PLAINTIFF'S EXHIBIT 17-E
DATE OF INJURY: 06/29/11

DOI: 06/29/11		WC CLAIM#: 7104454	WC CLAIM#: 7104454	
	Required Forms	Received Forms?		
	DWC-1	Y		
	DWC-1 ACK FORM	N		
DATE OF SERVICE:		7/6/11	7/18/11	PROVIDER'S NAME: DR. ECK
	Required Forms			
	EMPLOYER'S FIRST REPORT OF INJURY			
	PATIENT'S INITIAL VISIT FORM			
	EXAMINATION AND/OR CONSENT TO TREAT/AUTH TO RELEASE-PROVIDER FORM			
	CONSENT TO TREAT AND AUTH TO RELEASE INFO TO EMPLOYER-EMPLOYERS FORM			
	NURSE'S NOTES			
	DOCTOR'S NOTES (TYPED)			
	INJURY WORKSHEET			
	WORK STATUS REPORT WORKSHEET			
	WORK STATUS REPORT			
	DOCTOR'S FIRST REPORT OF INJURY			
	PR-2			
	INFORMATION			
	LAB RESULTS (IF APPLICABLE)			
	AIMS MILEAGE REIMBURSEMENT FORM			
	CLAIM SUMMARY-PAYMENTS			
	AIMS FULLY RECOVERED LETTER			

Tiffany Anderson:
THIS FORM WAS RECEIVED BY THE PLAINTIFF ONLY AFTER REPORTING THE INJURY TO WORKER'S COMP. DISTRICT MANAGER JOHN STROH FAILED TO FILE THIS FORM AND PAID CASH FOR PLAINTIFF'S DR'S VISIT TO AVOID REPORTING MY INJURY TO WORKER'S COMP. HE ALSO TALKED DIRECTLY TO THE PHYSICIAN.

Tiffany Anderson:
PLAINTIFF IS SATISFIED WITH THE DOCUMENTS RECEIVED; HOWEVER SUBSEQUENT PHYSICIANS COULD NOT READ DR. ECK'S NOTES. THEREFORE THEY SHOULD BE RESUBMITTED IN A TYPED VERSION TO BE USED FOR FUTURE EVALUATION PURPOSES. WE RESPECTFULLY REQUEST TYPED VERSIONS OF THE DOCTOR'S NOTES, AND THEY BE SENT TO DR. TABBADDOR.

NOTE PLAINTIFF WAS **NOT** SATISFIED WITH THE TREATMENT PLAN AND LACK OF CARE AND CONCERN FOR PLAINTIFF'S WELL BEING DURING THESE TWO VISITS.

U.S. HealthWorks
MEDICAL GROUP

NOTICE OF MISSED APPOINTMENT

USHW of California - Stockton
STOCKTON MEDICAL CENTER
3663 E. ARCH ROAD, SUITE # 400
STOCKTON, CA 95215
(209) 943-2202

Patient

Anderson, Tiffany
2 N Avena Avenue
Lodi, CA 95240

Case # 118-168567
Injury Date 6/29/11
SS# XXX-XX-5133
Missed Appt 7/13/11 9:30 AM
Claim#
File # Org 1174/sv

Employer

SJC MOSQUITO & VECTOR
7759 S. AIRPORT WAY
JOHN STROH
STOCKTON, CA 95206

Payor

SJC MOSQUITO & VECTOR
7759 S. AIRPORT WAY
JOHN STROH
STOCKTON, CA 95206

Our records show that you missed your scheduled appointment. It is very important that you keep all your appointments. Not only your employer has made a commitment to provide you with the proper medical care but also, failure to keep your appointments until the doctor releases you from care may jeopardize your recovery.

We have scheduled a new appointment for you on the date and time indicated below.

If our records are incorrect or the new scheduled appointment is not convenient for you, please call our office and we will accommodate you. A copy of this letter has been sent to your employer and to the insurance carrier.

Nuestros archivos demuestran que usted no asistio a su ultima cita. Es muy importante que asista a todas sus citas con el medico. No solo su empleador se ha comprometido a proveerle de tratamiento medico apropiado sino que tambien, el no asistir a sus citas antes que el medico le de de alta puede afectar su recuperacion.

Le hemos dado una nueva cita para el dia y la hora indicados abajo.

Si nuestros archivos estan incorrectos o si la nueva cita no le es conveniente por favor, llame a nuestra oficina para cambiarla a su conveniencia. Hemos enviado una copia de esta carta a su empleador y a la compania aseguradora.

Appointment (Cita): 7 / 18 / 2011 , 9:45 AM

17-E-2

U.S. HealthWorks MEDICAL GROUP

HX2

WC HEALTH HISTORY / HISTORIA MEDICA

Confidential / Confidencial

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

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

Yes/Sí	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	
X		1. Allergies or hives	Alérgias o urticaria
X		2. Medications	Medicinas
	X	3. Major illnesses or injuries	Enfermedades/lesiones importantes
X		4. Hospitalizations or surgeries	Hospitalizaciones o cirugías
X	X	5. Motor vehicle accidents	Accidentes de tránsito
	X	6. Blood transfusions	Transfusiones de sangre
X		7 Worked in a hazardous environment	Trabajo en ambientes peligrosos
X		8. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo
	X	9. Permanent disabilities	Incapacidad permanente
Yes/Sí	No	**FAMILY HISTORY / ANTECEDENTES FAMILIARES**	
	X	10. Blood diseases in relatives	Familiares con enfermedades de la sangre
	X	11. Cancer or leukemia in relatives	Familiares con cáncer o leucemia
	X	12. Diabetes in relatives	Familiares con diabetes
	X	13. Heart Disease	Familiares con enfermedades del corazón
	X	14. High Blood Pressure	Familiares con presión alta
	X	15. Strokes in relatives	Familiares con trombosis / ataques cerebrales
	X	16. Mental illnesses in relatives	Familiares con enfermedades mentales
Yes/Sí	No	**SOCIAL HISTORY / ANTECEDENTES SOCIALES**	
	X	17. Tobacco use. How much? NA/week	Uso de tabaco.)Cuanto?____/semana
	X	18. Alcohol use. How much? ____/week	Uso de alcohol.)Cuanto?____/semana

REVIEW OF SYSTEMS / REVISION DE SISTEMAS

Have you had or do you commonly have:)Tiene usted normalmente o ha tenido:

