# Omar Tirmizi, MD, FCCP

A Professional Corporation
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Internal Medicine, Pulmonary Disease
Diplomate, American Board of Internal Medicine, Critical Care Medicine
Diplomate, American Board of Internal Medicine, Sleep Medicine
Diplomate, American Board of Sleep Medicine
1674 Plum Lane – Redlands, California 92374
Office (888) 888-0098 – Fax (909) 307-8643

June 16, 2021

Natalia Foley
Defendants Law Group
8018 Santa Ana Canyon Rd., Suite 100.215
Anaheim Hills, CA 92808

SIBTF
160 Promenade Circle
Sacramento, CA 95834

| | |
|---|---|
| **RE:** | **Debra Sanchez** |
| **Date of Service:** | 06/16/21 |
| **Location:** | 1806 Flower Street Glendale, CA 91201 |
| **SIF Case No.:** | SIF11924493 |
| **WCAB No.:** | ADJ11924493; ADJ11924494 |

**INDEPENDENT MEDICAL EVALUATION**
**SIBTF**

Thank you for asking me to see and evaluate Debra Sanchez as an Independent Medical Examiner with respect to the applicant's Subsequent Injury Benefit Trust claim. I had the opportunity to obtain a history and perform an examination on Debra Sanchez in my office in Glendale, California at 1806 Flower Street Glendale, California 91201. This was a comprehensive assessment and 65 minutes of face-to-face time was required for the assessment. Additionally, at the time of my assessment, 552 pages were provided and reviewed in preparation of this report. This report is billed as ML-201 with a total of 552 pages reviewed.

Injured workers qualify for SIBTF benefits if they fall under the requirements of Labor Code 4751. This requires that the injured worker have a pre-existing disability which predates the compensable industrial injury. The pre-existing disability needs to be labor-disabling or ratable. The pre-existing disability can be industrial or non-industrial. The combined effects of the pre-existing disability and the subsequent injury must be greater than or equal to 70% and the combination of both disabilities must be greater than just the effect of the subsequent injury alone. Finally, the condition must meet one of two thresholds:

- The 35% requirement: Permanent disability from the subsequent injury is 35% or higher
- The opposite and corresponding requirement: The pre-existing disability affects an extremity (hand or arm or foot or leg) or an eye AND the permanent disability from the subsequent injury BOTH 1) affects the opposite and corresponding member and 2) is 5% or higher

The Subsequent Injury must be an industrial injury whereas the "Pre-existing disability" can be either industrial or non-industrial.

**HISTORY OF PRESENT ILLNESS/INJURY:** Debra Sanchez is a 55-year-old female. She has worked in the healthcare industry as a medical assistant and transcriptionist. Her work has predominantly been transcription of pathology reports. She worked for many years at Laguna Hills, after which she transitioned to Long Beach Hospital. She then worked at Torrance Memorial Hospital, as well. She started work at Keck USC Hospital in March 2014, and last worked there in February 2019.

Ms. Sanchez reports that prior to beginning work in March 2014, at Keck USC, she had known medical conditions of chronic migraines, as well as obesity. She also had a history of loud snoring and probable underlying OSA, although this was not diagnosed until much later. Ms. Sanchez underwent laparoscopic Roux-En-Y bypass in 2013, and began work at Keck USC Hospital in March 2014. She estimates that her weight, prior to the gastric bypass, was 180 pounds. When she began work at USC, her weight was 140 pounds. When she stopped work in February 2019, her weight was approximately 160 pounds. She now weighs 196 pounds. Overall, she has had weight loss of 40 pounds due to gastric bypass before she started work at USC. At USC, she gained 20 pounds and after completing work at USC, she has gained another 35 pounds. She attributes her weight gain at USC to stress. She states that she has a long-standing history of anxiety and depression. In fact, she was given Paxil in the year 2002. This medication was doubled while at USC to 40 mg. Paxil is associated with weight gain of approximately 10-15 pounds on average. After termination from employment, her weight has increased further.

Ms. Sanchez reports that she with diagnosed with OSA in 2015. She states that part of her stress was also her mother's illness with cancer and eventual demise. She was diagnosed with OSA and was given a CPAP machine; however, she is unable to tolerate it, due to difficulty with the device. She has a history of long-standing migraines, as well.

**WORK HISTORY**: Discussed above.

**PAST MEDICAL HISTORY**: 1) Anxiety and depression. 2) History of abnormal LFTs. 3) chronic migraines. 4) OSA.

**PAST SURGICAL HISTORY**: Roux-En-Y gastric bypass in 2013.

**HOME MEDICATIONS**: Paxil 40 mg daily (increased to this dose in 2016/2017).

**ALLERGIES**: None.

**SOCIAL HISTORY**: She denies alcohol or tobacco use. She denies marijuana.

**REVIEW OF SYSTEMS:**

A ten point review of systems for internal medicine was conducted. Relevant positives and negatives are noted in the body of this report.

**PHYSICAL EXAMINATION:**

**Vital Signs:** Blood pressure: 104/70. Heart rate: 84. Respirations: 18. O2 saturation is 98% on room air. Weight: 196 pounds. Height: 58 inches.

