skin color and temperature are within normal limits over the left arm and forearm. There is no tenderness to palpation of the left arm or forearm.

Right Hand and Wrist Examination

There is no clinical deformity of the right wrist or hand. There is no swelling of the right wrist or hand. There is no thenar or hypothenar atrophy. Skin color and temperature are within normal limits over the right wrist and hand. There are no soft tissue masses on the right wrist or hand.

There is no tenderness to palpation of the right wrist or hand. There is full motion of the right wrist with volar flexion 70 degrees, extension 50 degrees, radial flexion 30 degrees, and ulnar flexion 45 degrees. There is no pain with motion of the right wrist. There is no crepitus with motion of the right wrist. There is no ligamentous laxity of the right wrist. There is no pain with stress of the ligaments of the right wrist

There is full motion of all digits of the right hand without pain. Flexion brings the tip of the thumb to the 5th metacarpal head. The thumb extends to a straight line. Flexion brings the tip of the fingers to the distal palmar crease. Extension brings the fingers to a straight line. There is no triggering of any of the digits of the right hand.

Sensation is reported as within normal limits in all digits of the right hand. Right hand grip strength is 5/5. Hand intrinsics and thumb extensors are 5/5 in strength on the right.

Left Hand and Wrist Examination

There is no clinical deformity of the left wrist or hand. There is no swelling of the left wrist or hand. There is no thenar or hypothenar atrophy. Skin color and temperature are within normal limits over the left wrist and hand. There are no soft tissue masses on the left wrist or hand.

There is no tenderness to palpation of the left wrist or hand. There is full motion of the left wrist with volar flexion 70 degrees, extension 50 degrees, radial flexion 30 degrees and ulnar flexion 45 degrees. There is no pain with motion of the left wrist. There is no crepitus with motion of the left wrist. There is no ligamentous laxity of the left wrist. There is no pain with stress of the ligaments of the left wrist.

There is full motion of all digits of the left hand. Flexion brings the tip of the thumb to the 5th metacarpal head. The thumb extends to a straight line. Flexion brings the tips of the fingers to the distal palmar crease. Extension brings the fingers to a straight line. There is no triggering of any digits of the left hand.

Sensation is reported as within normal limits in all digits of the left hand. Left hand grip strength is 5/5. Hand intrinsics and thumb extensors are 5/5 in strength on the left.

DIAGNOSTIC STUDIES

MRI: None.

X-rays: X-rays of the right shoulder taken in this clinic on September 14, 2009 are unremarkable.

X-rays of the cervical spine taken in this clinic on September 14, 2009 show multilevel degenerative disc disease with moderate disc space narrowing at C4-5, C5-6 and C6-7. There is some loss of the normal lordosis. There is no evidence of fracture or other acute bony abnormality.

EMG/NCS: None.

Other: None.

ASSESSMENT

The patient has sustained an industrial neck and right trapezius injury. The patient has a cervical and right trapezius sprain/strain.

The patient has multilevel degenerative disc disease of the cervical spine. Her symptoms are most consistent with a cervical nerve root irritation. This would explain both the trapezius pain and the radiation of pain to the right upper extremity as well as the fact that the patient's symptoms are relieved by left lateral flexion of the neck.

Treatment options include, but are not limited to the following:

1. Continued conservative treatment with medications and observation.
2. Additional physical therapy.
3. Additional diagnostic studies, specifically an MRI scan of the cervical spine.

I feel the patient needs an MRI scan.

A consultation was held with the patient. The nature of the problem, treatment options, risks, and prognosis were discussed with the patient in layman's terms.

RECOMMENDATIONS

My findings and treatment recommendations have been discussed with the patient and discussed with or communicated to the referring physician. I have recommended an MRI scan of the cervical spine to rule out herniated disc. I have been asked to order that study.

PLAN

After discussion of treatment options, the patient has agreed to my recommendations.

We will request approval for an MRI scan of the cervical spine to rule out herniated disc.