Yes/Sí	No	CONSTITUTIONAL	
	X	19. Recent gain or loss of weight	Ganancia o pérdida de peso reciente
	X	20. Weakness, fatigue, or appetite loss	Debilidad, fatiga o pérdida de apetito
	X	21. Fever	Fiebre
Yes/Sí	No	**SKIN**	
	X	22. Skin diseases or problems	Enfermedades en la piel
X		23. Discoloration, pigmentation changes	Cambios de color en la piel
	X	24. Cancer/Tumors or cysts	Cáncer, tumores o quistes
		HEAD	
X		25. Frequent or severe headaches	Dolores de cabeza frecuentes o severos
Sí	No	**EYES / VISION**	
	X	26. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos
	X	27. Blurred, double or decreased vision	Visión borrosa, doble, o disminuída
	X	28. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos
	X	29. Light sensitivity	Sensibilidad a la luz
Yes/Sí	No	**EARS, NOSE, THROAT, MOUTH**	
	X	30. Loss or decreased hearing	Pérdida o disminución de la audición
	X	31. Ear pain, infection, discharge	Dolor, infección o secreción en oídos
	X	32. Nose / Sinus Problems	Problemas en la nariz o en senos nasales
	X	33. Dental/Gum Disease	Enfermedades dentales o de las encías
	X	34. Recurrent throat problems	Problemas de garganta recurrentes
	X	35. Voice Change / Hoarseness	Ronquera o cambios en la voz
Yes/Sí	No	**CARDIOVASCULAR SYSTEM**	
	X	36. Shortness of Breath	Dificultad para respirar
	X	37. Chest Pain or Pressure	Opresión o dolor en el pecho
	X	38. Palpitation/Pounding Heart	Palpitaciones o saltos del corazón
	X	39. High Blood Pressure	Presión sanguínea elevada
	X	40. Swelling Feet/Ankles	Hinchazón de pies o tobillos
	X	41. Varicose Veins	Venas varicosas

Yes/Sí	No	RESPIRATORY SYSTEM	
	X	42. Chronic/Recurrent Cough/Cold	Resfriado / tos crónica o recurrente
	X	43. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho
	X	44. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica
	X	45. Pneumonia	Pneumonía o pulmonía
	X	46. Tuberculosis	Tuberculosis
	X	47. Coughing of Blood	Tos con sangre
Yes/Sí	No	**GASTROINTESTINAL TRACT**	
	X	48. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes
	X	49. Nausea or vomiting	Náusea o vómitos
	X	50. Vomiting of Blood	Vómitos con sangre
	X	51. Abdominal pain	Dolor abdominal
	X	52. Liver disease	Enfermedades del hígado
	X	53. Change in Bowel Habits	Cambios en hábitos intestinales
	X	54. Frequent Constipation/Diarrhea	Constipación o diarea frecuentes
	X	55. Blood in stools/Black stools	Heces negras o con sangre
	X	56. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto
Yes/Sí	No	**GENITOURINARY TRACT**	
	X	57. Painful or difficult urination	Dificultad o dolor al orinar
	X	58. Blood in urine	Sangre en la orina
	X	59. Kidney infection/stones	Infecciones o cálculos del riñón
	X	60. Venereal Disease	Enfermedades venéreas
Yes/Sí	No	**MUSCULOSKELETAL**	
	X	61. Joint pain or disease	Enfermedades o dolor en las articulaciones
	X	63. Neck or back injury	Lesiones del cuello o de la espalda
	X	64. Foot Problems	Problemas en los pies
Yes/Sí	No	**NEUROLOGICAL**	
	X	65. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques
	X	66. Dizziness	Mareos o vértigo
	X	67. Muscle weakness or paralysis	Parálisis o debilidad muscular
	X	68. Numbness in arms or legs	Adormecimiento de manos o pies
Yes/Sí	No	**PSYCHIATRIC PROBLEMS**	
	X	69. Depression	Depresión
	X	70. Nervousness	Nerviosismo
	X	71. Mood swings	Cambios del humor o del carácter
	X	72. Sleep disturbances	Trastornos del sueño
	X	73. Alcoholism	Alcoholismo
	X	74. Drug abuse treatment/rehabilitation	Rehabilitación por adicción a drogas
Yes/Sí	No	**ENDOCRINE SYSTEM**	
	X	75. Increased appetite	Apetito exagerado
	X	76. Increased thirst	Sed exagerada
	X	77. Increased urination	Aumento en la frecuencia o cantidad de orina
	X	78. Diabetes/High Blood Sugar	Diabetes / Azúcar en la sangre
	X	79. Hair loss	Pérdida del cabello
Yes/Sí	No	**BLOOD DISORDERS**	
	X	80. Bleeding gums	Sangramiento por las encías
	X	81. Bruising	Moretones o cardenales
	X	82. Spontaneous nose bleeding	Sangramiento espontáneo por la naríz
	X	83. Easy bleeding or hard to stop	Sangramiento fácil o difícil de detener
Yes/Sí	No	**FOR WOMEN ONLY**	
	X	84. Pregnant?	Embarazada?
	X	85. Date last menstrual period?	Fecha última menstruación
	X	86. Irregular Menstruation?	¿Menstruación o períodos irregulares?
	X	87. Painful Menstruation	¿Menstruación o períodos dolorosos?

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

1. I have allergies.
2. I take IB Profin and anxiety medication
4. I've had 2 surgeries on my R. Knee
5. I was rear ended 12-2010
7. I am exposed to Chemicals at animal waste water.
8. I've had two knee surgeries

PROVIDER COMMENTS

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

Patient Signature (Firma del Paciente): _____ **Date** (Fecha): 7/6/11

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

Provider Initials: _____

ST1012A 11/09

7/6/11 17-E-3

U.S. HealthWorks MEDICAL GROUP

HX1

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

WC

Please complete the following information. (Por favor, complete la siguiente información)

Employer (Patrón): S.J. County Mosquito Control Date (Fecha): 7-6-11 SSN: 549-23-5133

First Name (Nombre): Tiffany Middle Initial (Inicial): K Last Name (Apellido): Anderson

Address (Dirección): 2 N. Aviena Avenue City (Ciudad): Lodi State (Estado): CA Zip (C. Postal): 95240

Telephone Numbers (Teléfonos) Home: (Casa): 209-329-9523 Work (Trabajo): 209-982-4675 Cell (Celular): same

Best number to reach you (Mejor número para llamarle): ☐ Home: (Casa) ☐ Work (Trabajo) ☒ Cell (Celular) Email: tiffanycanderson@me.com

Date of Birth (Fecha de Nacimiento): 8-22-70 Sex (Sexo): F Marital Status (Estado Civil): Single

Date of Injury (Fecha de lesión): 6-29-11 Time (Hora): 2:15 Last day worked (Ultimo día que trabajo): NA

Occupation (Ocupación): pesticide applicator Address where injury occurred (Dirección donde ocurrió la lesión): 30138 E HWY 120 Escalon

Was your problem caused by something that happened at work? (¿Fue su problema causado por algo sucedido en su trabajo? ☒ Yes (Si) ☐ No

Injury was reported to (La lesion fue reportada a): Brian Heise Date (Fecha): 6-29-11 Time (Hora): 3:15

Has U.S. HealthWorks ever treated you before? (Alguna vez ha sido tratado en U.S. HealthWorks?): NO When? (Cuándo?): NA

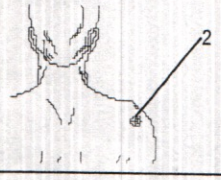
In case of emergency call: (En caso de emergencia llamar a:) Robert Blewett Tel: 415-516-5258

Please describe how your present injury/illness occurred. (Por favor describa cómo ocurrió su actual lesión o enfermedad.)