**HEENT:** Head examination reveals that the head is normocephalic, atraumatic without deformity or unusual swelling. Pupils are round, reactive to light and accommodation normally. There is no nystagmus, lid lag or exophthalmos. Nasal mucosa is pink. Vision is normal.

**Chest and Lung:** Reveals clear, normal, symmetrical breath sounds with no adventitious sound. Expansion is normal. There are no surgical scars.

**Cardiovascular:** Reveals normal S1, S2 without murmurs, rubs or clicks.

**Abdomen:** Soft with no tenderness or organomegaly.

**Musculoskeletal:** There is no tenderness to palpation. Range of motion is normal.

**Extremities:** There is no cyanosis, peripheral edema, or clubbing. There is no evidence of insufficiency or skin changes. Pedal pulses are strong and bounding.

**Neurological:** Cranial nerves II to XII are intact. Gait is normal without ataxia. DTRs are normal. Babinski is downgoing.

**REVIEW OF MEDICAL RECORDS**

**07/25/05 - Daisy Guevara, M.D. – Healthcare Partners – Progress Note. Subjective:** The patient complains of a cat bite on the right leg for one week. She also has had a recurrence of migraine headache and discoloration of both cheeks. **Vital Signs:** Blood pressure 104/60. Pulse 84. Respiration 20. Weight 185.6 pounds. **Assessment:** 1) Migraine headache. 2) Cat scratch. 3) Rash. 4) Obesity. **Plan:** 1) Administered a Toradol 60 mg injection. 2) Prescribed Keflex 500 mg and Fiorinal 1-2 tab Q6 hours prn. 3) Dermatology referral given. 4) Weight loss is advised.

**04/03/06 - Gregory Ochoa, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of joint pain, headaches with pressure behind the eyes, and irritation with urination since Tuesday, as well as burning and irritation in both ears. **Medication:** Paxil 20 mg 1 tab q morning. **Vital Signs:** Blood pressure 110/70. Pulse 75. Respiration 17. Weight 176 lb. 1.6 oz. **Diagnoses:** 1) Acute sinusitis NOS. 2) Dysuria. **Plan:** 1) She is advised to take all medications, drink plenty of fluid, and rest. 2) Return for worsening symptoms. 3) Prescribed Zithromax Z-pak 250 mg 2 tabs today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs Q8 hours prn, and ibuprofen 600 mg 1 tab tid.

**04/24/06 – Gregory Ochoa, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of a sore throat and earaches in both ears. She feels unwell and is unable to work. **Medications:** Zithromax Z-pak 250 mg 2 tab today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs q 8 hours prn, ibuprofen 600 mg 1 tab tid, and Paxil 20 mg 1 tab every morning. **Vital Signs:** Blood pressure 122/70. Pulse 80. Respiration 16. Weight 176 lb. 9.6 oz. **Plan:** Prescribed Chloraseptic 1.4% gargle q 2 hours, loratadine 10 mg 1 tab daily, ibuprofen 600 mg 1 tab tid, antipyrine-benzocaine 5.4-1.4 OT% solution 4 drops to right ear qid, and Sudafed 30 mg 2 tabs q6-8 hours prn.

**05/02/06 – Gregory Ochoa, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of migraine headaches for two days. **Medications:** Paxil 20 mg 1 tab in the am, Zithromax Z-pak 250 mg 2 tabs today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs q 6 hours prn, ibuprofen 600 mg 1 tab tid, Imitrex 100 mg 1 tab 1 time only, Chloraseptic 1.4% MT gargle q 2 hours, antipyrine-benzocaine 5.4-1.4% OT solution 4 drops to right ear qid. **Vital Signs:** Blood pressure 110/80. Pulse 84. Respiration 16. Weight 177 lb. 1.6 oz. **Plan:** 1) Prescribed Paxil 20 mg 1 tab in the morning, Imitrex 100 mg 1 tab 1 time only. 2) Administered a Toradol 30 mg/ml, 60 mg now. 3) She is advised to drink plenty of fluids and rest.

**09/14/06 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient complains of a rash on her pubic area, as well as chronic low back pain. **Medications:** Paxil 20 mg 1 tab in the am, Zithromax Z-pak 250 mg 2 tabs today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs q 6 hours prn, ibuprofen 600 mg 1 tab tid, Imitrex 100 mg 1 tab 1 time only, Chloraseptic 1.4% MT gargle q 2 hours, antipyrine-benzocaine 5.4-1.4% OT solution 4 drops to right ear qid. **Vital Signs:** Blood pressure 122/78. Pulse 78. Respiration 19. Weight 181 lb. 11.2 oz. **Assessment:** 1) Left pubis area – round scaly rash. 2) Hair diseases NEC. 3) Lumbago. **Plan:** 1) She is prescribed Mycelex OTC 1% external cream and Keflex 500 mg 1 cap q 6 hours. 2) X-rays of the lumbar spine are ordered.

**09/14/06 – Alan Todd Turner, M.D. – Talbert Medical Group – Lumbar Spine Series. History:** Pain. **Impression:** Normal lumbar spine series.

