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November 9, 2020

Natalia Foley, Esq.
Workers Defenders Law Group
8018 E. Santa Ana Canyon Road, Suite 100-215
Anaheim Hills, CA 92808

PATIENT:	Anisa Chaney
DOB:	September 6, 1973
OUR FILE #:	207853
SSN:	XXX-XX-6450
EMPLOYER:	Sunbridge Hallmark Health Services dba Playa Del Rey Center 7716 Manchester Avenue Playa del Rey, CA 90293
WCAB #:	ADJ13521045
CLAIM#:	2080381794-01
DATE OF INJURY:	CT January 6, 2020 to June 30, 2020; CT July 6, 2019 to July 5, 2020
DATE OF 1ST VISIT:	November 9, 2020
INSURER:	American Zurich Insurance Company P.O. Box 968005 Schaumburg, IL 60196
ADJUSTOR:	Eva Reale
PHONE #:	(818) 227-1725

Primary Treating Physician's Initial Evaluation Report

Dear Ms. Foley,

Thank you for referring Anisa Chaney, a 47-year-old female, to my office for occupational/internal medicine consultation. The patient is specifically referred for evaluation and treatment of various musculoskeletal and other injuries that she sustained during the course of her employment with Sunbridge Hallmark Health Services.

Job Description:

The patient began working for Sunbridge Hallmark Health Services, a skilled nursing facility on April 1, 2020 and she continued working for the facility until July 6, 2020. She worked as a registered nurse supervisor. Her work hours were from 11:00 pm to 7:00 am, five to six days per week. Her job duties involved managing staff to ensure patient care, direct patient care, administrative duties and managing facility needs. Physically, the job required for her to stand, squat, bend, walk, stoop, kneel and twist. She was also required to lift 50 or more pounds weight.

History of the Injury as Related by the Patient:

The patient filed two continuous trauma claims between the dates of July 6, 2019 and July 5, 2020 and between January 6, 2020 and June 30, 2020, for injuries that she sustained during the course of her employment.

The patient relates that at the time of her injuries she was working for Sunbridge Hallmark Health Services at Playa del Rey Center, a skilled nursing facility. She states that the company had a license facilitating up to 99 patients. She states that she worked as the supervisor and would provide supervising duties for the entire staff including the CNA's, LVN's and other registered nurses. She also performed administrative duties.

The patient states that throughout the course of her work there was a very low amount of staff. She states that she began to notice that she was performing various job duties besides her administrative duties as the registered nurse supervisor. She would perform duties for CNA's, LVN's and other RN's. She states that overtime she began to have increased stress levels. When she reported her stress to her supervisors, she was advised that additional personnel would be hired for assisting her. She states that the company never hired additional personnel causing her stress levels to continue.

The patient states that she eventually presented to an urgent care center as she had the onset of a panic attack. She was provided various medications and she was referred to a psychiatrist for which she continued in treatment with. She states that she was prescribed various medications including Prozac and Buspar. She did have some relief with both of these medications. However, at this time, the patient is on Tylenol and at times she takes Ativan. Her significant stress continues at the workplace.

The patient also has other symptoms including abdominal pain, nausea, vomiting, and diarrhea and weight loss. The patient also has difficulty with concentration and sleep. She also complains of headaches and dizziness.

The patient also complains of musculoskeletal pain that has progressed since leaving her workplace. She complains of pain in the cervical spine, left shoulder, left elbow and left hand. She also complains of numbness of the left hand, as well as dropping items with the left hand. The patient also complains of bilateral knee, left ankle and left foot pain.

Prior Treatment:

The patient has been in treatment with Dr. Valentine Hernandez prior to coming to this office.

Previous Work Descriptions:

Prior to working as a registered nurse, the patient worked in cosmetology.

Occupational Exposure:

The patient was exposed to chemicals, dust and vapors during the course of her work. The patient was exposed to excessive noise during the course of her work. She was exposed to excessive heat and cold.

Past Medical History:

The patient denies any history of previous medical or surgical conditions. She has no known allergies. There is no history of prior accidents or injuries. There is no other significant medical history.