6/53 I was walking around a dairy pond. I walked into a metal post holder by grass. The metal post broke open the skin to a post surgical incision. ~~and~~ The following day the open wound was exposed to dirty water from pastured with animal waste.

PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***

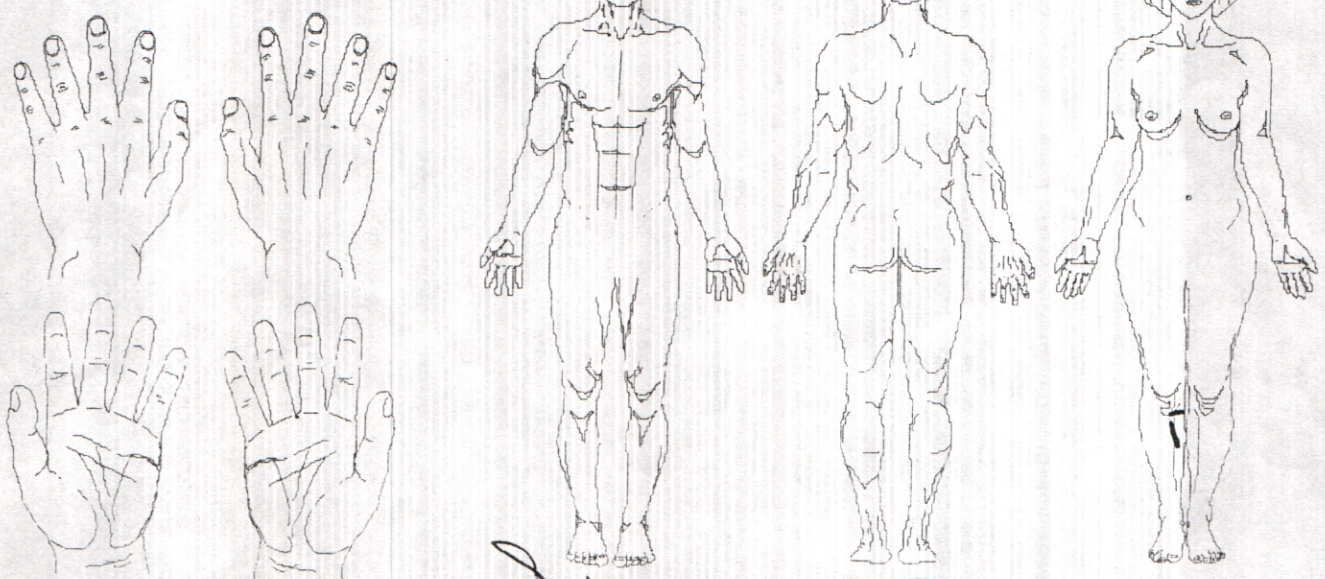
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, marque la zona del cuerpo en donde los siente en las figuras e indique el tipo de sintoma.

Symptoms (Síntomas)	Example (Ejemplo)
(1) Pain (Dolor)	
2. Numbness (Adormecimiento)	
(3) Burning (Quemazón)	
4. Pins/Needles (Pinchazos)	

Rate the intensity of your pain: / Indique la intensidad de su dolor:

NO PAIN / SIN DOLOR — MOST PAIN / DOLOR INTENSO

0 1 2 3 4 5 6 (7) 8 9 10



Patient Signature *(Firma del Paciente)* _____ Date *(Fecha)* 7/6/11

ST1012 (11/09)

17-E-4

U.S. HealthWorks MEDICAL GROUP

BIL

(1)

WC Worksheet
New Patient

MA / NURSE NOTES. Dominant hand: ☐ Right ☐ Left Allergies: NKDA

Medications: Ibuprofen, Antianxiety Problems/Side effects: none.

☐ Yes ☒ No History of ulcers or gastritis? ☐ Yes ☒ No Possibly pregnant? LMS - unknown. Last Tetanus Toxoid: 2004

Occupational History:

Job Title: Pesticide Applicater Length of employment with company 6 yrs Average hours per week: 50

Main Job Characteristics At The Time Of Injury:

☐ Sit down job ☒ Prolonged standing or walking ☒ Repetitive use of hands / keyboard / mouse ☒ Kneeling or squatting
☒ Bending ☒ Stooping ☒ Climbing ☐ Overhead work ☒ Operating hand tools / Machinery
☒ Lifting / Pulling / Pushing ☐ Up to 10 lbs. ☐ Up to 25 lbs. ☒ Up to 50 lbs. ☐ Up to ____ lbs. Other: ____

☐ Yes ☒ No Any lost work time? If Yes, specify number of full days lost: ____ and last date worked: ____

☐ Yes ☒ No Any other source of employment? If Yes, specify: ____

☐ Yes ☒ No Any sports or hobbies? If Yes, specify: ____

☐ Yes ☒ No Any previous treatment for the complaint(s) before coming to U.S. HealthWorks? If Yes, specify: ____

Chief Complaint: Pain in (R) knee

Ht: 64 in Wt: 145 lbs Pulse: 64 /min BP 142/100 (140/100, 120/100) mmHg Resp: 16 /min Temp: 97.7 °F

Completed by: tt SMA

PHYSICIAN HISTORY (Explain any **Yes** answers below.)

☐ Yes ☒ No Chemical / toxic exposure involved?
☒ Yes ☐ No Any previous occupational injuries or illnesses?
☐ Yes ☒ No Any pre-existing condition that could complicate or prolong the patient's diagnosis, treatment, and/or rate of recovery?

Hx (R) knee arthroscopy for meniscus injury 2008 and 2009
Last Td 2004

History of Present Illness/Injury: (Describe below the mechanism of injury, progression of illness, and the characteristics of the chief complaint)

Walked into a T-bar 6/29/11 contused and scrapped medial (R) knee over a Trocar scar. C/O exposure to waste water from a dairy farm the next day. claims it feels funny

Chief Complaint #1: Pain (R) knee
Location: medial joint
Quality: ☐ Faint ☐ Sharp ☒ Dull ☐ Tingling ☐ Burning
Severity: ☒ Minimal ☐ Mild ☐ Moderate ☐ Severe
Duration: ____ Min ____ Hours 7 Days
Timing: ☒ Occasional ☐ Intermittent ☐ Constant
Context: at work
Modifying Factors: Exacerbated by: movement
Lessened by: Rest

Chief Complaint #2: ____
Location: ____
Quality: ☐ Faint ☐ Sharp ☐ Dull ☐ Tingling ☐ Burning
Severity: ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe
Duration: ____ Min ____ Hours ____ Days
Timing: ☐ Occasional ☐ Intermittent ☐ Constant
Context: ____
Modifying Factors: Exacerbated by: ____
Lessened by: ____

Relevant History. Comments:

(-) HTN, DM, PUD, kidney or Liver Dz
(+) Anxiety - Takes Xanax over away
NKDA

Denies pregnancy. Last 2-3 months ago. Refuses UPT

☒ As part of my evaluation, I reviewed the information above, as well as the patient's **Medical, Family and Social History** and the **Review of Systems** collected today.