**08/01/07 – Florence Li Lee, N.P. – Healthcare Partners – Office Visit. Chief Complaints:** The patient presents for a routine gynecological examination. **Medications:** Paxil 20 mg 1 tab in the am, Mycelex OTC 1% external cream, Keflex 500 mg 1 cap po q6 hours, Imitrex 100 mg 1 tab 1 time only, Chloraseptic 1.4% gargle q 2 hours, loratadine 10 mg 1 tab daily, and ibuprofen 600 mg 1 tab tid, antipyrine-benzocaine 5.4-1.4% OT solution, and Sudafed 30 mg 2 tabs q 6-8 hours prn. **Vital Signs:** Blood pressure 110/60. Pulse 74. Respiration 17. Weight 188 pounds. **Assessment:** Well woman exam. **Plan:** 1) Labs are ordered. 2) Annual physical and pap are performed. 3) Instructed in self-breast exam. 4) Prescribed Ortho Evra 150-20 mcg/24 hour 1 patch weekly for 3 weeks, then off 1 week.

**06/26/08 – David Meacham, P.A. – Healthcare Partners – Office Visit. Chief Complaints:** The patient requests a medication refill. She has a history of migraines, menses-related. **Medications:** Paxil 20 mg 1 tab in the am and Vandazole 0.75% vaginal gel. **Vital Signs:**

Blood pressure 110/70. Pulse 76. Respiration 18. Weight 192 lb. 11.2 oz. **Diagnosis:** Depressive disorder NEC. **Plan:** She is prescribed Paxil 20 mg.

**02/13/09 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient presents for a recheck of her migraines. She reports her headaches have improved. She is requesting refills of her medication. She reports wheezing with cold weather and has a cough with phlegm. **Medication:** Paxil 20 mg 1 tab in the am. **Vital Signs:** Blood pressure 124/80. Pulse 80. Respiration 20. Weight 201 pounds. **Assessment:** 1) Routine medical exam. 2) Depressive reaction. 3) Migraine NOS w/o mention intractable, improved. **Plan:** Labs are ordered.

**11/13/09 – Gregory Ochoa, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of a sore throat for one day with chest congestion, fever, and body aches for three days. **Medication:** Paxil 20 mg 1 tab in the am. **Vital Signs:** Blood pressure 130/90. Pulse 88. Respiration 16. Weight 214 lb. 8 oz. BMI 43.30. **Diagnosis:** 1) Unspecified viral infection. 2) Migraine NOS w/o mention, intractable. **Plan:** She is prescribed promethazine with codeine 6.25-10 mg /5 mL 1 tasp Q4-6 hours prn, loratadine 10 mg 1 tab daily prn, ibuprofen 600 mg 1 tab prn, and Cepacol Sore Throat 10-4.5 mg.

**04/05/10 – Prasad Chode, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of upper respiratory symptoms with severe sore throat, cough, mild colored phlegm, and low grade fever. **Medications:** Paroxetine HCL 20 mg 1 tab in the am, loratadine 10 mg 1 tab prn, and ibuprofen 600 mg 1 tab prn. **Vital Signs:** Blood pressure 102/60. Pulse 74. Respiration 18. Weight 209 pounds. BMI 42.19. **Assessment:** 1) Acute upper respiratory infection. 2) Depressive reaction. 3) Migraine NOS w/o mention, intractable, improved. **Plan:** She is prescribed fluticasone propionate 50 mcg/act nasal spray and paroxetine HCl 20 mg.

**09/09/10 – Gregory Ochoa, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of severe headaches with no relief with medications and is unable to work due to her pain. **Medications:** Paroxetine HCl 20 mg 1 tab in the am, Flonase 50 mcg/act nasal spray 1 spray each nostril bid prn. **Vital Signs:** Blood pressure 110/70. Pulse 72. Respiration 18. Weight 197 pounds. BMI 41.18. **Assessment:** 1) Migraine NOS w/o mention, intractable. 2) Nausea with vomiting. **Plan:** 1) she is administered a Toradol 50 mg injection. 2) A referral for neurology is submitted. 3) Follow up with primary care physician if needed. 4) Prescribed promethazine HCl 25 mg. 5) Labs are ordered.

**10/25/11 – Healthcare Partners – Laboratory Report.** Lab results are noted to be within normal limits.

**02/17/12 – Demetra Bastas-Braktkic, N.P. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of earache in both ears, cough, body aches, and chest congestion. She has tried Robitussin with only minor relief and took Advil for body aches with some relief. She requests a refill of Paxil. **Vital Signs:** Blood pressure 104/70. Pulse 78. Respiration 18. Weight 210 pounds. BMI 42.39. **Assessment:** 1) Chronic sinusitis. 2) Bacterial

infection. 3) Depressive reaction, stable. **Plan:** Prescribed Flonase 50 mcg/act 30 mg, Keflex 500 mg, and paroxetine HCl 20 mg.

