Kathryn Raphael, M.D.
Internal Medicine

March 23, 2016

Patient:
D/I:
Employer:
DOB:
Claim No:
WCAB:

Dear

QUALIFIED MEDICAL EVALUATION

On XXX, I had the opportunity to interview and evaluate XXX regarding his "heart" condition.

The applicant arrived to my XXX, CA office on time, alone, and was interviewed and examined alone. The applicant was advised that a doctor-patient relationship was not established today, and that copies of my QME report would be sent to the requesting parties: XXX.

The applicant was advised regarding the unique nature of this industrial medical legal evaluation. This history and physical is not intended to be construed as a general or complete medical evaluation for the purpose of any medical diagnosis or treatment. The applicant is informed that my completed written report is not subject to the same doctor patient confidentiality that applies to medical reports generated by usual medical/surgical/psychiatric care. In contrast, my evaluation report is intended solely for medical-legal purposes.

I received and reviewed referral correspondence from XXX dated XXX. Additionally received and reviewed was correspondence from XXX dated XXX.

This report is submitted pursuant to 8 Cal. Code Regs. Section 9795(b)&(c) as an ML104-95, Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances and meets the requirement of ***four complexity factors***. These factors include:

(1) Two or more hours of face to face time with the patient, which shall count as **one complexity factor**;
(2) Two or more hours of records review, which shall count as **one complexity factor**;
(3) Two or more hours of medical research, which shall count as **one complexity factor;**
(4) addressing the issue of medical causation at the request of the parties, which shall count as **one complexity factor**;
(5) addressing the issue of apportionment at the request of the parties, which shall count as **one complexity factor**;

Time spent in face-to-face contact with the patient was 2 hours and 0 minutes. Time spent reviewing records was 8 hours and 45 minutes. Time spent preparing the report was 5 hours and 45 minutes. Total time spent on this case was 16 hours and 30 minutes.

GENERAL BACKGROUND

XXX is a XXX year old retired correctional officer for XXX. He was injured at work on XXX when he heard a loud noise and went to investigate. Per the applicant, there was a "big commotion" going on and an inmate had attempted to assault an officer through the bars of his jail cell. He returned to his office and felt his heart palpitating, felt light headed and sweaty. He sought medical attention for this initially on XXX.

JOB HISTORY

Date:	Company:	Location:	Type of work:
XXX	XXX		
XXX	XXX		

JOB DESCRIPTION

Average Day: 8 hours/day, 40 hours/week.

Job Title: Correctional Sergeant

Protective Equipment: Bullet proof and stab proof vests. Duty belt with baton, pepper spray, radio, tear gas grenades, spit mask, keys, handcuffs and flashlight.

Job Duties: Administrative segregation unit sergeant- in charge of inmates in solitary confinement.

CONFLICTS OR HARASSMENT AT WORK

None described by the applicant. No personnel files were provided for my review.

HISTORY OF INJURY AS TOLD BY APPLICANT

Date of injury: XXX

Mechanism of injury: He has two injuries. I am evaluating him for his second injury which he states occurred XXX at work. He was sitting at his desk and heard loud noises in the next room. He went to investigate this and saw a "big commotion". He suddenly felt his heart beating fast, felt light headed and sweaty. He returned to his office and sat in his chair and did not immediately seek medical attention.

His original injury which is for his right knee occurred while supervising the administration of an anti-psychotic injection to an inmate standing near inmate who was restrained by multiple coworkers, one of the coworkers thought that the inmate was resisting and accidently knocked down all of the officers including the applicant who twisted and landed on his right knee. DOI: XXX.

CURRENT WORK STATUS

Not working since retired XXX.

PREVIOUS WORKERS' COMPENSATION INJURIES

Denies.

Involved in 2 MVAs, first as a teenager with no lasting effects, and the second injury 15 years ago when he totaled his truck. He denies any chronic problems as a result although he was taken by ambulance to the Emergency Department for evaluation.

CURRENT COMPLAINTS

He denies any current chest pain, but states that he had chest pain twice in the last year.

PRE-EXISTING PERMANENT DISABILITY

Denies.

RECREATIONAL TOXIC EXPOSURES

The applicant denies hobbies involved with stained glass, paints, painting, woodworking, metal working, welding, photography or any recreational tasks that involve handling toxic chemicals. The applicant denies significant exposure to herbicides and/or pesticides. The applicant is unaware of any recreational exposures that would be contributing to his present symptom complex.

CURRENT MEDICATIONS

Drug Allergies: Sulfa drugs cause hives.

Medications:
Lipitor 20 mg one QD
Norvasc 5 mg ½ QD
Hytrin 5 mg one QHS
Lopressor 25 mg ½ QD
Cozaar 100 mg one QD
HCTZ 25 mg one QD
Antibiotic for scalp infection one QD
Ibuprofen OTC 1-2 times per week prn
Naprosyn one prn
Metamucil one packet daily
Loratadine one QD prn allergies.

PAST MEDICAL HISTORY

Dominant Hand: Right

Surgery:
XXX Right knee arthroscopy w/ partial medial meniscectomy.
XXX Right bunionectomy.

Medical:
Hypertension since age 27.
Hypercholesterolemia

Psych:

Emotional stress:

Work: Work was stressful.
Home: None.

FAMILY HISTORY

Mother - Alive and well age XXX.
Father - HTN & DM age XXX
Siblings - One sister age XXX in good health.
Children - No children.

SOCIAL ACTIVITIES

Goes to gym four times a week. Lives XXX. He has someone do the mowing and bundling of the hay. He retired from his job as a correctional officer in XXX.

SOCIAL HISTORY

School: Completed 12th grade.

Marital: Married.

Smoking: Smokes about 2 cigars a week.

Alcohol: Drinks 1-2 drinks on Friday nights,

Caffeine: Two cups of coffee daily.

Stress: No bankruptcy, felony convictions. No history of alcoholism or drug abuse.

Home environment: Lives with his wife and two dogs XXX.

ACTIVITIES OF DAILY LIVING (ADLs)

Self-Care/Personal Hygiene (toilet, dress, eat, groom): Normal.

Communication (write, see, hear, speak): Normal.

Physical Activity (stand, walk, sit, lie, stairs): Pain with prolonged standing and walking in right knee and back. Sitting increases low back pain. Can't lie down except on left side, right side of low back is painful. Stairclimbing is painful to his low back and his right knee. He has 3 sets of stairs in his house.

Sensory Function (hear, see, feel, taste, smell): Normal.

Hand, non-specialized activities (grasping, lifting, tactile discrimination): Normal.