Provider Signature

C MOSQUITO & VECTOR 159356
DOS: 7/06/11 DOI: 6/29/11 DOB: 8/22/70
Patient: Anderson, Tiffany
Case # : 118-168567 Ref # : Org 1174/s\

HE DOCUMENTATION ABOVE.

ident #: ____

WC Worksheet
New Patient

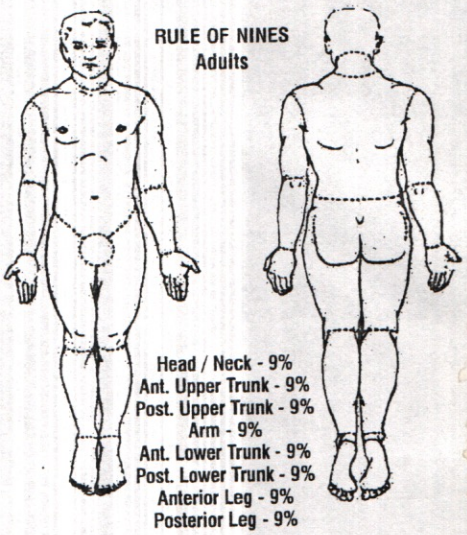
Date: 17-E-5

Relevant History (Check all that apply and **explain any Yes answers** below.)

1. Time since the injury occurred? Minutes: _____ Hours: _____ Days: 7
   ☐ Tetanus Booster? ☐ 0-5 years ago ☐ 5-10 years ago ☐ >10 years ago ☐ Unknown
   ☐ Yes ☐ No Diabetes?
4. ☐ Yes ☐ No Immunosuppressive therapy or state?
5. ☐ Yes ☐ No First aid provided? If Yes, explain: _____

EXAM: (Check all the statements that apply and **explain any Yes answers** below.)

6. ☐ Yes ☐ No **Malnourished** and/or **underdeveloped**?
7. ☐ Yes ☐ No **Disoriented** to time, place and person and/or **non-alert**?
8. ☐ Yes ☐ No **Mood and affect** appear **inappropriate**?



BURNS:

9. ☐ Yes ☐ No **1st Degree Burns** _____ % _____
10. ☐ Yes ☐ No **2nd Degree Burns** _____ % _____
11. ☐ Yes ☐ No **3rd Degree Burns** _____ % _____

Deep 2nd degree burns involving most of the hands, feet, face, or perineum most likely need care at a burn unit.

12. ☐ Yes ☐ No **Circumferential burn**?
13. ☐ Yes ☐ No **Respiratory tract injury?** (Smoke Inhalation) Symptoms: Signs:
14. ☐ Yes ☐ No ☐ Signs of **clubbing,** ☐ **cyanosis** or ☐ **edema**?

WOUNDS:

15. ☐ **Location #1:** medial knee
16. **Shape:** ☒ Linear ☐ Irregular Other: _____
17. **Depth:** ☐ Skin ☐ Subcutaneous ☐ Fascia
18. **Condition:** ☐ Contaminated ☐ Infected Explain: _____
19. **Size Length:** 2 cms. 20. **Other:** _____

21. ☐ **Location #2:** _____
22. **Shape:** ☐ Linear ☐ Irregular Other: _____
23. **Depth:** ☐ Skin ☐ Subcutaneous ☐ Fascia
24. **Condition:** ☐ Contaminated ☐ Infected Explain: _____
25. **Size Length:** _____ cms. 26. **Other:** _____

(Additional locations may be described in the space below.)

2cm healing abrasion medial knee almost fully healed. ⊕ resolving ecchymosis from TTP. ⊖ swelling or Erythema NOS OI

(Check all that apply and **explain any YES answers.** If not all items in a statement are positive, circle and explain those that apply.)

27. ☐ Yes ☒ No Signs of **infection** or **contamination**?
28. ☐ Yes ☒ No **Tendon damage**?
29. ☒ Yes ☐ No **Ecchymosis**?
30. ☐ Yes ☒ No **Nerve damage**?
31. ☐ Yes ☒ No **Vascular damage**?
32. ☐ Yes ☒ No **Fracture** associated?
33. ☐ Yes ☒ No Signs of **lymphangitis, lymphedema** or **regional lymphadenopathy**?
34. ☐ Yes ☒ No Signs of **apparent respiratory distress** (tachypnea, hyperpnea, etc.)?
35. ☐ Yes ☒ No **Restrictions to range of motion**?

Joint: _____ Explain: _____
Joint: _____ Explain: _____

Explanation of abnormalities and other physical findings:

FROM. no Ligament instability ⊖ mc murray
↓gait

Other injuries associated with this incident: _____ (Document appropriately)

DIAGNOSTIC TESTS: Radiographic series of: _____ Number of views____ X-Ray #: _____

☐ CBC / Differential ☐ Chemistry ☐ Urinalysis. Dipstick ☐ Urinalysis ☐ Wound C&S Other: _____

Results: Preliminary **X-ray reading:** ☐ Normal ☐ Abnormal: _____ ☐ Sent to radiologist
Laboratory: ☐ Normal ☐ Abnormal: _____ ☐ Discussed with patient

SDC MOSQUITO & VECTOR 159356
DOS: 7/06/11 DOI: 6/29/11 DOB: 8/22/70
Patient: Anderson, Tiffany
Case # : 118-168567 Ref # : Org 1174/s\

THE DOCUMENTATION ABOVE.

ncident #: _____

OPEN WOUNDS / BURNS
Page 1 of 2 *WC New Patient*

Date: 17-E-6

DIAGNOSES: (Specify all diagnoses by numbering in order of importance.)

#___ Open Wound _____ #___ Crush Injury _____ #___ Degree Burn _____

#___ Degree Burn _____ #1 Abrasion @ face #___ _____

☑ **Work-related** ☐ **Not Work-related** ☐ **Pending determination.**

☑ **First Aid Case**

PHYSICIAN COMMENTS (Explain any No answers.)

1. ☑ Yes ☐ No According to the patient, was the present injury/illness caused by a single specific event?
2. ☐ Yes ☐ No Are findings consistent with the patient's statement?

TREATMENT PLAN:

☐ Cryotherapy locally for 15 min. STAT.

☐ Injection administered. Med/Manufacturer:_____ Dose:_____ Route:____ Location: _____ Lot: _____ Exp. Date: _____

☐ **Td** ☑ **Tdap** 0.5 mL IM STAT. Location: _____ Lot: ____ Exp. Date: _____

☐ For examination and treatment a **surgical tray with sterile instruments** was opened and prepared.

☐ A **sterile field** was prepared and sterile drapes were used.

☐ The wound was **cleansed and disinfected** with ☐ Saline ☐ Iodine Solution ☐ Hydrogen Peroxide Other: _____

☐ Local ☐ Regional ☐ Digital block **anesthesia** with [_____ mL] of ☐ Xylocaine ☐ Marcaine 1% / 1.5% / 2% ☐ w/ Epinephrine _____%

☐ The wound was **explored.**

☐ **Irrigation** and **drainage** performed. ☐ Simple ☐ Complex

☐ **Non-surgical debridement** performed: ☐ Infected ☐ Not-infected

☐ **Surgical debridement** performed with: ☐ Scissors ☐ Scalpel ☐ Dermatome ☐ Burr ☐ Other: _____

☐ **Sutures** / ☐ **Staples** were placed:

☐ Skin Sutures: #: ____ Type: _____ ☐ Tendon Sutures: #:_____ Type: _____

☐ Subcutaneous Sutures: #: ____ Type: _____ ☐ Fascia Sutures: #:_____ Type: _____

☐ **Antibiotic** ointment / ☐ **Silvadene** cream ☐ Nailbed Sutures: #:_____ Type: _____

☐ **Sterile dressing** was applied.