**06/14/12 – Demetra Bastas-Braktkic, N.P. – Healthcare Partners – Office Visit. Chief Complaint:** The patient presents for a physical and Pap smear. She is asking for a lap band referral. She states she eats right and exercises but cannot lose weight. Her BMI is 41. **Medications:** Paroxetine HCl 20 mg 1 tab in the am and Relpax 40 mg 1 tab 1 time only, repeat after 24 hours as needed, multivitamin. **Vital Signs:** Blood pressure 124/90. Pulse 66. Respiration 16. Weight 214 lb. 8 oz. BMI 43.32 kg. **Assessment:** 1) Routine gynecological examination. 2) Screening malignant neoplasm breast, unspecified. 3) Special screen exam HPV. 4) Screening malignant neoplasm cervix. 5) Routine medical exam. **Plan:** 1) Labs are ordered. 2) Referral for mammogram screening. 3) Lab for cervical screening done. 4) Exercise and diet are reviewed.

**06/22/12 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient presents requesting a referral for bariatric surgery. She has had right knee pain for two weeks, and also complains of dark pigments in the facial area. **Medications:** Paroxetine HCl 20 mg 1 tab in the am, terconazole 0.4% vaginal cream, and Relpax 40 mg 1 tab 1 time only, repeat after 24 hours as needed. **Vital Signs:** Blood pressure 138/76. Weight 215 pounds. BMI 43.42. **Assessment:** 1) Morbid obesity. 2) Joint pain-leg, right, acute. 3) Uncertain behavior neoplasm skin. **Plan:** 1) Labs are ordered. 2) She is encouraged to eat less and exercise daily. 3) X-rays of the right knee are ordered. 4) She is prescribed ibuprofen 600 mg 1 tab 3 times daily. 5) Referral given for consultation with dermatology.

**09/18/12 – Healthcare Partners – Laboratory Report.** No abnormal values are noted.

**09/25/12 – Aileen Takahashi, M.D. – Association of South Bay Surgeons – Consultation. History:** The patient presents with an interest in bariatric surgery. She has been overweight for at least seven years. Her efforts at weight loss includes phentermine with a weight loss of 60 pounds in 1995, maintained for about 10 years, and a 20 pound weight loss in 2010 with Weight Watchers, maintained for one year. She walks every other day for 30-40 minutes. Comorbidities are joint pain in the knees, and dyspnea on exertion. **Past Medical History:** Migraines. **Medication:** Paroxetine 20 mg daily. **Allergies:** Sensitivity to avocados with swelling and nausea. **Family History:** Positive for myocardial infarction, hypertension, and diabetes. Her mother was recently diagnosed with ductal carcinoma in situ. **Social History:** She reports rare alcohol use. **Review of Systems:** Positive for migraines, dyspnea on exertion and swelling of the feet/ankles, backaches and joint pain. **Vital Signs:** Blood pressure 110/62. Respiration 20. Weight 217 pounds. BMI 45. Waist measurement 48.2 inches. Hip measurement 52.2 inches. **Assessment/Plan:** 46-year-old woman with a BMI of 45 and long history of morbid obesity. She meets all criteria for bariatric surgery. She has an interest in the gastric bypass and the sleeve. She will enter the program and start her workup.

**01/16/13 – Maleah Grover-McKay, M.D. – Office Visit. Subjective:** The patient has been referred for a consultation for bariatric surgery. Her body mass index is 44.58. She has no shortness of breath or chest pain. She gets dizzy only with her migraines. OSA screening shows she snores and she is not sure if she stops breathing. She always likes to take a nap at 1:00 pm.

ECG is pending. **Medications:** Phendimetrazine tartrate 35 mg 1 tab before meals and paroxetine HCl 20 mg 1 tab in the am. **Labs:** Labs on 09/09/12 show elevated hemoglobin at 5.9, elevated AST at 49, elevated ALT at 68. On 09/18/12, elevated glucose is noted at 100. **Vital Signs:** Blood pressure 112/68. Pulse 80. Respiration 18. Weight 217 pounds. **Diagnoses:** 1) Preoperative exam, other unspecified. 2) Morbid obesity. 3) Migraine NOS w/o mention intractable, improved. 4) Respiratory abnormal NEC: snoring. 5) Dietary surveillance/counsel. **Plan:** 1) Echo and ECG are ordered. 2) Aspirin is recommended. 3) The patient will ask about apnea and will have a sleep study if positive. 4) Medication is noted to be helping with her appetite.

**01/16/13 – Talbert Medical Group – Echocardiogram. Vital Signs:** Height 59 inches. Weight 218 pounds. **Interpretation Summary:** A complete two-dimensional transthoracic echocardiogram was performed. The study was diagnostic quality. There is no comparison study available. EF 63% by MOD. There is mild concentric left ventricular hypertrophy. Grade 1 diastolic dysfunction (abnormal relaxation pattern).

**01/16/13 – Talbert Medical Group – EKG. Interpretation:** Sinus rhythm. RSR (VI) nondiagnostic. Left axis anterior fascicular block. Abnormal.

**01/17/13 – Paige Larrabee, N.P. - Talbert Medical Group – Letter.** The patient's echocardiogram are noted to be essentially normal with an ejection fraction of 63%.