Travel (car, airplane, public transportation): Driving or riding in a car worsens his right knee and right lower back pain.

Sexual (erectile and other forms of male/female dysfunction): Normal, but decreased frequency due to back and knee pain.

Sleep (restful, nocturnal pattern, naps during day): Pain awakens him frequently from sleep. His wife says he snores. Tested for sleep apnea one year ago which was normal. Has had weight gain of about 40 pounds since injury, less than 10 pounds in the past year.

Epworth Sleepiness Scale (Johns MW, *A new method for measuring daytime sleepiness*, the Epworth Sleepiness Scale, Sleep, 14(6):540-545).

0 = would never doze or sleep.
1 = slight chance of dozing or sleeping.
2 = moderate chance of dozing or sleeping.
3 = high chance of dozing or sleeping.

Situation	Chance of Dozing or Sleeping
Sitting and reading	3
Watching TV	3
Sitting inactive in a public place	3
Being a passenger in a motor vehicle for an hour or more	2
Lying down in the afternoon	3
Sitting and talking to someone	0
Sitting quietly after lunch (no alcohol)	0
Stopped for a few minutes in traffic while driving	0

Total 14

Total score - 14. This is the Epworth Score. A score of 10 or more is considered sleepy. A score of 18 or more is considered very sleepy.

REVIEW OF SYSTEMS

HEENT: No eyes, ears, nose, throat complaints. Has seasonal allergies.

LUNGS: No wheezing, cough or shortness of breath.

HEART: No cardiovascular chest pain or palpitations.
GI: No digestive complaints.

GU: No kidney, bladder problems.

SEXUAL FUNCTION: Normal but increased frequency because of knee pain.

PSYCH: No complaints.

Musculo-Skeletal: Constant 3-4/10 right knee pain worse with prolonged sitting or standing, constant 4-5/10 low back pain.

Neurologic: No headaches. No fainting or seizures.

Skin: Scalp rash/infection for which he takes antibiotics.

MEDICAL RECORD REVIEW

844 pages

XXX **XXX** F/U for HTN. Requests testosterone check. Problem list: HTN, allergic rhinitis, hyperlipidemia, obesity. Meds: HCTZ 25 mg, Cozaar 100 mg, amlodipine 5 mg. PE: BP 145/98,64, Ht. 6”1”,WT. 293 lb., normal exam. TX. Increase amlodipine 10 mg., Check testosterone, TSH and CBC plus differential.

XXX **XXX** sore throat for 3 days. TX: Coming in for throat culture today. Yellow exudates on left side of pharynx with mild swelling. A/P high, add Hytrin 5 mg daily at bedtime.

XXX **XXX** lesion at the mouth of the ear canal and history of cerumen impaction. Tx: Debrided under scope.

XXX **XXX** cough x2 days, right lower back pain worse with motion, no radiation to legs. Dry cracking on hands, irritated eyes. Meds: Losartan 100 mg daily, amlodipine 10 mg daily, Terazosin 5 mg daily, HCTZ 25 mg daily. PE: BP 129/62, P 78, WT. 289 lb.. Normal exam except pain with motion of the back, SI joints and sciatic notches non-tender, positive SLR 75° bilaterally. Dx: Bronchitis, low back pain, hyperlipidemia, HTN, obesity, conjunctivitis. Tx: Hydrocodone–acetaminophen seen 5/500 mg tabs 1-2 every 6 hours when necessary pain, codeine cough syrup 2 teaspoons every 4 hours when necessary cough, EES 5 mg/gram POTH OINT 3 times a day x5 days in affected eyes. Check FBS, lipid panel, ALT, TSH, CR, CBC,K,Na.

XXX **XXX** secure message, requests for muscle relaxer for back spasms. Rx: Methocarbamol 750 mg 1 3 times a day when necessary muscle spasm.

XXX **XXX** history of cerumen impaction, last cleaned 7–8 months ago. PE: Right and left side dry cerumen- removed. (all labs of XXX WNL).

XXX **XXX** here for follow-up back pain and cough. Had chills and fever to 101 when return to work XXX. Meds: Losartan 100 mg one daily, HCTZ 25 mg one daily, Cheratussin a.c. 10–100 milligrams/5 male 2 teaspoon every 4 hours when necessary, amlodipine 10 mg one daily, Terazol 7 5 mg one daily, Vicodin 5/500 one to 2 every 6 hours when necessary pain, Methocarbamol 750 mg 1 3 times a day when necessary muscle spasm. PE: BP/PA 131/55, P 80,Wt. 288 lb., BMI 38.08. PE within normal limits except positive stress SLR 80° bilaterally. Tx; continue Vicodin, off work through 1/30.

XXX **XXX** symptoms of a cold, congestion, pressure on face sinuses, plugging and aching right ear, no chills lump right jaw. PE: BP 126/74, P 78,WT. 289 lb., BMI 37.69. PE: WNL except right ear slightly red, left ear cerumen impaction, 1.5 cm node right lower jaw area. Dx: Otitis media, HTN. Hyperlipidemia, severe obesity equivalent. Tx amoxicillin clavulanate 875–125 one twice a day until gone.

XXX **XXX** cerumen impaction. PE B/P 119/54, P 57, Wt. 287 lb., BMI 37.86., Cerumen impaction bilaterally PE otherwise normal. Tx bilateral ear wash.

XXX **XXX** F/U exam, left elbow pain for several months, and no trauma cannot fully extend elbow. Pain in right knee with walking and some swelling, right lower back pain. Meds: Amlodipine 10 mg one daily, Terazosin 5 mg one daily, losartan 100 mg one daily, HCTZ 25 mg one daily. PE: B/P 131/63, P 67, Wt. 297 lb., BMI 38.12. PE within normal limits with the exception of small left olecranon bursitis tender on flexion and extension. Dx: HTN, severe obesity equivalent, hyperlipidemia, URI, arthritis right knee, elbow joint pain. Tx: Back video program, Naprosyn 500 mg 1 twice a day with food when necessary pain.

XXX **XXX x-ray left elbow:** Impression: Mild degenerative changes without evidence of acute traumatic abnormality.

XXX **XXX x-ray right knee:** Impression: Mild osteoarthritis.

XXX **XXX** bald spot right scalp x3 weeks slightly sore, rash on feet. Meds: HCTZ 25 mg one daily, Naprosyn 500 mg 1 twice a day when necessary pain, Amlodipine 10 mg one daily, Terazosin 5 mg one daily, losartan 100 mg one daily, clotrimazole 1% apply to affected areas twice a day., Cephalexin 500 mg 1 4 times a day until gone. PE: B/P 124/63, P 68, Wt. 291 LB, BMI 38.4. Bald spot right scalp 3 cm, tinea pedis, with dry crusty slightly inflamed right interdigital space right foot. Dx: Alopecia Areata, Tinea Pedis. Plan: clotrimazole 1% BID to affected area, cephalexin 500 mg one QID.