☐ **Patient tolerated procedure well** without complications.

Medications / Supplied (Check all that apply, write the prescription in the blanks and circle (D) for Dispensed and (P) for Prescribed.)

☐ Acetaminophen (Tylenol) ES 500 mg (#40) _____ D / P	☐ Acetaminophen/ Cod. 300/30 mg (Tylenol #3) (#20) _____ D / P
☐ Acetaminophen/ Hyd. 500/5 mg (Vicodin) (#20) _____ D / P	☐ Cephalexin (Keflex) 500 mg (#40) _____ D / P
☐ Cefadroxil (Duricef) 500 mg (#20) _____ D / P	☐ Ibuprofen (Advil, Motrin) 200 / 600 / 800 mg (#40) _____ D / P
☐ Naproxen Sodium (Aleve) 220 (#28) _____ D / P	☐ Naproxen (Naprosyn) 375 (#40) / 500 mg (#20) (#40) _____ D / P
☐ Ranitidine (Zantac) 150 mg (#20) _____ D / P	☑ Injectables. Specify: Tdap _____ D / P
☐ Other _____ D / P	☐ Other _____ D / P

☐ **The following medical supplies were dispensed and the patient instructed in their proper use:**

1. _____ 2. _____ 3. _____

Other:

☐ **Interpreter used** ☐ **Certified interpreter unavailable.** Name: _____

Work Status: ☑ Regular work ☐ Modified work ☐ Off work. Explain: _____

☐ **Counseling visit:** Total duration of visit: ____ mins. Total duration of patient counseling: ____ mins. Refer DOT

Return to clinic on: 7/13

☐ **Discharged from care.** No further treatment is anticipated at this center at this time.

MA/Nurse completing medical orders: _____

LABELS
Date 1ST Time 10:17
Medication Tdap Site R Delt
Dose 0.5ml Route IM
Manufacture Adacel
Lot # C3469 7BA Exp 11-2-13
VIS Publication Date 11/19/08

John Stroh

CONSULT / REFERRAL:

☐ **Patient advised to follow up with personal physician.**

☐ **Consult/** ☐ **Referral** ☐ ER ☐ Other: _____

Reasons:

PATIENT EDUCATION.

Patient voiced understanding of: ☑ **aftercare instructions** and **medication side effects**

☑ **work restrictions** and expected **progression of the injury**

Patient was given **educational material** on _____ ☐ **Krames Booklet**

EMPLOYER CONTACT: ☑ **Discussed case** / ☐ **Left detailed message** with: Eddie Buckosi _____ on the issues of:

☑ Causation ☑ Diagnoses ☑ Prognosis ☑ Work Status Other: _____

PROVIDER. Signature: _____ Name: Jon Eck, M.D.

SJC MOSQUITO & VECTOR 159356

DOS: 7/06/11 DOI: 6/29/11 DOB: 8/22/70

Patient: Anderson, Tiffany

Case # : 118-168567 Ref # : Org 1174/s

DOCUMENTATION ABOVE.

OPEN WOUNDS / BURNS
Page 2 of 2 *WC New Patient*

t #: _____ Date: 17-E-7

U.S. HealthWorks MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation

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

☐ Additional pages attached

Patient Last Anderson First Tiffany M.I. ____ Date of Exam: 7/6/2011 Case #: 118-168556

Occupation: ____ SS# ____ Date of Birth 8/27/70 Date of Injury 6/29/11 Claim # ____

Employer: SJ County Mosquito Cntrl Contact: ____ Tel: ____ Fax: ____

Claims Administrator ____ Tel: ____ Fax: ____

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

☐ Significant change in patient's condition ☐ Need for referral or consultation ☐ Info requested by: ____
☐ Significant change in work status ☐ Need for surgery or hospitalization ☐ Released from care ☐ Request for authorization
☐ Significant change in treatment plan ☐ Periodic Report (45 days after last report) ☐ Other: DFR

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

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

SUBJECTIVE COMPLAINTS (Document and describe significant complaints.)

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

Tdap given

DIAGNOSES (Include ICD-9 code, if possible)

abrasion/contusion ® knee

TREATMENT

☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Evaluation
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other ____
☐ Medications / Supplies Dispensed Tdap
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty ____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now ____ weeks

WORK STATUS ☐ First Aid Case

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

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

☐ Medical status was discussed with employer representative ~~Edie Eccles~~ John Stroh

DISCHARGE STATUS

☐ Return to full duty on (DATE)____ with no limitations or restrictions.
☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Name JON ECK, M.D. Cal. Lic # ____ Date of Exam ____

Specialty: ____ Signature (Original) ____

Treated at: U.S. HealthWorks / Stockton, 3663 E. Arch Road, Suite 400, Stockton, CA 95215 Tel: (209) 943-2202 • Fax: (209) 943-2209

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS:	YOUR NEXT APPOINTMENT WITH THE DOCTOR IS:
☐ MON ☐ TUE ☑ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: 7/13 TIME: 9:30 AM ☐ Before / After Shift	DATE: ____ TIME: ____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

17-E-8

U.S. HealthWorks MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation

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

☐ Additional pages attached

Patient Last _____ First _____ M.I. _____ Date of Exam: _____ Case #: _____

Occupation: _____ SS# _____ Date of Birth _____ Date of Injury _____ Claim # _____

Employer: _____ Contact: _____ Tel: _____ Fax: _____

Claims Administrator _____ Tel: _____ Fax: _____

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

☐ Significant change in patient's condition ☐ Need for referral or consultation ☐ Info requested by: _____
☐ Significant change in work status ☐ Need for surgery or hospitalization ☐ Released from care ☐ Request for authorization
☐ Significant change in treatment plan ☐ Periodic Report (45 days after last report) ☐ Other: _____

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

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

SUBJECTIVE COMPLAINTS (Document and describe significant complaints.)