**03/08/13 – Demetra Bastas-Braktkic, N.P. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of cough, bronchitis/chest pressure, and body aches since yesterday. **Review of Systems:** Positive for fever, malaise/fatigue, congestion. Cough, sputum production, shortness of breath. **Medications:** Paroxetine HCl 20 mg 1 tab in am phendimetrazine tartrate 35 mg 1 tab before meals. **Vital Signs:** Blood pressure 120/74. Pulse 88. Respiration 20. Weight 204 lb. 4 oz. BMI 41.96. **Assessment:** 1) Bacterial infection NOS. 2) Cough. 3) Dietary surveillance/counsel. 4) Screening malignant neoplasm breast, unspecified. **Plan:** 1) She is prescribed amoxicillin 500 mg. 2) Administered Rocephin 1 gm injection, ceftriaxone sodium 250 mg injection, and lidocaine injection. 3) Prescribed promethazine HCl 6.25 mg/5 mL or syrup. 4) Handout given on exercise and healthy food choices. 5) Routine mammogram is ordered.

**04/01/13 – Anita Boorman, D.O. – Talbert Plaza/Radiology Department – Chest X-ray. Clinical Indication:** Preoperative evaluation. **Impression:** Normal chest x-ray.

**04/01/13 – Ana Shah, M.D. – Talbert Plaza/Radiology Department – Bilateral Screening Mammography. Impression:** BIRADS 2: Benign. There is no mammographic evidence of malignancy.

**06/11/13 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient presents for a preoperative examination. She is scheduled for bariatric surgery on 06/20/13. She has a left earache. **Medications:** Paroxetine for depression. **Review of Systems:** Positive for mild left earache. **Vital Signs:** Blood pressure 110/64. Pulse 68. Respiration 20. Weight 200 lb. 7 oz. BMI 41.17. **Diagnoses:** 1) Preoperative examination. 2) Morbid obesity. 3)

Body mass index 40.0-44.9, adult. 4) Vitamin D Deficiency NOS. 5) Otitis Media, NOS, left acute. **Plan:** 1) ECG. 2) Labs are ordered. 3) No contraindication to surgery is noted. 4) Augmentin is prescribed. 5) Continue paroxetine. 6) Proceed with bariatric surgery.

**06/11/13 (11:39:53) – Healthcare Partners – EKG. Interpretation:** Sinus bradycardia. Left axis. Abnormal.

**06/11/13 (11:41:36) – Healthcare Partners – EKG. Interpretation:** Sinus rhythm. Left axis. Abnormal.

**06/20/13 – Aileen Takahashi, M.D. – Healthcare Partners – Operative Report. Preoperative Diagnoses:** 1) Morbid obesity with a BMI of 46, down to 42 in preparation for surgery. 2) Joint pain. 3) Dyspnea on exertion. 4) Elevated liver function test. 5) Hypovitaminosis D and A. 6) Migraines. **Postoperative Diagnoses:** 1) Morbid obesity with a BMI of 46, down to 42 in preparation for surgery. 2) Joint pain. 3) Dyspnea on exertion. 4) Elevated liver function test. 5) Hypovitaminosis D and A. 6) Migraines. 7) Hiatal hernia. **Procedure:** Laparoscopic short limb gastric bypass (30 cc pouch with 100 cm antecolic, ante gastric roux limb) and hiatal hernia repair.

**06/23/13 – Aileen Takahashi, M.D. – Healthcare Partners – Discharge Summary. Date of Admission:** 06/20/13. **Date of Discharge:** 06/23/13. **Admission Diagnoses:** 1) Morbid obesity with a BMI of 46, down to 42 in preparation for surgery. 2) Joint pain. 3) Dyspnea on exertion. 4) Elevated liver function test. 5) Hypovitaminosis D and A. 6) Migraines. **Discharge Diagnoses:** 1) Morbid obesity with a BMI of 46, down to 42 in preparation for surgery. 2) Joint pain. 3) Dyspnea on exertion. 4) Elevated liver function test. 5) Hypovitaminosis D and A. 6) Migraines. 7) Hiatal hernia. **Procedures Performed:** Laparoscopic short limb gastric bypass and hiatal hernia repair on 06/20/13. **Hospital Course:** The patient underwent laparoscopic short limb gastric bypass. A large hiatal hernia was noted at surgery. She is slow on her oral intake and is unable to be discharged until postop day #3. **Condition on Discharge:** She is tolerating a bariatric liquid diet. Her pain is well-controlled on oral medication and her incisions are healing with no evidence of infection. Labs were acceptable. **Discharge Instructions:** She is to return for follow up, ambulate 5 times a day, avoid driving, and continue her liquid diet. **Discharge Medications:** She will continue paroxetine 20 mg po daily and multivitamins. She will hold Vitamin D and Vitamin A. She will discontinue amoxicillin/clavulanate 825/125 Q12 hours and phentermine 37.5 mg.

**07/03/13 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient presents for morbid obesity. She is doing well post gastric bypass and has lost 10-15 pounds. **Vital Signs:** Blood pressure 100/64. Pulse 70. Respiration 18. Height 4 feet 10.5 inches. Weight 188 pounds. **Medications:** Ursodiol 300 mg 1 cap bid, omeprazole 40 mg 1 cap daily, enoxaparin sodium 30 mg/0.3 mL solution, paroxetine HCl 20 mg 1 tab in the morning, amoxicillin-pot clavulanate 875-125 mg 1 tab Q12 hours, phendimetrazine tartrate 35 mg 1 tab before meals. **Diagnoses:** 1) Migraine NOS without mention intractable, improved. 2) Chronic sinusitis NOS. 3) Morbid obesity. 4) Respiratory abnormal "nec": snoring; she will ask about apnea. 5) Major depression single episode, mild. **Plan:** 1) Labs are ordered. 2) Follow up with surgeon.