XXX **XXX** dermatology. Hair loss. Correctional officer at XXX. PE: B/P 121/71, P 49 right vertex of scalp with mildly tender 1.5 cm nodule with overlying hair loss. Dx: Pilar cyst. Tx: Kenalog injection 0.3 male of 2.5 mg/ml.

XXX **XXX** dermatology. Follow up appointment for cyst.PE: B/P 129/63, P 67, 2 cm cystic nodule on scalp. DX; Pilar cyst, Tx: Refer to HNS for excision.

XXX **XXX** Industrial work status report. XXX-year-old male here for palpitations/racing heartbeats on and off for several months but getting worse, lasting 20 min. or so, he usually sits down relaxant symptoms subside. He gets them more at work, stress from work, manager and more work now. He has to deal with the inmates and has to be prepared at all times. He does feel tense even before he gets to work, no chest pain no diaphoresis, but weak. He does exercises without much problem but out of breath fast. He took himself off from work since XXX as he does not feel he can handle well at work and if he has problems with the inmates. He notes some swelling on lower legs. PE: B/P 126/60, P 77, Wt. 295lb., BMI 37.89. Normal exam with trace pedal edema noted. DX: Palpitations, peripheral edema, severe obesity equivalent, hypertension–controlled. Tx: EKG, treadmill, TSH, chest x-ray PA and lateral, B–type natural reticulocyte peptide, CBC with differential, creatinine with GFR, sodium, potassium. Modified work duty until XXX: avoid contact w/ inmates, no altercation. Full work duty on XXX.

XXX **XXX** twelve-lead EKG:
Normal EKG.

XXX **XXXCXR:** Impression: No acute cardiopulmonary disease. Aortic atherosclerosis.

XXX **XXX** Doctor's First Report of Occupational Injury. DOI: XXX Employer : XXX correctional sergeant. Pt. c/o heart as well as feet, R knee, low back, L elbow, R wrist pain from

working at the prison, cumulative trauma. Pt. states he was hit by an inmate at work one yr. ago causing twisting right knee with pain and swelling, otherwise no acute injury, repetitive physical altercations, handcuffing, running to respond to alarms. Pt. notes heart palpitations related to stress at work. Pt. on 30 day Holter monitor, day 2 per Dr. XXX, PCP. Pt. given shoe inserts by Dr. XXX. No GI complaints. Vitals: BP 128/62, P 67, ht. 6'2". Normal exam with exception of slight limited range of motion left elbow, tender over ulnar aspect right wrist, and tender to palpation over the metatarsal head of the first and second toes bilaterally, and antalgic gait. Dx. Derangement of R knee, R wrist sprain, sprain/strain of back, L Morton's neuroma, R Morton's neuroma, left elbow OA, palpitations. Heart palpitations could be non-heart related or related to underlying heart condition, not likely due to or aggravated by factors of employment. Pt. disagrees and advised to seek second opinion. Plan: x-ray of R wrist, lumbosacral spine, bilat. feet. Possible f/u MRI of R knee. Request for PT, start HEP. Use wrist brace at night and PRN.

XXX **XXX** X-ray R knee shows mild osteoarthritis, small joint effusion. X-ray L elbow shows mild degenerative changes, no evidence acute trauma.

XXX **XXX** Industrial work status report. Dx. Derangement of R knee, R wrist sprain, sprain/strain of back, L Morton's neuroma. Modified activity: no lifting/carrying/pushing/pulling over 20 lbs. Avoid physical altercation.

XXX **XXX head and neck surgery.** Here for excision cyst of scalp. PE: B/P 129/75, P 66 2 cm area of hair loss with 1.5 cm raised area right parietal scalp. Dx: Pilar Cyst. Lx: excision of cyst.

XXX **XXX cardiology** height 6 foot 2 inches, weight 294 pounds, BMI 37.73. Labs: CBC wnl, Cr. 1.26, cholesterol 191, Trigli. 116, HDL 45, LDL calculated 123.Baseline EKG: Normal sinus rhythm at 72 bpm. Delayed R-wave progression.
Exercise stress test Bruce protocol: Exercise duration 8:51 minutes, exercise capacity: Good, stage reached: 3, METS: 10.1, test stopped due to fatigue. Impression: This stress test is negative for ischemia.

XXX **XXX echocardiogram:** Findings:
Mild mitral regurgitation.
No aortic stenosis or insufficiency.
Trace tricuspid regurgitation.
No pulmonic regurgitation.
Normal size left atrium.
Left ventricle: Normal diastolic function with normal left ventricular filling pressures.
Normal right atrial size.
Normal right ventricular size and systolic function.

XXX **XXX cardiology consult:** XXX yr XXX male. He is on maximum security prison guard and had palpitations after subduing a prisoner. Event monitor with 9 beats of

asymptomatic ventricular tachycardia. Treadmill stress test negative. He is here for advice. He denies illicit drug use, smoking. He drinks one cup of coffee daily. Meds: Lipitor, Hytrin, Cozaar, Norvasc, Esidrix/HydroDIURIL, Claritin, glucosamine, Naprosyn, vitamins. PE: B/page 132/63, P 64, height 6 foot 2 inches, weight 296 pounds, BMI 37.99, normal exam. EKG: Normal, echocardiogram: WNL. DX: Ventricular tachycardia, non-sustained. In setting of normal ejection fraction, normal treadmill stress test–benign Cardiac CT angiogram will confirm absence of coronary artery disease, but if negative also, then no need for further workup. If palpitations recur on metoprolol, can try other antiarrhythmic agent versus ablation.

XXX **XXX** Follow up visit. C/o low back pain, R knee pain, not taking any pain meds, no wrist pain, less foot pain d/t wearing non-work shoes. Off work. Vitals: BP 132/69, P 64, positive McMurray's right knee, tender ulnar aspect right wrist, antalgic gait. Dx. Sprain/strain knee, strain/sprain back, derangement of R knee. X-ray ordered. PT for low back pain, D/c wrist brace, continue HEP for R knee. Modified duty. RTC 2 wks.

XXX **XXX. x-ray right wrist:** Impression: Possible age–indeterminate fracture versus degenerative changes from old trauma in the medial base of the fifth metacarpal. Clinical correlation with follow up study recommended, if this is the region of the pain. Mild degenerative changes.