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

DIAGNOSES (Include ICD-9 code, if possible)

TREATMENT

☐ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Evaluation
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other _____

☐ Medications / Supplies Dispensed _____

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

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

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

☐ Off work until (DATE) _____ Estimated period of total temporary disability ___ days,

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

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

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

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

☐ Medical status was discussed with employer representative _____

DISCHARGE STATUS

☐ Return to full duty on (DATE)_____ with no limitations or restrictions.
☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Name _____ Cal. Lic # _____ Date of Exam _____

Specialty: _____ Signature (Original) _____

Executed at: U.S. HealthWorks / Stockton, 3663 E. Arch Road, Suite 400, Stockton, CA 95215 Tel: (209) 943-2202 • Fax: (209) 943-2209

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

U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Anderson First: Tiffany Date of Exam: 7/06/11 Case #: 118168567

SS#: XXX-XX-5133 Date of Birth: 8/22/70 Date of Injury: 6/29/11 Claim #: _____

Employer: SJC MOSQUITO & VECTOR Contact: JOHN STROH Tel.: (209) 982-4675 Fax: 209 982-0120

Claims Administrator: AIMS Tel.: (800) 444-6157 Fax: 916 563-1919

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

☐ improved as expected ☐ improved, but slower than expected ☐ work status pending PR2

☐ worsened ☐ reached plateau and no further improvement is expected ☐ not improved significantly

☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

924.11 CONTUSION OF KNEE R

TREATMENT

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

☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☒ Meds / Supplies Dispensed TDAP

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

Estimated length of treatment is now _____ weeks

WORK STATUS ☒ First Aid Case

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

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

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

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

( ) No work near moving machinery

( ) No / ( ) Limited use of R / L hand to ____ hrs/day

( ) No / ( ) Limited standing or walking to ____ hrs/day

( ) No / ( ) Limited overhead work to ____ hrs/day

( ) No / ( ) Limited stooping and bending to ____ hrs/day

( ) No / ( ) Limited kneeling or squatting to ____ hrs/day

( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push

Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs

( ) No climbing

( ) Sit down job.

( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage

( ) Other _____

( ) Must keep _____ elevated

( ) Keep wound/bandage clean and dry

( ) Must take a ____ minute stretch break every ____ minutes from

( ) Keyboard / ( ) _____

( ) Other _____

_____

☐ Medical status was discussed with employer representative. Name _____

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

DISCHARGE STATUS ☐ Return to full duty on (Date) _____ with no limitations or restrictions. Released from care without ratable disability or need for future medical care.

☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.

☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

TREATING PROVIDER

Name ECK, JON L., M.D. Lic. # G67867 Date of Exam 7/06/11

Specialty _____ Signature _____ Signature on File

Issued at: USHW of California - Stockton, 3663 E. ARCH ROAD, SUITE # 400, STOCKTON, CA 95215 Tel: (209) 943-2202

Checkin Time 9:50 AM Checkout Time 11:18 AM Next Visit Date 7/13/11 Time 9:30 AM

17-E-9

4(1)

U.S. HealthWorks MEDICAL GROUP

OPEN WOUNDS / BURNS
WC Established Patient

MA / NURSE NOTES: Since last visit:
Current Medications: IB profin
Any medication/ treatment problems or side effects: HPI reviewed None
[redacted]llergies: NKDA Pulse: 72 BP: 150/102 Resp: 16 Temp: 98.3 **Completed by:** [signature] 7/18/11
[redacted]**UBJECTIVE COMPLAINTS:** ☑ I reviewed the patient's **health history** as documented on (date of first visit) 7/6/11 and updated any changes below.
[redacted]PI: Chief Complaint: Ⓡ Knee pain Location:
Quality: ☐ Faint ☐ Sharp ☑ Dull ☐ Tingling ☐ Burning Severity: ☑ Minimal ☐ Mild ☐ Moderate ☐ Severe
Timing: ☑ Occasional ☐ Intermittent ☐ Constant Duration: ____Min ____Hrs ____Days
Since the last visit: ☐ Yes ☑ No Any **new symptoms** or **complaints**? If so, describe:
Patient is ☑ better/☐ worse/☐ same. Treatment [☑ was/☐ was not] followed and [☑ was/☐ was not] tolerated. Current Work Duty: ☑ Regular/☐ Modified /☐ Off
Employer reports she was doing fine and wanted to be D/C'd & being seen. Today she tells me she had severe pain ā 11 day on 7/8 she almost went to ER. claims constant dull min pain medially
Associated Signs/Symptoms: ☑ None ☐ Yes ☐ No; Ecchymosis? ☐ Yes ☐ No; Redness? ☐ Yes ☐ No; Swelling? ☐ Yes ☐ No; Bleeding?
☐ Yes ☐ No; Increased pain? ☐ Yes ☐ No; Fever/Chills? ☐ Yes ☐ No; Foul odor? ☐ Yes ☐ No; Discharge? Other: Knee

OBJECTIVE FINDINGS: (Check all that apply and **explain any Yes answers** below) Hx meniscus surgery x2 Ⓛ knee
1. ☐ Yes ☑ No **Disoriented** to time, place and person, or **non-alert**?
Burns **1st Degree Burns** Healed abrasion ant Ⓡ knee/leg
2nd Degree Burns
3rd Degree Burns
Wounded Areas: Healed abrasion
5. Location #1: Ant Ⓡ Tibial, medial knee 11. Location #2:
6. Shape: ☐ Linear ☐ Irregular Other 12. Shape: ☐ Linear ☐ Irregular Other
7. Depth: ☐ Single Layer ☐ Multiple Layers: 13. Depth: ☐ Single Layer ☐ Multiple Layers:
8. Condition: ☐ Contaminated ☐ Infected. Explain 14. Condition: ☐ Contaminated ☐ Infected. Explain
9. Size Length:____cms. 10. Other: 15. Size Length:____cms. 16. Other:
17. ☐ Yes ☐ No **Sutures disrupted?** 18. ☐ Yes ☐ No **Circumferential burn?** 19. ☐ Yes ☐ No Signs of **infection?**
20. ☐ Yes ☐ No **Tendon damage**? 21. ☐ Yes ☐ No **Ecchymosis**? 22. ☐ Yes ☐ No **Vascular damage?**
23. ☐ Yes ☐ No Signs of **lymphangitis, lymphedema** or regional **lymphadenopathy**? 24. ☐ Yes ☐ No **Fracture associated?**
25. ☐ Yes ☐ No Signs of **respiratory distress** due to smoke inhalation? 26. ☐ Yes ☐ No Restrictions to **range of motion?**
[redacted] exam except tenderness TTP medial joint line, Fem and Tibia condyle. Gmc negative Ⓝ ligament instability or pain ĉ Valgus a varus stress. FROM, Ⓝ gait
NOSOI
DIAGNOSTIC TESTS: ☑ Additional / ☐ Repeat Radiographs: Ⓡ Knee Number of views 4 X-Ray #: 44889
Preliminary x-ray reading: ☑ Normal ☐ Abnormal: ☑ Sent to radiologist
☐ Additional /☐ Repeat **Laboratory:**
Laboratory: ☐ Normal ☐ Abnormal:

DIAGNOSES: Current Diagnoses: Contusion Abrasion Ⓡ leg ☐ Diagnosis added ICD9:
TREATMENT PLAN:
☐ **Surgical tray opened and sterile field prepared** ☐ **Sutures removed** ☐ **Wound cleaned and redressed** ☐ **SteriStrips applied**
Medications ☐ New / ☐ Refill / ☐ Continue Specify: ☐ Dispensed ☐ Prescribed
Supplies ☐ The patient was instructed in the use and care of the following applied/fitted medical supplies:
☐ **Dressings dispensed** Other:
☐ **Physical Therapy:** Evaluate and treat ____ times/week for ____ weeks F/U ĉ PCP for ↑BP
Work Status: ☑ Regular ☐ Modified ☐ Off work
Interpreter ☐ required Name:
Return to clinic on: DC
☐ **Counseling Visit.** Total duration of visit:____mins. Total duration of patient counseling:____ mins. d/w Eddie
No objective findings x̄ Healed superficial abrasion
D/w pt. She agrees to cont Reg work. no further TX indicated (1st Aid)
MA/Nurse completing medical orders:
☐ **Referral** / ☐ **Consult** to: **Reason:**
☐ **Discharged from care.** No further treatment is anticipated at this center at this time.