**11/17/14 – Demetra Bastas-Braktkic, N.P. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of vaginal discomfort for 4 months. She is also fasting for blood work. She needs a refill for her paroxetine. **Medications:** Paroxetine HCL 20 mg 1 tab in am. Noted previously to be taking enoxaparin sodium 30 mg/0.3 mL subcutaneous solution, omeprazole 40 mg DR, phendimetrazine tartrate 35 mg, and Ursodiol 300 mg, which have been discontinued. **Past Medical History:** Positive for chronic sinusitis and vaginitis. **Vital Signs:** Blood pressure 102/80. Heart rate 78. Respiration 18. Weight 162 pounds. BMI 33.28. **Assessment:** 1) Vaginitis. 2) Major depressive disorder, single episode, mild. **Plan:** 1) She is prescribed Miconazole 7.2% vaginal cream and refilled paroxetine HCl 20 mg 1 tab in am. 2) Labs are ordered. 3) She is advised to avoid sexual contact until her symptoms have resolved. 4) She is to keep the area dry and clean. 5) Proper hygiene is encouraged. 6) Recommend 7-day Monistat.

**11/17/14 – Healthcare Partners – Laboratory Report.** Out of range values include BUN high at 27 and vitamin D, 25-hydroxy low at 29.3 ng/ml. All other lab values are normal.

**12/23/14 – Betty Fletcher, M.D. – Healthcare Partners – Office Visit. History:** The patient complains of groin itching for six months, treated with miconazole x 5 days and this improved, but now has returned. **Medications:** Miconazole 7.2% vaginal cream, paroxetine HCl 20 mg 1 tab in am. **Vital Signs:** Blood pressure 100/70. Heart rate 74. Respiration 17. Weight 166.375 pounds. BMI 34.18. **Assessment:** Vaginitis. **Plan:** 1) Urinalysis and swab for vaginitis are ordered. 2) Prescribed Nystatin-triamcinolone 1% external cream and metronidazole 500 mg 1 tab bid.

**12/23/14 – Healthcare Partners – Laboratory Report.** STD testing is noted to be negative.

**01/02/15 – Jamshid Sheik, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of earaches and cough for one week. **Medications:** Metronidazole 500 mg 1 tab bid, miconazole 7.2% vaginal cream, nystatin-triamcinolone 1% cream, paroxetine HCl 20 mg 1 tab in the am. **Vital Signs:** Blood pressure 104/64. Heart rate 78. Respiration 18. Weight 166 pounds. BMI 34.10. **Assessment:** Otitis media. **Plan:** Prescribed ciprofloxacin HCl 500 mg 1 tab Q12 hours.

**01/09/15 – Aileen Takahashi, M.D. – Association of South Bay Surgeons – Follow Up Note. Chief Complaint:** The patient is seen for a postoperative examination. She wants to lose another 30 pounds but has not been working on it. Her surgery was on 06/20/13. She has had a 36 pound recent weight loss. She is eating frequent small meals, high protein, and 2-3 protein drinks. She had bypass with Roux-en-Y for morbid obesity. Active problems include morbid obesity. **Medications:** B-12 tabs once daily, Biotin once daily, Cipro 500 mg 1 tab bid, multivitamin chew 2 tabs once daily, paroxetine HCL 20 mg 1 tab daily, and vitamin D3. **Plan:** 1) Exercise tolerance is discussed. 2) Recommend low fat diet, small meals, high protein, and controlled carbohydrates. 3) She is to increase exercise to 3 times a week.

**02/17/15 – Lori Zanini, R.D. – Healthcare Partners – SOAP Note. History:** The patient presents for a nutrition assessment. She had gastric bypass surgery (Roux-en-Y) in June 2014.

Her initial weight was 219 pounds at the time of surgery and she is currently 163 pounds. Her desired weight is 120-130 pounds. **Assessment:** 1) Patient reports increased stress secondary to mother's cancer diagnosis. 2) Patient states she is drinking ETOH on occasion to deal with stress. 3) Reports being "bored" and this leads her to eating/drinking more than she would like. 4) Reports she takes at least 2-30 grams protein shakes daily and is adhering to supplement recommendations. **Plan:** 1) The patient is encouraged to consume adequate protein. 2) She is to continue with supplement recommendations. 3) Avoid gas forming foods. 4) Consume higher intake of nutrient-dense foods. 5) Seek mental health support. 6) Regular activity is discussed. 7) Follow up with dietician specializing in bariatrics and find a support group.

**05/14/15 – Demetra Bastas-Braktkic, N.P. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of pressure around her head and eyes for three days, and that it could be due to stress. Her mother is dying of cancer. **Medications:** Triamcinolone acetonide 0.1% external cream, fluconazole 100 mg 1 tab daily for 10 days, and paroxetine HCl 20 mg 1 tab in the morning. **Vital Signs:** Blood pressure 102/70. Heart rate 67. Respirations 17. Weight 167 lb. 12.8 oz. BMI 34.47. **Assessment:** 1) Major depressive disorder, single episode, mild. 2) Insomnia secondary to increased stressors. **Plan:** 1) Continue paroxetine. 2) Stop alcohol before bed and substitute with melatonin and sleep hygiene. 3) Prescribed melatonin 3 mg 1 tab at bedtime, can increase to 2 or 3 tabs.