XXX **XXX x-ray right foot:** Impression: Weight bearing views. There is little arch to the foot. No fracture or dislocation is identified. A single screw is present in the distal first metatarsal apparently for fixation of an osteotomy which is now well healed. It appears the medial aspect of the first metatarsal head was shaved also. Mild to moderate degenerative changes involve the first metatarsophalangeal joint. A very small dorsal calcaneal traction osteophyte is noted also. **X-ray left foot:** Impression: Weight bearing views. There is little arch to the foot. No fracture or dislocation is seen. Very small dorsal Caucasian meal traction osteophyte is noted. **X-ray lumbar spine:** Impression: Questionable pars defect of L5-S1. Additional oblique views may be helpful. Mild levoscoliosis and minimal grade 10 series subluxation of L2 over L3 are likely due to moderate to severe degenerative changes through the mid to lower lumbar spine as described.

XXX **XXX**. X-ray lumbar spine for chronic low back pain for yrs. Impression: questionable pars defect of L5-S1. Additional oblique view may be helpful. Mild levoscoliosis, minimal grade 1 posterior subluxation of L2 over L3 likely due to moderate to severe degenerative changes through mid to lower lumbar spine. Mild to moderate facet hypertrophy throughout the rest of visible lower thoracic and upper lumbar spine.

XXX **XXX PT.** Physical therapy. Visit 1/6.

XXX **XXX** secure message to patient: Your cardiac CT angiogram scan showed no blockage. There is nothing wrong with your heart. Let me know if you have any questions.

XXX **XXX** a computed tomography angiography of coronaries:

1) Calcium score of 0 translates into a five-year cumulative coronary event rate 0.5% according to the multiethnic study of atherosclerosis.
2) Left main artery is normal.
3) Type III LAD with possible mild mid stenosis.
4) Diagonal artery, small to medium sized, suggestive of ostial lesion.
5) Circumflex artery free of disease.
6) Dominant right coronary artery small-caliber (due to poor contrast filling) without significant obstructive disease.
7) Study limited by obesity and somewhat poor contrast filling. By agreement with the department of radiology, only the cardiac portion of the study is being reviewed by the department of cardiology. A radiologist will review the remainder of the study and an addendum will follow.

Recommendations:

1) Final management per referring physician.
2) Suggest confirmation of above findings with confirmatory studies.

XXX **XXX ambulatory polysomnography interpretation:**
The apnea–hypopnea index of 7 (normal<5) **is C/w mild obstructive sleep apnea.**
It should be noted that the severity of the study does not always correlate with the severity of symptoms.
Referral to mild sleep apnea class will be arranged by respiratory care services.
According to Department of Transportation recommendations, an individual may be certified to drive a CMV if that individual has an AHA <20 and has no daytime sleepiness. This individual has an Epworth score of 2 which is low on the scale of daytime sleepiness.

XXX **XXX PT.** Physical therapy. Visit 2/6.

XXX **XXX.** walk-in visit to discuss cardiac CT angiogram results. Told of results. Patient states no palpitations on metoprolol. Normal cardiovascular system–continue medications. No restrictions. Okay to return to work per occupational medicine.

XXX **XXX** Follow up visit. Vitals: BP 127/61, P 69. Dx. Derangement of R knee, R wrist sprain, lumbar spine sprain. X-rays ordered, consider MRI of R knee, continue PT, HEP. Modified duty. RTC 2 wks.

XXX **XXX.** cardiology testing event monitoring report:
Event monitoring started XXX.
Baseline recording showed normal sinus rhythm with rates of 57 bpm.
Patient made no recordings with symptoms.
There are auto-capture recordings showing premature atrial complexes, super–ventricular couplets, premature ventricular complexes. There is 17–beat run of wide–complex tachycardia–

non-–sustained ventricular tachycardia versus rate related aberrant proximal super–ventricular tachycardia.
Impressions: No significant arrhythmias recorded.

XXX **XXX PT.** Physical therapy. Visit 3/6.

XXX **XXX PT.** Physical therapy. Visit 4/6.

XXX **XXX**. Follow up visit. Pt. taking Advil, no improvement in low back pain, no loss of bowel or bladder control. R knee pain. Vitals: BP 129/64, P 71. Dx. R knee sprain, derangement of R knee, R wrist sprain. R wrist x-ray shows possible age-indeterminate fractures vs. degenerative changes from old trauma in medial base of fifth metacarpal. Clinical correlation recommended. Mild degenerative changes.
Hx. 5 yrs. bilat. foot pain. R foot x-ray: little arch to the foot, no fracture, dislocation. A single screw is present in distal first metatarsal apparently for fixation of osteotomy, now well healed. Appears medial aspect of first metatarsal head also was shaved. Mild to moderate degenerative changes, first metatarsophalangeal joint. Very small dorsal calcaneal traction osteophyte is noted. L foot x-ray: no fracture, dislocation, small dorsal calcaneal traction osteophyte noted. Assessment: R wrist w/ mild degenerative changes, pre-existing condition, lumbar spine w/ mild to moderate degenerative changes- , pre-existing condition. Plan: R knee MRI, r/o derangement of knee. Rx Xanax 0.25mg HS for anxiety. Hx. claustrophobia, take support person for MRI. RTC 1 wk.

XXX **XXX** MRI R knee. Impression: moderate tri-compartmental osteoarthritis. Small joint effusion. Medial meniscus is diminutive w/ probable small radial tear of body of medial meniscus.

XXX **XXX respiratory therapist** mild OSA treatment class. Auto CPAP setting.

XXX **XXX PT.** Physical therapy. Visit 5/6.

XXX **XXX** Follow up to review R knee MRI. Vitals: BP 117/65, P 76. Dx. Derangement of R knee, R wrist sprain, lumbar spine strain, R knee sprain. Schedule consult w/ ortho. to discuss R knee acute injury vs. degenerative change. Recommend weight loss, continue PT, HEP, modified duty, RTC 2 wks.

XXX **XXX PT.** Physical therapy. Visit 6/6.

XXX **XXX Orthopedic consult**. Pt. w/ increased R knee pain over 6 months, no prior injury. Episode of being knocked to ground, landed on R hip 1 yr. ago. Running produces swelling, pain. Pt. taking Advil. Previously tried naproxen w/ stomach upset. Off work. X-ray shows good joint spaces. R knee MRI: small medial osteophytes, squaring medially w/ compression of medial meniscus and degenerative tearing posteriorly, patchy chondromalacia of

medial femoral condyle. Assessment: R knee pain from gradual degenerative change aggravated by obesity. Plan: weight loss, cortisone injection, continue ibuprofen. Consider arthroscopy to trim torn medial meniscus, may not improve pain which can be from early degenerative arthritis.