LABELS

PHYSICIAN Signature: [signature]
Name:

S[redacted] MOSQUITO & VECTOR 159356
DOS: 7/18/11 DOI: 6/29/11 DOB: 8/22/70
Patient: Anderson, Tiffany
Case # : 118-168567 Ref # : Org 1174/s\

THE DOCUMENTATION ABOVE.

OPEN WOUNDS / BURNS
WC Established Patient
Injury:________ Incident #:________ Date:________

17-E-10

Case # 118168567

U.S. HealthWorks
MEDICAL GROUP

ADMINISTRATIVE DISCHARGE

USHW of California - Stockton
STOCKTON MEDICAL CENTER
3663 E. ARCH ROAD, SUITE # 400
STOCKTON, CA 95215
(209) 943-2202

Date: 7/15/11

Employer: SJC MOSQUITO & VECTOR

Address: 7759 S. AIRPORT WAY
JOHN STROH
STOCKTON, CA 95206

Ins.Carrier: SJC MOSQUITO & VECTOR

Address: 7759 S. AIRPORT WAY
JOHN STROH
STOCKTON, CA 95206

Employee: Anderson, Tiffany

Date of Injury: 6/29/11

Social Security #: XXX-XX-5133

Diagnosis: CONTUSION OF KNEE

Our records show that the aformentioned patient has failed to keep consecutive appointments on the following dates: 0/00/00 7/13/11 although we have sent letters of notification to the patient for each scheduled appointment.

The patient was last seen on 7/06/11 and the last work status was as follows:
07/06/11

The patient has failed to comply with our request to come back for a follow-up examination and is no longer under our care.

Additional comments:
pt no longer feels the need to be seen, requested case to be closed.

Should you wish to schedule this patient for a final evaluation, please contact our office.

Sincerely,

Primary Treating Physician

ECK, JON L., M.D.

17-E-11

2 Copy

U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Anderson First: Tiffany Date of Exam: 7/18/11 Case #: 118168567

SS#: XXX-XX-5133 Date of Birth: 8/22/70 Date of Injury: 6/29/11 Claim #: _____

Employer: SJC MOSQUITO & VECTOR Contact: JOHN STROH Tel.: (209) 982-4675 Fax: 209 982-0120

Claims Administrator: SJC MOSQUITO & VECTOR Tel.: (209) 982-4675 Fax: 209 982-0120

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

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

DIAGNOSES (Include ICD-9 code, if possible)

924.11 CONTUSION OF KNEE R

TREATMENT

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

☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☐ Meds / Supplies Dispensed _____

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

Estimated length of treatment is now _____ weeks

WORK STATUS ☒ First Aid Case

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

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

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

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

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

☐ Medical status was discussed with employer representative. Name _____

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

DISCHARGE STATUS

☒ Return to full duty on (Date) 7/18/11 with no limitations or restrictions. Released from care without ratable disability or need for future medical care.

☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.

☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

TREATING PROVIDER

Name ECK, JON L., M.D. Lic. # G67867 Date of Exam 7/18/11

Specialty _____ Signature Signature on File

Issued at: USHW of California - Stockton, 3663 E. ARCH ROAD, SUITE # 400, STOCKTON, CA 95215 Tel: (209) 943-2202

Checkin Time 8:44 AM Checkout Time 10:42 AM

17-E-12

7/18/11

Current Symptoms:

The patient has drawn her symptoms on a diagram outlining the human body. The body parts reported are the knees.

The patient was asked to describe his pain based on the McGill Pain Questionnaire short form. The character of the pain is described as ache.

The patient's present pain intensity on a numeric rating scale (NMRS) is 3-7/10. The patient does not have visibly disabling pain.

From the patient's perspective the cause of pain is from the original injury. Aggravating factors include general activities and normal work. Palliative measures include rest.

The patient has taken a proactive approach to their condition, and is actively engaged in moving forward with a self directed management program.

The impact of the pain is problematic because the persistent symptoms have affected the quality of life (QOL) and activities of daily living. He is much more limited in social and recreational activities, and it has affected his outlook and mood.

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

GENERAL APPEARANCE:
The patient is well-developed, well-nourished, and in no distress. The patient is alert, and oriented x3.

HEENT:
Normocephalic, atraumatic. Palpatory examination normal. Pupils are equal, round, and reactive to light. Extraocular muscles are intact. Sclerae are non-icteric. Conjunctiva are pink, non-icteric.

NECK:
There is no significant lymphadenopathy or mass. Trachea is mid-line. The thyroid is without enlargement or palpable nodule. There is no evidence of jugular vein distention.

CARDIOVASCULAR:
The heart has a regular rate and rhythm. Pulses are normal.

RESPIRATORY:
Lungs are clear.

LUMBAR SPINE:
Gait is normal.
Normal Lumbar flexion.
Straight leg raise is negative.
Spasm and guarding is noted lumbar spine mild soreness/ no spasm/ guarding.

FABER TEST Negative.

Patrick Test Negative.

17-E-13

U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Anderson First: Tiffany Date of Exam: 7/18/11 Case #: 118168567

SS#: XXX-XX-8133 Date of Birth: 8/22/70 Date of Injury: 5/29/11 Claim #:

Employer: SJC MOSQUITO & VECTOR Contact: JOHN STROH Tel.: (209) 982-4675 Fax: 209 982-0120

Claims Administrator: SJC MOSQUITO & VECTOR Tel.: (209) 982-4675 Fax: 209 982-0120

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

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

DIAGNOSES (Include ICD-9 code, if possible)

924.11 CONTUSION OF KNEE R

TREATMENT

- [X] Office Visit / Injury Treatment
- [ ] Start / [ ] Continue [ ] Therapy: ___ times / week for ___ weeks. [ ] Ergonomic Eval
- [ ] Start / [ ] Continue [ ] Chiro: ___ times / week for ___ weeks. [ ] Other
- [ ] Meds / Supplies Dispensed
- [ ] Consultation / [ ] Referral [ ] Requested / [ ] Pending. Specialty [ ] Work status to be determined by specialist.