Medications:	Extra-strength Tylenol.
Physical Therapy:	None at this time.
Other Treatment:	None at this time.
Work Status:	The patient will continue modified work duties (if available) with restrictions of limited overhead work, 20 lbs. weight limit, 20 lbs. pushing and pulling limit.
Follow-up Appointment:	No further orthopedic appointments have been scheduled as only a one-time consultation was requested and approved. I will be happy to see the patient again anytime it is felt to be necessary.

The patient will return for follow-up with in two weeks.

Thank you very much for allowing me to evaluate this patient.

DISCLOSURE STATEMENT

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Sincerely,

Apollo Zeus, md

Apollo Zeus, M.D.

HARRISON PLAZA IMAGING CENTER

DOE, Jane
DOB: 04/12/1953 Sex: F

Date of Service: 11/23/2009 7:39:00AM
Exam: (MOD) HF MRI CERVICAL SPINE WITHOUT CONTRAST

EXAMINATION: MRI CERVICAL SPINE WITHOUT CONTRAST

HISTORY: 56-year-old female with neck pain for one-and-a-half months. Pain also radiates to the right shoulder. Pain occurred during work.

PROCEDURE: The examination was performed in a GE 1.5 Scanner. Sequences are T1 and T2 sagittal with T2 gradient echo axial.

FINDINGS: The brainstem, cerebellum and spinal cord appear normal.

There is reversal of the normal lordotic curvature compatible with muscle spasm.

There is mild disc space narrowing at the C4-5, C5-6 and C6-7.

C2-3: The disc height appears normal. There is no disc bulge or disc protrusion. No neural foraminal narrowing is seen. Spinal canal appears normal.

C3-4: The disc height appears normal. There is no disc bulge or disc protrusion. No neural foraminal narrowing is seen. Spinal canal appears normal.

C4-5: There is 2-mm diffuse disc bulge which minimally flattens the thecal sac. There is no evidence of neural foraminal narrowing. The uncovertebral joints appear normal. The spinal canal is unremarkable.

C5-6: There is 2-mm diffuse disc bulge which minimally flattens the thecal sac. There is mild right neural foraminal narrowing secondary to degenerative changes in the right uncovertebral. The left side appears normal. There is no evidence of spinal canal stenosis.

C6-7: There is 2-mm right paracentral disc bulge, which impinges on the thecal sac. There is right neural foraminal narrowing secondary mild degenerative changes in the uncovertebral joints. There is no evidence of spinal canal stenosis.

C7-T1: The disc appears normal. There are normal neural foramina bilaterally. No abnormalities seen in the

HARRISON PLAZA IMAGING CENTER

DOE, Jane
DOB: 04/12/1953 Sex: F

Date of Service: 11/23/2009 7:39:00AM
Exam: (MOD) HF MRI CERVICAL SPINE WITHOUT CONTRAST

uncovertebral joints or central spinal canal.

IMPRESSION:

1. Reversal of the normal lordotic curvature compatible with muscle spasm.

2. Mild degenerative disc disease at C4-5, C5-6 and C6-7.

3. At C4-5 and C5-6, there are small disc bulges which flatten the thecal sac.

4. At C5-6 and C6-7, there is mild right neural foraminal narrowing secondary to mild degenerative changes in the uncovertebral joints.

Dictated By: Hagrid, R MD
Transcribed By: tra/eData Services
Signed Electronically By: Rubeus Hagrid, MD

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA

Within 5 days of your **initial examination**, for every occupational injury or illness send this report to **insurer or employer** (only if self-insured). 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 one copy of this report directly to the Division of Labor Statistics and Research, P.O. Box 603, San Francisco, CA 94101; and notify your local health officer by telephone within 24 hours and by sending a copy of this report within seven days.

1. **INSURER NAME AND ADDRESS**
   O'GARA INSURANCE - 88TH FUENTE OSMENA CULVER, CA 45678

PLEASE DO NOT USE THIS COLUMN

2. **EMPLOYER NAME**
   LANDSCAPE DEVELOPMENT, INC.