XXX **XXX respiratory therapist** auto CPAP returned. No data on CPAP ST car. The patient stated he didn't want a machine at this time. The patient has mild OSA and if he changes his mind we'll need to do another CPAP trial.

XXX **XXX** Follow up visit. Hx: Brought an incident report on XXX. Posterior right thigh was hit by a coworker behind the dictation, causing falling on his back interested right knee with pain and swelling. He wore a sleeve for right knee and thigh for at least a couple weeks other than that no acute injury. Patient recalled all the pain to repetitive physical altercation, and cuffing inmates, physical training, prolonged standing/walking, running to respond to alarms over the past 26 years of work. Has been off work due to no modified duty available. Pt. w/ intermittent low back pain, R knee pain, no improvement, intermittent swelling, R wrist stiffness, no pain/numbness, L elbow, no issues. No foot pain. L extremity weakness. No chest pain, no Dyspnea on exertion, no SOB. Nonsmoker. No palpitations on metoprolol. Pt. Vitals: BP 121/64, P 53. Dx. Derangement of R knee, R Morton's neuroma/lumbosacral spondylosis without myelopathy. Assessment: derangement of R knee d/t gradual degenerative changes from cumulative trauma over 26 yrs. as correctional officer, aggravated by fall XXX and obesity. XXX note by Dr. XXX documented Holter monitor: 9 beats slow ventricular tachycardia on autocapture without symptoms. Negative treadmill stress test for ischemia. If persistent ventricular ectopy, consider CT angiography of coronaries to exclude CAD. Palpitations secondary to ventricular tachycardia on autocapture without symptoms as per Dr. Chang's (cardiologist) note. "After careful review of all available evidence it is my opinion that the patient's current medical condition, more likely than not, was not caused or aggravated by factors of employment, I based this opinion on hx. and exam." Normal cardiovascular system. Pt. disagrees, advised to f/u w/ second opinion.
Low back pain secondary to lumbar spondylosis, moderate to severe degenerative changes, pre-existing condition, aggravated by obesity. R Morton's neuroma, industrial injury from cumulative trauma (need to wear wide shoes). L elbow osteoarthritis, asymptomatic, pre-existing wear and tear of joint caused or aggravated by employment. R wrist osteoarthritis, stiff, but otherwise asymptomatic, caused by pre-existing wear and tear of joint caused by factors of employment, Plan: weight loss recommended, continue metoprolol, continue HEP, ice/heat, "he has a procedure on XXX, wanting to avoid any pain meds." Return to work, modified duty for 2 wks. RTC 2 wks.

XXX **XXX** Unscheduled follow up visit. Pt. went to work, modified duty, c/o worsening pain, swelling R knee, left work early, took Vicodin. Pt. using crutches and R knee brace. Pt. wishes to proceed w/ R knee arthroscopy, claim is on delay authorization pending. Vitals: BP 129/65, P 66. Dx. Derangement of R knee. Rx Voltaren 1% topical, pt. dislikes pills. Weight loss recommended, no indication of TTD, modified duty, RTC 2 wks.

XXX **XXX.** Follow up visit. Awaiting surgery on XXX. Vitals: BP 130/65, P 63. Dx. Derangement of R knee. Continue HEP, Voltaren gel, recommend weight loss, on modified duty, RTC 3 wks.

XXX **XXX** Pt. ADLs questionnaire. DOI: XXX. Current medications: losartan 100mg, HCTZ 25mg, metoprolol 12.5mg, amlodipine 10mg, terazosin 5mg, naproxen 500mg. Internal medical problems: heart palpitations, HTN. Pt. complaints of upset stomach, dry mouth, R foot pain, R low back pain, problems w/ erection, sleep disturbance since the injury. No complaints regarding sleepiness, depression, sleep apnea. Pt. also notes, since the injury, trouble defecating, dressing himself, getting on and off the toilet as well as standing, sitting, walking, lifting and climbing stairs in addition to riding in a car, driving and shopping/running errands. Pt. states he has gained 20 lbs. since injury. Pt. has had an ECHO in last 5 yrs. Pt. has had broken bone/s in last 20 yrs.

XXX **XXX**. Follow up visit. Pt. awaiting surgery, feeling pain in L knee as well as R. Vitals: BP 115/57, P 52. Dx. Derangement of R knee.

XXX **XXX** Follow up visit. Pt. awaiting surgery. Vitals: BP 120/61, P 65. Dx. Derangement of R knee. RTC 3 wks.

XXX **XXX Orthopedic surgery report**. Dx. Tear of R knee medial meniscus w/ degenerative change. Procedure: R knee arthroscopy w/ partial medial meniscectomy. Completed without complication. Activity as tolerated.

XXX **XXX**Follow up visit. Pt. post-op, reluctant to return to work, concerned re safety at work, advised no take downs of inmates. Vitals: BP 112/62, P 86. Dx. Derangement of R knee. RTC 2 wks.

XXX **XXX** Post-op check for R knee arthroscopy. No signs of infection, complication, incision healing well. Follow surgeon's instructions re level of activity. Pt. on modified duty, f/u w/ Dr. XXX 4 wks.

XXX **XXX** Follow up. Still w/ R knee pain, feeling like it is 'giving out.' Pt. not taking any pain meds. Vitals: BP 120/67, P 63. Dx. Derangement of R knee. Plan: Voltaren 1% topical, follow post-op instructions, quad strengthening exercises, f/u w/ Dr. XXX. Modified duty. RTC 3 wks.

XXX **XXX** Follow up R knee arthroscopy. Vitals: BP 118/63, P 73. Dx. Derangement of R knee. Plan: Voltaren 1% topical, weight loss, ice/heat, f/u w/ ortho, begin PT, HEP. Modified duty, no running, deep squatting, limited walking, no lifting over 25 lbs. RTC 3 wks.

XXX **XXX PT.** Physical therapy. Visit 1/6. Knee arthroscopy documented as on Left

side. Dx. Derangement of R knee. Weight 304 lbs., last reading on XXX 294 lbs. Continue PT, HEP.

XXX **XXX PT.** Physical therapy. Visit 2/6.

XXX **XXX PT**. Physical therapy. Visit 3/6.

XXX **XXX** Follow up R knee arthroscopy XXX for reabsorbed tear of medial meniscus and chondromalacia. Pt. healing well. Pt. off work due to no modified work available. Continue exercises, likely return to full duty on approx. XXX.