Estimated length of treatment is now ___ weeks

WORK STATUS [X] First Aid Case

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

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

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

[ ] Medical status was discussed with employer representative. Name

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

DISCHARGE STATUS

- [X] Return to full duty on (Date) 7/18/11 with no limitations or restrictions. Released from care without ratable disability or need for future medical care.
- [ ] Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
- [ ] NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

TREATING PROVIDER

Name ECK, JON L, M.D. Lic. # G67667 Date of Exam 7/18/11

Specialty Signature Signature on File

Issued at: USHW of California - Stockton, 3663 E. ARCH ROAD, SUITE # 400, STOCKTON, CA 95215 Tel: (209) 943-2202

Checkin Time 8:44 AM Checkout Time 10:42 AM

17-E-14

U.S. HealthWorks

MEDICAL NECESSITY / REASONS FOR KNEE IMAGING STUDIES

SJC MOSQUITO & VECTOR 159356
DOS: 7/18/11 DOI: 6/29/11 DOB: 8/22/70
Patient: Anderson, Tiffany Sex: M F Date of Service:_____
Case # : 118-168567 Ref # : Org 1174/s\ f Injury:_____ Claim Number:_____

KNEE

Criteria for ordering imaging studies *(ACOEM p 331)* are:

- Red flags present for possible serious knee condition
- History of trauma
- Boney crepitation, abnormal mobility, angulation of leg, new deformity
- Point tenderness
- Inabiity to bear weight or walk *(ACOEM p 331)*, inability to walk (four steps) or bear weight immediately or within a week of the trauma *(ACOEM p 343)*
- Displaced patella, tibia or fibula or history of dislocation
- Penetrating wound of knee
- Diabetes, history of immunosuppression, systemic signs/symptoms of infection/sepsis
- Localized heat, swelling erythema, soft tissue swelling NOT consistent with effusion
- Severe pain on motion
- History of cancer or palpable tumor
- History of gout, pseudogout, inflammatory arthritis or rheumatoid arthritis, recurrent episodes, swelling in other joints
- Painful, swollen joints without systemic symptoms, local effusion, heat
- Need to rule out compartment syndrome
- History consistent with fracture and/or dislocation
- Possible collateral ligament tear – "stress films" ((*ACOEM p 335*)
- Twisting, direct lateral OR medial blow to the knee, excessive abduction or adduction, tenderness at joint line or tenderness at ligament origin or insertion. *(ACOEM p 335)*
- Joint Effusion within 24 hours of direct blow or fall *(ACOEM p 341)*
- Palpable tenderness over fibular head or patella *(ACOEM p 341)*
- Inability to flex knee to 90 degrees *(ACOEM p 343)*
- Plain films recommended for "suspected red flags" or optional for tense hemarthroses *(ACOEM p 347)*

Other:

Treating Physician

Name: Jon Eck, M.D.
Signature: Jon Eck Date: 7/18/11

17-E-15

U.S. HealthWorks
MEDICAL GROUP

X-RAY INTERPRETATION REQUEST

From Dr. ~~Dr Eck~~ ECK, M.D. Date 7/18/11

Patient _____ Age _____

X-Ray No. 44889

Examination 1. (RT) knee

2. _____

3. _____

4. _____

SJC MOSQUITO & VECTOR 159356
DOS: 7/18/11 DOI: 6/29/11 DOB: 8/22/70
Patient: Anderson, Tiffany
Case # : 118-168567 Ref # : Org 1174/s

Reason:

- ☐ Trauma
- ☐ Routine Exam
- ☐ Fracture Follow-up
- ☐ Recent Surgery
- ☐ Other _____
- ☒ Pain
- ☐ Cough
- ☐ Fever
- ☐ Known Malignancy

ST 1014 (Rev. 03/05)

17-E-116

U.S. HealthWorks
MEDICAL GROUP

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

☐ *Additional pages attached*

Patient Last Anderson First Tiffany DOB 8/22/70 Date of Exam: 7/18/11 Case #: 118168567

[redacted]cupation Pesticide Applicator SS# 549-23-5133 Date of Injury 6/29/11 Claim # _____

[redacted]mployer: SJC MOSQUITO & VECTOR Contact: JOHN STROH Tel: (209) 982-4675 Fax: 209 982-0120

Claims Administrator SJC MOSQUITO & VECTOR Tel: (209) 982-4675 Fax: 209 982-0120

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

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

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

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

SUBJECTIVE COMPLAINTS (Document and describe significant complaints)

clo intermittent pain @ knee

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

No obj finding
Healed superficial abrasion
⊖ McMurray. ⊖ ligament instability. ↓ gait

DIAGNOSES (Include ICD-9 code, if possible)

Contusion/Abrasion @ knee

TREATMENT

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

[redacted]leds / Supplies Dispensed _____

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

Estimated length of treatment is now _____ weeks

WORK STATUS ☐ First Aid Case

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

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

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

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

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

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

☐ Medical status was discussed with employer representative _____

DISCHARGE STATUS

☐ Return to full duty on (Date) _____ with no limitations or restrictions. Released from care without ratable disability or need for future medical care.

☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.

☐ **NON-INDUSTRIAL.** Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code S 139.3.

[redacted]Na JON ECK, M.D. Cal. Lic # _____ Date of Exam 7/18/11

[redacted]Sp[redacted]y: _____ Signature _____

Executed at: USHW of California - Stockton, 3663 E. ARCH ROAD, SUITE # 400, STOCKTON, CA 95215 Tel: (209) 943-2202

17-E-17

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

ATE: NC TIME: _____ ☐ Before / After Shift

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

YOUR NEXT APPOINTMENT FOR PHYSICAL THERAPY IS ON:

☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT

DATE: _____ TIME: _____ ☐ Before / After Shift

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

U.S. HealthWorks
MEDICAL GROUP

CONSENT FOR X-RAY EXAMINATION

I, Tiffany Anderson hereby certify that:

1. Before undergoing any X-ray examination, I have been informed by U.S. HealthWorks Medical Group that radiation exposure may be harmful to my health and to the health of my offspring, in case I am pregnant.

2. I have been asked to notify the X-ray technician, by means of this statement, if I am or if I believe that I might be pregnant, before I undergo any X-ray examination.

3. I have been asked to provide this information so that, in case of pregnancy, appropriate measures can be taken to protect the well-being of both my descendant(s) and I, while still receiving the best possible medical care.

4. My last menstrual period started on 1-2011 and to the best of my knowledge,
   [X] ***I am not pregnant*** and I consent to an X-ray examination, as indicated by the physician.
   [ ] ***I am pregnant.***

AUTORIZACION PARA EXAMEN DE RAYOS X

Yo, _____ certifico que:

1. Antes de cualquier exámen de rayos X, he sido informada por U.S. HealthWorks Medical Group que la exposición a radiaciones puede ser perjudicial para mi salud y para la salud de mi hijo(a), en caso de estar embarazada.

2. Se me ha pedido que notifique al técnico de rayos X, por intermedio de esta certificación, si estoy embarazada o creo estar embarazada, antes de que se me haga algún exámen de rayos X.

3. Se me ha pedido que suministre esta información para que en caso de estar embarazada, puedan tomarse las medidas necesarias para proteger a mi hijo(a) y a mi, mientras recibo el mejor cuidado médico posible.

4. Mi último período menstrual comenzó el _____ y hasta donde yo sé,
   [ ] ***no estoy embarazada*** y doy mi consentimiento para un exámen de rayos X, tal como fue indicado por el médico.
   [ ] ***si estoy embarazada.***

SIGNATURE (Firma)

17-E-18
DATE (Fecha)