**01/05/16 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient tripped and fell, hurting her right elbow 3 months ago and has right elbow pain with swelling. She also has had right knee pain and swelling for 3-4 months. **Medications:** Melatonin 3 mg 1 tab at bedtime, paroxetine HCl 20 mg 1 tab daily, triamcinolone acetonide 0.1% external cream. **Vital Signs:** Blood pressure 100/80. Heart rate 76. Respiration 18. Weight 168 pounds. BMI 34.51. **Assessment:** 1) Right elbow pain. 2) Right knee pain. **Plan:** 1) X-rays of the right elbow are ordered. 2) X-rays of the right knee are ordered.

**01/05/16 – Duke Nguyen, M.D. – Healthcare Partners – X-ray Elbow. History:** Elbow pain. **Impression:** Normal right elbow.

**03/02/16 – Lemik Torossian, O.D. – USC Eye Institute – Referral Letter.** The patient has been referred to a glaucoma specialist due to the appearance of her angles and for her greater risk for angle closure.

**03/07/16 – Demetra Bastas-Braktkic, N.P. – Healthcare Partners – Office Visit. Chief Complaint:** The patient complains of migraines for 2 days. The patient has been followed at USC for eye surgery and "narrowing angle of the lens." She also needs to find a grief counselor as she recently lost her mother. The patient works in pathology and deals with cancer daily. **Medications:** Paroxetine HCl 20 mg 1 tab daily. **Vital Signs:** Blood pressure 110/82. Heart rate 78. Respiration 18. Weight 178 lb. 4 oz. BMI 36.62. **Assessment:** 1) Major depressive disorder, single episode, mild. 2) Migraine. **Plan:** 1) Handout given to the patient. 2) She is administered a Ketorolac tromethamine 60 mg/2 mL injection.

**04/18/16 – Ehsan Sadri, M.D. – Atlantis Eye Care – Office Visit. History:** The patient presents for a glaucoma evaluation. **Past Ocular History:** Migraines. **Medication:** Bacitracin

500 unit/gram eye ointment. **Assessment:** 1) Dry eye syndrome of bilateral lacrimal glands. 2) Anatomical narrow angle of bilateral eye. 3) Age-related nuclear cataract, bilateral. **Plan:** 1) Cataract surgery is recommended.

**05/19/16 – Illegible Physician Signature – Watermark Medical – ARES Sleep Study Report. Overall AHI:** 14. **Overall RDI:** 26. **% time <90% SpO2:** 8.0%. **Mean SpO2:** 94.1%. **% time snoring > 30 dB:** 51.2%. **Interpretation/Comments:** Findings are consistent with mild to moderate, non-positional obstructive sleep apnea (OSA). **Clinical History:** The patient presents with a 13 inch neck, BMI of 40, Epworth sleepiness score of 13, no co-morbidities and symptoms of nocturnal snoring and witnessed apneas. The patient has a high pre-test probability of having moderate OSA. **Sleep Study Findings:** The patient slept for approximately 6.1 hours with a sleep latency of 10 minutes and sleep efficiency of 87.6%. Mild sleep disordered breathing (AHI 14) is noted based on 4% hypopnea desaturation criteria. The patient slept supine 77.9% of the night and is 1.2 times as likely to have apneas/hypopneas when supine. The overall respiratory disturbance is moderate (RDI 26), based on hypopnea desaturation criterial with confirmation by surrogate arousal indicators. The apneas/hypopneas are accompanied by mild oxygen desaturation (percent time below 90% SpO2: 8.0%. Min SpO2: 80.5%. Average desaturation across all sleep disordered breathing events is 4.0%. Snoring occurs 51.2% (30 dB) of the study, 44.2% is very loud. The mean pulse rate is 70 BPM with frequent pulse rate variability (48 evens with >= 6 BPM/increase/decrease per hour). **Treatment:** 1) Consider CPAP as initial treatment choice. 2) Mandibular advancement splint or ENT referral.

**07/05/16 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient complains of a wet cough and green phlegm for 3 weeks with wheezing, chest congestion, and body aches. She started a CPAP one month ago. **Medications:** Paroxetine HCL 20 mg 1 tab daily. **Vital Signs:** Blood pressure 100/76. Heart rate 61. Respiration 20. Height 4 feet 10 inches. Weight 183. BMI 38.25. **Assessment:** Cough with sputum. **Plan:** 1) She is prescribed prednisone 20 mg 1 tab for 7 days, promethazine-codeine 6.25-10 mg/5 mL oral syrup 1 tsp po 3x daily prn cough, and amoxicillin-pot clavulanate 875-125 mg 1 tab bid after meals. 2) She is administered ceftriaxone sodium 1 gm injection, lidocaine HCl 1% injection, and methylprednisolone acetate 40 mg/mL injection.