XXX **XXX** up visit. S/p L knee arthroscopy XXX, healing, taking pain meds PRN. R knee pain since XXX, difficulty walking, gives out. No other complaints. Vitals: BP 122/63, P 84. Exam shows R quadriceps atrophy. Dx. Derangement of R knee. Plan: Voltaren 1% topical, weight loss, ice/heat, HEP, quad strengthening, continue PT. Return to modified work, no running. RTC 2 wks.

XXX **XXX PT.** Physical therapy. Visit 4/6.

XXX **XXX** PT. Physical therapy. Visit 5/6.

XXX **XXX** Follow up visit. R knee healing, pt. completed PT. Vitals: BP 133/63, P 76. Dx. Derangement of R knee. Plan: Voltaren 1% topical, weight loss, ice/heat, HEP, quad strengthening. Modified duty, no running. RTC 2 wks.

XXX **XXX PT.** Physical therapy. Visit 6/12.

XXX **XXX**. Follow up visit. Cleared by Dr. XXX for full duty on XXX. Pt. plans to retire soon. Pt. has not worked since surgery on XXX. Vitals: BP 135/65, P 74. Dx. Derangement of R knee. Plan: Voltaren 1% topical, weight loss, ice/heat, HEP, quad strengthening, continue PT. Return to full duty XXX. RTC 2 wks.

XXX **XXX** PT. Physical therapy. Visit 7/12.

XXX **XXX PT.** Physical therapy. Visit 8/12 for derangement of R knee. Pt. c/o R knee pain. “L knee arthroscopy XXX.” Pt. compliant w/ exercise program.

XXX **XXX PT.** Physical therapy. Visit 9/12.

XXX **XXX PT.** Physical therapy. Visit 10/12.

XXX **XXX** Follow up. Pain in R knee at end of day. Vitals: BP 128/68, P 65, wt. 287 lbs. Dx. Derangement of R knee. Plan: weight loss, OTC pain meds PRN, ice/heat, HEP, quad

strengthening. Return to full duty. Approaching MMI. RTC 2 wks.

XXX **XXX** P&S report and impairment rating. Pt. feels fine in R wrist and low back. Vitals: BP 118/52, P 65, BMI 38. Dx. Derangement of R knee. Pt. reached MMI. 1%WPI. Pt. released to full duty XXX, did not return to work, is to be retired XXX. Causation: 100% attributable to injury of XXX. No other factors causing permanent disability. Apportionment is not medically indicated. Continuing or future medical treatment is not indicated as related to this injury. Possible non-prescription medication and home exercise may be used for flare-ups. Weight loss and exercise recommended.

XXX **XXX** Industrial work status report. DOI: XXX. Dx. Derangement of knee. Evaluated XXX cleared to return to full duty.

PHYSICAL EXAM

Blood pressure	140/98
Pulse	66
Height	6’2”
Weight	308 pounds
BMI	39.5

General Appearance	This applicant is obese, alert, oriented and in no acute distress. He appears to be an accurate and reliable historian.
HEENT	Pupils are equal and reactive to light and accommodation. Sclera anicteric. Funduscopic exam normal. Ear canals clear. Tympanic membranes are normal. Nose is patent. Pharynx unremarkable.
Neck	Supple, no masses. Carotids equal without bruit. No jugular venous distension. Thyroid not palpable.
Heart	Regular rate. No murmur, gallop or rub. The peripheral pulses are intact in the lower extremities.
Lung Fields	Lungs are clear to auscultation and percussion. There is no wheezing on forced expiration.
Abdomen	Soft, obese, non-tender. No guarding or rebound. No masses. No organomegaly. Bowel sounds are normal.
Extremities	No cyanosis or edema. Circumference of distal thighs R/L= 47.5 cm/47.5 cm.

Lymphatics	No abnormal lymph glands.
Musculoskeletal	Within normal limits. There is full range of motion of all joints. Muscle strength, muscle bulk and tone appear to be normal in the upper and lower extremities 5/5 including hand grip bilaterally.
Gait:	Normal.
Neurologic	Cranial nerves II-XII intact. Deep tendon reflexes are 2+ symmetric and preserved in the upper and lower extremities. Light touch sensation is preserved. Romberg is normal. Mental status is within normal limits.
Skin	Normal.

DIAGNOSES

Hypertension
History of non-sustained ventricular tachycardia
Mild obstructive sleep apnea – untreated at present
Hypercholesterolemia
Obesity

DISCUSSION

Mr. XXX has a history of hypertension for the past 26 years. He has worked as a Correctional Officer in the California Prison system for the past 27 years. By his self-reported history, the applicant was diagnosed and treated for hypertension beginning 26 years ago, approximately one year after beginning as a Correctional Officer. Hypertension develops over a period of years and is caused by an increased systemic vascular resistance. There are multiple factors that can cause this increase including obesity, abnormalities in lipid and glucose metabolism, genetic susceptibility and sleep apnea. The applicant's hypertension pre-dated his employment as a correctional officer.

The applicant had an episode of palpitations on the date of injury – XXX, felt his heart beating fast, felt light headed and sweaty while responding to an altercation in the jail. A Holter Monitor begun on XXX showed "There are auto-capture recordings showing premature atrial complexes, super–ventricular couplets, premature ventricular complexes. There is 17–beat run of wide–complex tachycardia–non-–sustained ventricular tachycardia versus rate related aberrant proximal super–ventricular tachycardia. (Of note, Mr. Hilliard did not note any symptoms during that event). Impression: No significant arrhythmias recorded."

An Exercise stress test on a treadmill was done, an echocardiogram and a cardiac CT. These were all negative for heart disease. The applicant has been treated with a beta blocker-metoprolol and has not had palpitations since. He has non-sustained ventricular tachycardia (NSVT) in the absence of apparent structural heart disease. **NSVT is caused by an abnormal electrical circuit in the heart and cannot be caused by stress in hearts that do not have the aberrant circuit**. The presence of these abnormal electrical circuits in the heart is not caused by stress, but stress can cause NSVT in a patient with an aberrant circuit. The prognosis for patients with NSVT in the absence of structural heart disease is essentially benign. For most patients with NSVT who are asymptomatic and no structural heart disease in found on the workup, no treatment is necessary. If they are symptomatic (such as experiencing palpitations) a beta blocker is recommended. They can also be cured with catheter ablation techniques.