Previous Workers' Compensation Injuries:

None

Social History:

The patient is married. She has two children. She does not smoke cigarettes, drink alcoholic beverages or use recreational drugs.

Family History:

The patient's parents have died. Her mother died of a brain aneurysm with a known diagnosis of hypertension and depression. Her father died of liver disease secondary to alcoholism. She has one brother and one sister who are alive and well. There is no other significant family medical history.

Review of Systems:

The patient complains of headaches, dizziness, lightheadedness, chest pain, palpitations, and shortness of breath. She denies a complaint of eye pain, visual difficulty, ear pain, hearing problems, sinus problems, sinus congestion, cough, throat pain, postnasal drip, jaw pain, jaw clenching, dry mouth, wheezing, hemoptysis or expectoration. The patient complains of abdominal pain, nausea, vomiting, diarrhea, and weight loss. She denies a complaint of acid reflux or constipation. The patient denies any genitourinary complaints including dysuria, frequency, urgency or urinary tract infections. The patient's musculoskeletal complaints involve cervical spine pain 8/10, lumbar spine pain 7/10, left shoulder pain 8/10, left elbow pain 7/10, left wrist pain 7/10, bilateral hand pain 5/10, left hip pain 6-8/10, right knee pain 6/10, left knee pain 7/10, left ankle pain 6/10 and left foot pain 6/10. There is a complaint of peripheral edema and swelling of the ankles. The patient's psychosocial complaints include anxiety, depression, difficulty concentrating, difficulty sleeping, and difficulty making decisions. There is no hair loss or dermatologic complaints. There is no intolerance to excessive heat or cold. There is a complaint of diaphoresis, but denies a complaint of fever, chills or lymphadenopathy.

Activities of Daily Living Affected by Workplace Injury:

The patient complains of difficulty sleeping due to her musculoskeletal pain. She wakes up several times a night because of the pain. She also has problems with dressing, self-grooming, climbing stairs and performing housework. She denies any problems with bathing, toileting, walking, shopping, cooking, or driving.

Review of Records:

Please note that if medical records have been received for review, they will be reviewed and commented upon in a subsequent communication.

Current Medications:

The patient currently takes Tylenol 1,000 mg BID, Ativan 0.5 mg PRN, Prozac 10 mg BID and Buspar 10 mg BID.

Physical Examination:

The patient is a left handed 47-year-old alert, cooperative and oriented African/American female, in no acute distress. The following vital signs and measurements are taken today on examination: Weight: 130 pounds. Blood Pressure: 109/53. Pulse: 65. Respiration: 16. Temperature: 97.0 degrees F.

Skin:

No abnormalities were detected.

Head:

The patient's head is normocephalic and atraumatic. The patient's facial muscles show good contour and symmetry. There is no scleral icterus and no tenderness of the skull noted on examination. There is left sided TMJ tenderness.

EENT:

Pupils are equally reactive to light and accommodation. Extraocular movements are intact. The throat is clear. Hearing appears to be uninvolved. The nasal passages are clear and the mucosa is normal in appearance. The patient's neck is overall supple with no evidence of lymphadenopathy, thyromegaly or bruits.

Thorax:

The patient exhibits good bilateral rib excursion during respiration. Lungs are clear during percussion and auscultation. The heart reveals a regular rate and rhythm and no murmurs are noted.

Abdomen:

The abdomen is flat, non-tender without organomegaly. Normoactive bowel sounds are present.

Genitalia and Rectal:

Examination is deferred.

Musculoskeletal Examination:

The patient is ambulatory. There are no grossly visible abnormalities of the upper or lower extremities or the axial skeleton. There are no deformities. There is tenderness of the left side of the cervical spine. There is tenderness of the lumbar paraspinal musculature. There is tenderness of the left shoulder. There is a tenderness of the left elbow. There is tenderness of the left wrist. Tinel's is positive at the left wrist. There is tenderness of the left hand. There is tenderness of the left knee.

