

Khosrow Tabaddor, M.D.
ORTHOPAEDIC SURGEON

8/16/2016

RE: Claim # VE0700184

Tiffany Anderson
1900 Lakeshore Drive
Lodi, CA 95242

ATTENTION:
QUESTIONNAIRE MUST BE
COMPLETED BEFORE
APPOINTMENT

Dear Ms. Anderson:

This is a reminder letter of your upcoming appointment for a Qualified Medical Evaluation.

DATE: Monday, September 12, 2016
TIME: 5:30:00 PM
LOCATION: 333 San Carlos Way, Ste. B
Stockton, CA 95207
TELEPHONE: (559) 222-2294

Enclosed you will find a map plus a questionnaire. Please fill out the questionnaire immediately and bring to the appointment completed. Do not mail it in to the office. Make copies of your questionnaire before your appointment. Copies cannot be made at the office.

If you have additional records that have not been served on the QME, please mail the records to the carrier so that all parties can be copied before the QME views them. Your appointment will last about one to two hours. If you have recent X-Rays, MRI films, or CT scans bring only them to the appointment.

If for any reason you are going to be late or unable to make this appointment, please contact our office immediately. Due to limited space in our waiting room, we request that you bring no more than one person with you to your appointment.

Please call (559) 492-5602 or (559) 492-5569 to confirm that you have received our letter. We look forward to seeing you at your appointment!

Sincerely,

Khosrow Tabaddor, M.D.
ORTHOPAEDIC SURGEON

cc: AIMS P.O. Box 269120 Sacramento, CA 95826-9120 Nancy Urton, Claims Examiner
L/O Stockwell, Harris, Woolverton and Helphrey 1545 River Park Drive, Ste. 330 Sacramento, CA 9581

1 of 12



Address 333 San Carlos Way
Stockton, CA 95207

Notes My office is located in Suite B
inside the office of Dr. Scott
Inoue D.C.



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2 of 12

Please read the following required disclosure notice:

ARTICLE 4. Evaluation Procedures

§40. Disclosure Requirements: Injured Workers

(a) An evaluator selected from a QME panel shall advise an injured worker prior to or at the time of the actual evaluation of the following:

(1) That he or she is entitled to ask the evaluator and the evaluator shall promptly answer questions about any matter concerning the evaluation process in which the QME and the injured worker are involved;

(2) That subject to section 41(g), the injured worker may discontinue the evaluation based on good cause. Good cause includes: (A) discriminatory conduct by the evaluator towards the worker based on race, sex, national origin, religion, or sexual preference, (B) abusive, hostile or rude behavior including behavior that clearly demonstrates a bias against injured workers, and (C) instances where the evaluator requests the worker to submit to an unnecessary exam or procedure.

(b) When required as a condition of probation by the Administrative Director or his/her licensing authority, the QME shall disclose his/her probationary status. The QME shall be entitled to explain any circumstances surrounding the probation. If at that time, the injured worker declines to proceed with the evaluation, such termination shall be considered by the Administrative Director to have occurred for good cause.

(c) If the injured worker declines to ask any questions relating to the evaluation procedure as set forth in section 40(a), and does not otherwise object on the grounds of good cause to the exam proceedings under section 41(a) during the exam itself, the injured worker shall have no right to object to the QME comprehensive medical-legal evaluation based on a violation of this section.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, and 4067 Labor Code.

I have read the above notice: Date: _____

Examinee Name: _____ Examinee Signature: _____

I have read the above notice to the examinee and they fully understand what I read to them:

Interpreter Name: _____ Interpreter Signature: _____

3 of 12

Activity	Frequency	Number of Hours A Day.									
		Continuous	Intermittent	0	1	2	3	4	5	6	More than 8 hours
A. Sitting											
B. Walking											
C. Standing											
D. Bending											
E. Squatting											
F. Climbing											
G. Kneeling											
H. Twisting											
2 a. Hand Manipulation Required?		NO YES (Check b, c, d) Left YES NO									
2 b. Simple Grasping?		Right	Yes	No		Left	Yes	No			
2 C. Power Grasping?		Right	Yes	No		Left	Yes	No			
2 d. Pushing and pulling?		Right	Yes	No		Left	Yes	No			
2 e. fine Manipulation:		Right	Yes	No		Left	Yes	No			
3. (a) Does the job require working to reach or work above the shoulders?									Yes	No	Frequency
3 (b) Reaching above or below shoulder level?									Yes	No	Frequency
4. Does the job require use of his/her feet to operate foot controls or for repetitive movements										Yes	No
5. Are there Special visual or auditory requirements.										Yes	No

LIFTING FREQUENCY CARRYING FREQUENCY

- _____ A. 10 LBS OR LESS
- _____ B. 11 TO 25 LBS
- _____ C. 26 TO 50 LBS
- _____ D. 51 TO 75 LBS
- _____ E. 76 TO 100 LBS
- _____ F. OVER 100 LBS