The applicant had two episodes of non-sustained ventricular tachycardia, during the episode that occurred at work he had symptoms of palpitations, and he had no symptoms during his second episode which was documented while he was wearing a Holter monitor and was not at work. He has been symptom free following his second episode and has been taking a beta blocker since that time**. His prognosis is excellent since he has no structural heart disease. His cardiologist Dr. XXX that Mr. XXX had a normal heart and his angiogram showed no blockage**.

DISABILITY STATUS/DATE OF MAXIMAL MEDICAL IMPROVEMENT

Mr. XXX cardiac conditions reached maximum medical improvement on XXX, three months after being put on a beta blocker (metoprolol) by the cardiologist Dr. XXX. He has not had palpitations since XXX.

Appropriate Periods of Temporary Total Disability: XXX to XXX. Advised to work modified duty during this time- no modified duty available by his employer. RTW full duty XXX for this injury.

ACTIVITY RESTRICTIONS: None for internal medical problems.

IMPAIRMENT RATING

Discussion utilizing AMA Guides to the Evaluation of Permanent Impairment, 5th edition.

Cardiovascular Systemic and Pulmonary Arteries

Subjective complaints: Mr. XXX has no subjective complaints regarding his hypertension. He is asymptomatic despite elevated blood pressure readings (which is

true in most hypertensive patients).

Objective findings: My physical examination of the applicant does not reveal any funduscopic changes consistent with Class 2 hypertension eg, copper or silver wiring, and his blood tests including Creatinine and glomerular filtration rate, and blood urea nitrogen have been within normal limits. There is no evidence of end-organ damage.

Mr. XXX has Stage 1 hypertension; B/P 140 systolic and 98 diastolic.

Reference Chapter 4 "The Cardiovascular System: Systemic and Pulmonary Arteries", Section 4.1 Hypertensive Cardiovascular Disease on pages 66 to 69.

Class 1 with 0-9% Whole Person Impairment described as *"Asymptomatic, stage 1 or 2 hypertension without medications or normal blood pressure on anti-hypertension medications and no evidence of end-organ damage."*

The applicant's condition is closest to example 4-1 on page 67:

"55 year old woman with essential hypertension 5 years ago. Medication: Angiotensin II antagonist and diuretic. Normal B/P readings prior to visit. Asymptomatic; denies medication side effects. Physical exam: Normal; B/P 105/78, Clinical studies: ECG normal. Sx: Essential hypertension with adequate control. Impairment Rating: 0-3% impairment of the whole person"

Mr. XXX has a 3% WPI for his Hypertensive Cardiovascular disease. There is no impact on the applicant's ADLs.

Cardiovascular Heart and Aorta

Subjective complaints: The applicant denies any further palpitations, shortness of breath, faintness, chest pain or weakness.

Objective findings: **Holter monitor: Event monitoring started XXX.**
Baseline recording showed normal sinus rhythm with rates of 57 bpm.
Patient made no recordings with symptoms.
There are auto-capture recordings showing premature atrial complexes, super–ventricular couplets, premature ventricular complexes. There is 17–beat run of wide–complex tachycardia–non-–sustained ventricular tachycardia versus rate related aberrant proximal super–ventricular tachycardia.
Impressions: No significant arrhythmias recorded.

XXX CT angiogram results. Patient states no palpitations on metoprolol. Normal cardiovascular system–continue medications.

XXX Exercise stress test Bruce protocol: Exercise duration 8:51 minutes, exercise capacity: Good, stage reached: 3, METS: 10.1, test stopped due to fatigue. Impression: This stress test is negative for ischemia.

The applicant has a Class 2 impairment due to arrhythmias.

Reference Chapter 3 "The Cardiovascular System: Heart and Aorta", Section 3.7 Arrhythmias page 56-59.

Class 2 with 10-29% Whole Person Impairment described as "*Asymptomatic during ordinary activities and a cardia arrhythmia is documented by ECG, or has had an isolated syncopal episode* and *moderate dietary adjustment, use of drugs, or an artificial pacemaker required to prevent symptoms related to the arrhythmia* or *arrhythmia persists and there is organic heart disease* or has recovered from surgery or a catheter procedure to correct arrhythmia or *implantable cardioverter-defibrillator to treat arrhythmia and meets above criteria for impairment*"

Mr. XXX has been asymptomatic for more than one year (since XXX). He does not appear to have any further occurrences of arrhythmias since beginning his beta blocker medication on XXX. He has no limitations of his activities of daily living as a result of his non-sustained ventricular tachycardia occurrence which has occurred twice.

There are no analogous examples of patient's rating in the Guides, nor in the Guides casebook. The closest example is 3-45:

"62 year old man with 1 year history of atrial fibrillation with irregular ventricular response 75 BPM. PE: PR: 75 BPM. Clinical studies: ECG, chest roentgenogram, and echocardiogram: normal. DX: Atrial fibrillation with controlled ventricular response. Impairment Rating: 15% impairment of the whole person."

Class 1 impairment states that there is no documentation of three or more consecutive ectopic beats and also that there is no evidence of organic heart disease. It is clear that the applicant had more than 3 consecutive beats of non-sustained ventricular tachycardia therefore he has a Class 2 impairment. However, this was only documented one time and he has not had symptoms since his original episode. As his cardiologist stated "normal cardiovascular system-continue medications. No restrictions." He has no limitations on his activities of daily living as a result of arrhythmias. Therefore his rating is at the low end of Class 2.

The applicant has a 10% WPI for his arrhythmias.

Impact of Almaraz/Guzman III decision on rating permanent impairment for this case.

None. The permanent impairment ratings given are accurate and use appropriate sections of the AMA Guides, 5th edition as mandated by the California Labor Code.

APPORTIONMENT OF PERMANENT DISABILITY BASED ON CAUSATION

In preparation for apportionment in this report, I am aware of the direction in Section Labor Code 4663 that apportionment of permanent disability shall be based on causation. All of my medical opinions are based on a reasonable degree of medical probability and not based on speculation.

Cardiovascular Systemic and Pulmonary Arteries

In his history, the applicant states that he was diagnosed with hypertension one year after he began working as a correctional officer. Prior to his injury of XXX he was taking 4 medications for his hypertension: Norvasc, Hytrin, Cozaar and HCTZ. There is no evidence of worsening of Mr. XXX hypertension following the event of XXX, however on a cumulative basis it is likely that the inherent stress working as a Correctional Officer contributed to his need for 4 medications to control his HTN.

Mr. XXX is obese and obesity is linked to hypertension. He has a BMI of 39.5, a BMI of 39.9 would place him in the morbidly obese category.