CASE NO.

3. Address: No. and Street: 2nd FLOOR UNIT 12 | City: GREENBELT CITY | Zip: CA 12355

INDUSTRY

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

COUNTY

5. **PATIENT NAME** (First name, middle initial, last name): JANE DOE
6. Sex: ☐ Male ☒ Female
7. Date of Birth: Mo. Day Yr. 4/12/1953

AGE

8. Address: No. and Street: 45th FLR UNIT 123 GLORIETTA BLDG. | City: MONTREAL | Zip: CA 12345
9. Telephone Number: (606) 555-5555

HAZARD

10. Occupation (Specific job title): LANDSCAPE MAINTENANCE WORKER
11. Social Security Number: 987-65-4321

DISEASE

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

HOSPITOLIZATION

13. Date and hour of injury or onset of illness: Mo. Day Yr. 09/04/09 | Hour 8:00 AM
14. Date last worked: Mo. Day Yr. 9/14/09

OCCUPATION

15. Date and hour of first Examination or treatment: Mo. Day Yr. 9/14/09 | Hour 9:04 AM
16. Have you (or your office) previously treated patient ☐ YES ☒ NO

RETURN DATE/CODE

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

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

Patient states "running power shears and lifting trimmers."

18./19./20. **SUBJECTIVE COMPLAINTS / OBJECTIVE FINDINGS / DIAGNOSIS** Chemical or toxic compounds involved? ☐ YES ☒ NO

EXAMINATION: Neck-Stiffness. Posterior cervical tenderness. Restricted range of motion, extension 40/55, lat flexion 35/40 bilaterally, lat rotation 60/70 bilaterally. Positive cervical compression test with lower cervical irritation. No tenderness paracervical, sternocleidomastoid or triceps muscles. Normal sensation to light touch and pinprick. No muscle weakness.
Right shoulder-Tenderness AC joint. Tenderness trapezius muscles. Positive impingement sign. No erythema, ecchymosis, scars, masses or swelling. No deformity or subluxation of shoulder joint. No deformity clavicle. Full range of motion. No tenderness biceps tendon. No tenderness rotator cuff. Normal sensation to light touch and pinprick. No muscle weakness.

DIAGNOSIS: CERVICAL SPRAIN WITH DEGENERATIVE JOINT DISEASE; RIGHT SHOULDER SPRAIN/STRAIN; RIGHT WRIST/FOREARM SPRAIN/STRAIN

Diagnosis:
847.0 SPRAIN OF NECK — 722.4 CERVICAL DISC DEGEN
440.8 SPRAIN SHOULDER/ARM NEC R — 726.6 SHOULDER REGION NEC R

X-ray and laboratory results (State if none or pending.) XRAY CERVICAL SPINE 3V: DEGENERATIVE JOINT DISEASE NOTED. RIGHT SHOULDER 3V: NORMAL. WET READINGS. SENT TO RADIOLOGIST. DISCUSSED WITH PATIENT.

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

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

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)
Comprehensive history, examination, and evaluation were performed of the injured area. Pertinent orthopedic and neurological tests were performed. Dispensed Acetamenophen 500mg ES 1 q 6 hours. Ordered PT 3x week for 2 weeks. Patient given aftercare instructions and informed of medication side effects. Return to clinic in 3 days.

If further treatment required, specify treatment. YES. Office follow-up / PT Estimated duration 14 days

24. If hospitalized as inpatient give hospital name and location. Date Admitted Estimated stay

25. **WORK STATUS** Is patient able to perform usual work? ☐ Yes ☒ No
    If "no", patient can return to: Regular Work Modified work: 9/14/09
    Specify restrictions No overhead work. Limit lift, push & pull up to 10 lbs.

Doctor's Signature D. Howser, MD Date 9/14/2009 CA License Number
Doctor Name and Degree **DOOGIE HOWSER, MD** IRS Number
Address Telephone Number

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.