Range of Motion Testing:

Cervical Spine:	Normal
Flexion	40/50
Extension	50/60
Right Rotation	70/80
Left Rotation	70/80
Right Lateral Flexion	35/45
Left Lateral Flexion	35/45

Thoracic Spine:	
Flexion	60/60
Right Rotation	30/30
Left Rotation	30/30

Lumbo-Sacral Spine:	
Flexion	50/60
Extension	20/25
Right Lateral Flexion	20/25
Left Lateral Flexion	20/25

Shoulder:	*Right*	*Left*
Flexion	180/180	150/180
Extension	50/50	40/50
Abduction	180/180	140/180
Adduction	50/50	40/50
Internal Rotation	90/90	70/90
External Rotation	90/90	70/90

Hips:	*Right*	*Left*
Flexion	130/140	110/140
Extension	0/0	0/0
Abduction	40/45	40/45
Adduction	25/30	25/30
Internal Rotation	40/45	40/45
External Rotation	40/45	40/45

Elbow:	*Right*	*Left*
Flexion	140/140	140/140

Forearm	*Right*	*Left:*
Pronation	80/80	70/80
Supination	80/80	70/80

Wrist:	*Right*	*Left*
Dorsiflexion	60/60	50/60
Palmar Flexion	60/60	50/60
Radial Deviation	20/20	15/20
Ulnar Deviation	30/30	25/30

Knee:	*Right*	*Left*
Flexion	130/130	130/130

Ankle/Foot:	*Right*	*Left*
Dorsiflexion	15/15	15/15
Plantar Flexion	40/40	40/40
Inversion	30/30	30/30
Eversion	20/20	20/20

Neurological Examination:

Cranial nerves 2-12 are intact. Deep tendon reflexes are 2+ bilaterally. Superficial reflexes are found to be within normal limits. There are no abnormal reflexes detected and there is no abnormality of sensation or coordination.

Radiological Data:

None performed

Special Diagnostic Testing:

A pulmonary function test is performed revealing an FVC of 2.74 L (104.1%), an FEV 1 of 2.22 L (90.0%), and an FEF of 2.43 L/s (77.8%).

A 12-lead electrocardiogram is performed revealing normal sinus rhythm and a heart rate of 71 per minute.

A pulse oximetry test is performed today and is recorded at 99%.

Laboratory Testing:

The following laboratory tests were ordered today: a complete blood count, chemistry panel, thyroid panel, TSH, lipid panel, sedimentation rate, hemoglobin A1C, H. Pylori, C-reactive protein, and a urinalysis.

A random blood sugar is performed today and is recorded at 67 mg/dL. The urinalysis performed by dipstick method was reported as 1+ protein.

Subjective Complaints:

1. Headaches
2. Dizziness
3. Lightheadedness
4. Chest pain
5. Palpitations
6. Shortness of breath
7. Abdominal pain
8. Nausea
9. Vomiting
10. Diarrhea
11. Weight loss
12. Cervical spine pain
13. Lumbar spine pain
14. Left shoulder pain
15. Left elbow pain
16. Left wrist pain
17. Bilateral hand pain
18. Left hip pain
19. Right knee pain
20. Left knee pain
21. Left ankle pain
22. Left foot pain
23. Peripheral edema and swelling of the ankles
24. Anxiety
25. Depression
26. Difficulty concentrating
27. Difficulty sleeping
28. Difficulty making decisions
29. Diaphoresis

Objective Findings:

1. Left sided TMJ tenderness
2. Tenderness of the left side of the cervical spine

3. Tenderness of the lumbar paraspinal musculature
4. Tenderness of the left shoulder
5. Tenderness of the left elbow
6. Tenderness of the left wrist
7. Tinel's is positive at the left wrist
8. Tenderness of the left hand
9. Tenderness of the left knee

Diagnoses:

1. MUSCULOSKELETAL INJURIES INVOLVING CERVICAL SPINE, LUMBAR SPINE, LEFT SHOULDER, LEFT ELBOW, LEFT WRIST, BILATERAL HANDS, LEFT HIP, BILATERAL KNEES, LEFT ANKLE AND LEFT FOOT
2. CERVICAL SPINE SPRAIN/STRAIN
3. LUMBAR SPINE SPRAIN/STRAIN
4. INTERNAL DERANGEMENT, LEFT SHOULDER
5. EPICONDYLITIS LEFT ELBOW
6. CARPAL TUNNEL SYNDROME LEFT WRIST
7. INTERNAL DERANGEMENT LEFT KNEE
8. INTERNAL DERANGEMENT BILATERAL ANKLES
9. ELEVATED BLOOD PRESSURE, RULE OUT HYPERTENSION
10. CEPHALGIA
11. VERTIGO
12. CHEST PAIN
13. PALPITATIONS
14. DYSPNEA
15. GASTRITIS SECONDARY TO NSAID MEDICATIONS
16. NAUSEA/VOMITING
17. IRRITABLE BOWEL SYNDROME MANIFESTED BY DIARRHEA
18. WEIGHT LOSS
19. PERIPHERAL EDEMA/SWELLING OF ANKLES
20. ANXIETY DISORDER
21. DEPRESSIVE DISORDER
22. SLEEP DISORDER
23. DIAPHORESIS

Discussion:

This patient suffered significant musculoskeletal injuries, as well as injuries based on the level of stress that was placed upon her at the workplace. She has noted elevated blood pressures and will require close monitoring to rule out a diagnosis of hypertension. She was prescribed NSAID medications and developed symptoms of gastritis/GERD, along with symptoms of nausea and vomiting and diarrhea. Due to her musculoskeletal pain and other conditions,

she developed an anxiety and depressive disorder. She also complains of difficulty with sleep because of her pain.

Please be advised that the listed diagnoses represent medical diagnoses and/or a differential diagnosis to a reasonable degree of medical probability based on the history provided to me by the patient and the findings of my examination. I believe that these diagnoses are industrial in origin and are either initiated or aggravated by the patient's employment and are, therefore, industrial in origin. I reserve the right to alter my opinions based upon receipt of additional information in the form of prior medical records or other documentary evidence that relates to this case. Please be advised that the denial of the claim by the employer will affect my ability to either confirm or reject any of the stated diagnoses, which will also affect my ability to provide evidentiary support for my opinions. Treatment authorization, if already approved, is appreciated. If treatment has not yet been approved, it is hereby requested.

The various diagnoses listed appear to be consistent with the type of work that would typically cause such abnormalities. I, therefore, believe that the diagnoses listed thus far are AOE/COE.

Disability Status:

The patient is to continue on temporary and total disability for a period of one month.

Treatment:

The patient is to continue with her current medications. She is prescribed Ativan 0.5 mg daily, Flurbiprofen topical cream to apply BID and Gabapentin topical cream to apply BID. She is referred for an EMG nerve conduction study of the upper extremities. She will be reevaluated in six weeks.

Attestation:

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 it to be true.

I further declare under penalty of perjury that I personally performed the evaluation of the patient and that I personally performed the cognitive services necessary to produce this report at the above address, and that, except as otherwise stated herein, the evaluation was performed and the time spent

performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

The laboratory tests, if taken, were performed by Metro Lab in Encino, CA. X-rays, if taken, were administered by Jose Navarro, licensed x-ray technician #RHP 80136, and read by me. The chiropractic care and physical therapy treatments are provided under the direction of Scott Mintz, D.C.

I obtained the history, performed the physical examination and dictated this entire report. This report was transcribed by Susan Jervis, transcriptionist.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.

Based on Labor Code Statute 4628, a fee of $64.50 per page for a total of 11 pages has been added to cover reasonable costs of the clerical expense necessary to produce this report.

Disclaimer:

The examination of this patient was performed by Dr. Koruon Daldalyan. It should be noted; however, that aside from the physical examination, the editing of this report and the reviews deemed necessary and appropriate to identify and determine relevant medical issues including diagnosis, causation and treatment recommendations have been performed by me in consultation with Dr. Koruon Daldalyan.

Should you have any questions or concerns regarding the evaluation or treatment provided to this patient or this report, please feel free to contact me.

Sincerely,

Marvin Pietruszka, M.D., M.Sc., F.C.A.P.
Clinical Associate Professor of Pathology
University of Southern California
Keck School of Medicine
QME 008609

Koruon Daldalyan, M.D.
Board Certified, Internal Medicine