The applicant has sleep apnea and although it is mild, it does pose a risk for developing hypertension and hypertension that may be difficult to control. Mr. XXX has untreated sleep apnea which more likely than not contributes to his need for 4 medications for adequate control of his hypertension.

Mr. XXX works in a stressful environment as a Correctional Officer and stress can increase hypertension making it more difficult to control.

The applicant's hypertension is 70% non-industrial, pre-existed his employment and he has other risk factors (obesity and sleep apnea) of a non-industrial nature which have contributed to his hypertension as noted above.

Mr. XXX hypertension is 30% industrial and related to his work as a Correctional Officer which is a stressful occupation.

Cardiovascular Heart and Aorta

Mr. XXX denied any pre-existing history of heart palpitations prior to his injury at work on XXX. As of his QME examination with me he had only experienced two incidents of palpitations, one at work, and a second one while wearing a Holter monitor which was asymptomatic.

The stress which the applicant experienced at work on XXX caused a "lighting up" of his underlying pathology of an aberrant electrical circuit in his heart. It is medically probable that **his arrhythmia is 100% due to stress at work on an industrial basis**.

FUTURE MEDICAL CARE

Should include continuing metoprolol unless advised by his cardiologist to discontinue. The applicant should continue to take his medications for hypertension and have visits with his internist at least annually. He is at risk for developing atherosclerotic heart disease due to his multiple risk factors of obesity, hypertension, hypercholesterolemia and sleep apnea. The applicant gives a history of compliance taking his medications for HTN and elevated cholesterol which is beneficial to him. He should strongly consider treatment for his sleep apnea and work on significant weight loss- both modifiable risk factors for cardiac disease prevention.

REFERENCES

1) Brotman, Golden, Wittstein. "The cardiovascular toll of stress." The Lancet (9/22/07) Volume 370, No 9592, p1089-1100.

2) Pickering. "Mental stress as a casual factor in the development of hypertension and cardiovascular disease." Current Hypertension Reports Volume 3, Issue 3, pp 249-254.

3) Lytsy, Per, Ingelsson, Erik, Lind, Lars, Arnlov, Johan, Sundstrom, Johan. "Interplay of overweight and insulin resistance on hypertension development." Journal of Hypertension 32.4 (2014): 834-839.

4) ME Diaz. "Hypertension and obesity." Journal of Human Hypertension (2002) 16 (Suppl 1), 518-522.

5) Pedrosa RP, Drager LF, Gonzaga CC, Sousa MG, de Paula LK, Amaro AC, Amodeo C, Borteolotto LA, Krieger EM, Bradley TD, Lorenzi-Filho G. "Obstructive sleep apnea: the most common secondary cause of hypertension associated with resistant hypertension." Hypertension 58 (2011): 811-817.

6) Andren, Hansson, Section. "Circulatory Effects of Stress in Essential Hypertension." Acta Medica Scandinavica, 209 (1981): 69-72.

7) Kulkami, O'Farrell, Erasi, Kochar. "Stress and hypertension." WMJ 11 (1998) 34-8.

DISCLOSURE:

In compliance with Labor Code Section 4628, I personally examined XXX at XXX I reviewed the medical records as set forth in this report. The history was taken by me by direct questions on my part and through the use of a questionnaire completed by the examinee which I reviewed with the examinee. In addition to conduction of the examination, I personally composed and drafted the conclusions of this report. All conclusions are mine alone. Pursuant to 8 Cal. Code Regs, Section 49.2-49.9, I have complied with the requirement for face to face time with the patient in this evaluation. Electronically submitted reports are provided to all parties in accordance with DWC regulations for report submission.

> I declare under penalty of perjury 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 describes the information provided to me and, except as noted herein, that I believe to be true.
>
> In accordance with Labor Code Section 5703 (a) (1), there has not been a violation of Labor Code Section 139.3. This statement is made under penalty of perjury.

Dated this _____ day of November, 2015 in Alameda County

END OF REPORT

DECLARATION/SIGNATURE PAGE

I personally took the history from and performed a physical examination of the applicant on the date indicated in the medical-legal office located at XXX I also personally reviewed the applicant's records provided to me jointly by the parties. I prepared this medical legal report entirely by myself except when specifically stated to the contrary. The medical legal opinions expressed in this report are solely my own. If other physicians have been consulted, such information has been explicitly stated herein.

When additional medical testing and/or consultation(s) is(are) required for, but not limited to, clarifying issues of industrial causation, permanent impairment/disability ratings, apportionment, need for present or future medical care and other facets of industrial disability, the insurance carrier will be contacted advising of the need for testing and/or consultation(s) authorization(s). A copy of my medical reports concerning the applicant will generally be provided to a consultant at the time my office schedules a given consultation. I am always available in writing for clarification of any testing/consultation(s) requests which should never be subject to utilization review since they are requested solely for the medical legal purpose of, but not limited to, clarifying issues such as industrial causation, impairment rating and apportionment. Without the requested testing and/or consultation(s), I will be unable to complete medical legal conclusions for this case.

If additional records are required by me to complete the medical legal analysis of the applicant's case, a written request will be made simultaneously to the parties requesting them to provide such records for my review. If there is an urgent medical need for a particular test and/or consultation, whether industrial in nature or not, the applicant will be immediately referred back to the primary treating physician and/or a hospital emergency room. In general, medical legal conclusions are provisional until any requested medical record review, testing and consultation have been completed and then reviewed by myself resulting in a supplemental report(s) being issued. If reevaluation of the applicant is required, it is the responsibility of the parties to schedule the repeat appointment with my office. Generally, absent receipt of requested records, I will be unable to complete medical legal conclusions for this case. Reports are always issued within the 30 day period mandated by the California Labor Code using the currently available records; upon receipt of additional requested records, testing and/or consultation(s), a supplemental report will be issued.

I declare under penalty of perjury that the information obtained for the preparation of this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information indicated to have been received from others. As to that received 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 to the best of my knowledge.

The evaluation of this applicant and the time spent performing the evaluation was in compliance with the guidelines established by the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code or any other relevant sections or revisions of the Labor Code. The listing of the actual hours I spent preparing this report is correct and made under penalty of perjury.

I also declare under penalty of perjury that I have not knowingly violated the provisions of the California Labor Code Section 139.3 with regard to the evaluation of this applicant and preparation of this report. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred exam or evaluation.

PERSONALLY DICTATED, REVIEWED, EDITED AND MEDICAL LEGAL OPINION VERIFIED AS ATTESTED HERETO BY MY ORIGINAL SIGNATURE:

Signed: ____/_____/____ , in Albany, California, County of Alameda.

_____
Kathryn Raphael, MD
Internal Medicine