Longest Distance Carries: _____

Heaviest item carried and how far? _____

	YES	NO	Description
7. Driving Cars, Trucks, Forklifts or other moving equipment:			_____
8. Working near hazardous equipment and machinery:			_____
9. Walking on uneven grounds:			_____
10. Exposure to dust, gas, or fumes:			_____
11. Exposure to noise:			_____
12. Exposure to extremes in temperature or humidity:			_____
13. Work at Heights:			_____

5 of 12

HISTORY OF INJURY

In your own words, please describe the injury and include... What were you doing? How did it occur?
 What part of your body was hurt? (Use other side if necessary)

Did you report the injury? _____ If so, to whom? _____ When? _____

Describe your medical treatment:

(Where, when, by whom, what type. Where were you seen first? What treatment did you receive? Were you referred elsewhere?)

Were you able to continue working? _____ If yes, modified or regular. Were you later taken off work? _____ If so, when and by whom? _____

Were x-rays or other special studies done? yes no

SPECIAL STUDIES	Body Part	Date Performed	Location Performed	Result
EMG, NCV				
CT Scan				
MRI				
Bone Scan				
Myelogram				
Arthrogram				
Other				

Did you receive physical therapy? yes no If yes, for how long? _____
 How often? _____

Did this treatment help? yes no
 Explain: _____

Did you have surgery? yes no
 If yes, when? _____

Are you still receiving treatment? yes no
 If yes, what type? _____

6 of 12

Please list the names and dates from the first doctor you saw to the present:

Name	Specialty	City	Referred By	Exam Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

With the treatment provided to date, do you feel your condition is: Fully recovered Improved No change Worse

Have you missed any time from work because of the injury? yes no
If yes, what was your first day of lost time? _____

If yes, when did you return to work? _____

Were you ever told to return to modified work? yes no

If yes, did you return to work? yes no When? _____

Is modified work available? yes no

When do you expect to return to your regular work? _____

Are you currently receiving disability as a result of the work injury in question? yes no

If yes, from whom? Workers' compensation insurance carrier

State disability insurance fund

For how long? _____ years _____ months

Have you been recommended for, or have you participated in, a vocational rehabilitation program as a result of this injury? yes no

CURRENT MEDICAL TREATMENT

Are you still seeing a doctor at this time? yes no If yes, date last seen: _____

Next appointment _____ Doctor's name _____ E MD O DC

Are you taking any medications? yes no

If yes, name of medications: _____

How often do you take them? _____

Does the medication help you? _____

Are you receiving physical therapy? yes no

Is physical therapy helping? _____

4 707
12

How much could you lift before? _____

PAST MEDICAL HISTORY

Prior to the injury in question, have you ever had similar problems with, or injuries to, the body part or parts involved in this claim? yes no

If yes, please give details (IMPORTANT: Were you having problems at the time of the injury? Give dates, doctors, etc.): _____

Have you had any work or non-work injuries since the injury involved in this claim? yes no
If yes, please explain: _____

Have you ever had any other work-related injuries? yes no If yes, please explain _____

Have you ever been involved in any motor vehicle accidents? yes no If yes, please describe: _____

Have you had any other serious accidents, sports injuries, or illnesses? yes no If yes, please describe: _____

Did you ever receive a permanent disability settlement? yes no
If yes, when? _____

Do you have any medical problems or serious illnesses you are being treated for? _____

Have you had any surgeries? If so, please describe: _____

Do you have any allergies yes no If yes, list: _____

Check below if you have had any of the following diseases/illnesses as a child or as an adult:

	Diabetes	Kidney Disease	Epilepsy/Seizures
Anemia	Pneumonia	Fracture	Hepatitis/Jaundice
Hernia	Chicken Pox	Tuberculosis	High Blood Pressure
Cancer	Skin Problems	Rheumatic Fever	Gallbladder
Polio	Stool Disorders	Thyroid Disorder	Bleeding Disorder
Ulcer	Mental Disorder	Arthritis	Asthma
Sexually Transmitted Disease		Heart Disease	Other

Do you have a personal family doctor or chiropractor? yes no

If yes, name: _____

Date last seen: _____ For what? _____

EXAMINEE PROFILE

Marital Status: Married Single Separated Divorced Widowed

Number of children _____

Years of education completed: _____ College Degree(s) _____

Special Training _____

Do you smoke cigarettes? yes no If yes, how much? _____

Do you drink alcoholic beverages? yes no If yes, how often? _____

Do you have any history of drug or alcohol habit/dependency/or abuse? yes no

Comment: _____

Do you have any hobbies, special skills, or interests? yes no If yes, describe: _____

Do you participate in a fitness program, or any sports activities? yes no If yes, describe: _____

Has the injury in question hindered or stopped you from doing any of your usual activities? yes no
 If yes, please explain your reasons why: _____

11 of
12