**10/24/16 – Thiri Oo, M.D. – Healthcare Partners – Office Visit. Chief Complaint:** The patient presents for bilateral knee pain after she fell on her knees four days ago. She fell previously with knee problems one month ago and also 10 months ago. She also has left elbow pain. **Medications:** Paroxetine HCL 20 mg 1 tab daily, triamcinolone acetonide 0.1% external cream. **Vital Signs:** Blood pressure 110/68. Heart rate 64. Respiration 18. Weight 183 lb. BMI 38.25. **Assessment:** 1) Knee pain, bilateral. 2) Arthralgia of left elbow. **Plan:** 1) Left elbow x-rays are ordered. 2) She is prescribed ibuprofen 800 mg 1 tab tid prn pain. 3) Referral given for physical therapy. 4) Referral to orthopedic surgeon for bilateral knee pain.

**12/09/16 – Healthcare Partners – Laboratory Report.** Out of range labs include sodium high at 146 mmol/L, carbon dioxide high at 31 mmol/L, AST high at 57 IU/L, ALT high at 61 IU/L, hemoglobin A1C high at 5.9%, iron bind. Cap high at 515 ug/dL, UIBC high at 449 ug/dL, iron saturation low at 31%, ferritin low at 14 ng/mL, and LDH high at 287 IU/L.

**11/27/17 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient reports having depression this past week and feels down, due to her mother's death. She takes paroxetine and reports drinking alcohol to go to sleep, one glassful every night. **Medications:** Triamcinolone Acetonide 0.1% external cream. **Vital Signs:** Blood pressure 123/77. Weight 166 lb. 7 oz. BMI 50.79. Heart rate 86. **Assessment:** 1) Moderate major depression, single episode. **Plan:** 1) She is prescribed paroxetine HCl 40 mg 1 tab q day. 2) She is referred to behavioral health. 3) Labs are ordered.

**10/23/18 – Paula Bendigo, NP-C – Healthcare Partners – Office Visit. Chief Complaint:** The patient reports chronic migraine headaches, worsened with depression and stress at work in pathology, as well as her mother's death in 2015. Light bothers her and her symptoms are associated with nausea. **Medications:** Paroxetine HCl 40 mg 1 tab q day. **Review of Systems:** Positive for headache and dizziness. **Vital Signs:** Blood pressure 124/70. Heart rate 99. Respiration 18. Weight 179 lb. 2 oz. BMI 54.66. **Assessment:** 1) Migraine. 2) Scalp mass. 3) Screening for breast cancer. 4) Screening for colon cancer. **Plan:** 1) Labs are ordered. 2) The patient is administered a Ketoralac tromethamine 60 mg/2 mL IM injection. 3) An ultrasound of the head is ordered for the scalp mass. 4) Mammogram is ordered. 5) Occult blood fecal test is given to the patient.

**10/24/18 – Healthcare Partners – Laboratory Report.** Normal lab values are noted for CBC, CMP, hemoglobin A1C, Lipid, and TSH w/reflex.

**10/24/18 – Paula Bendigo, NP-C – Healthcare Partners – Results Letter.** The patient's recent labs including CBC, chemistry panel, thyroid function, hemoglobin A1C, and lipids are noted to be normal. She is advised to continue with diet and exercise goals, limit sugars, simple carbohydrates, starchy foods, and sugary drinks, and increase her cardiovascular exercise.

**10/31/18 – Paula Bendigo, NP-C – Healthcare Partners – Results Letter.** The patient's stool test is noted to be normal.

**02/08/19 – Workers' Compensation Claim Form (DWC1).** The date of injury is 01/20/18 to 02/01/19. The injury is described as stress due to a hostile work environment.

**02/08/19 – Workers' Compensation Claim Form (DWC1).** The date of injury is 02/08/18 to 02/07/19. The injury is described as stress and strain due to repetitive movement over a period of time, lower back, neck, shoulders, elbows, wrist, ankles, knees, and tailbone.

**02/09/19 – Workers' Compensation Appeals Board – Application for Adjudication of Claim.** The applicant claims to have sustained a CT injury, while employed for the University of Southern California as a pathology office coordinator from 01/20/18 and ending on 02/01/19. Body parts injured include 841 nervous system – stress. The injury is described as stress, depression, and anxiety due to a hostile work environment.

**02/09/19 – Workers' Compensation Appeals Board – Application for Adjudication of Claim.** The applicant claims to have sustained a CT injury while employed for the University of Southern California as a pathology office coordinator from 02/08/18 and ending on 02/07/19.

Body parts injured include 420 back, 450 shoulders, 300 upper extremities, 200 neck, and 500 lower extremities. The injury occurred from stress and strain due to repetitive movement over a period of time, injuring the lower back, neck, shoulders, knees, ankles, hips, and elbows.

**02/14/19 – Daisy Guevara, M.D. – Healthcare Partners – Office Visit. Chief Complaints:** The patient complains of body aches for two months with depression and anxiety, and pain in left elbow for one month. She has been taking Aleve. She denies the right elbow pain as being work related. **Medications:** Magnesium 200 mg 1 tab bid, Paroxetine HCl 40 mg 1 tab q day, sumatriptan succinate 50 mg 1 tab, and triamcinolone acetonide 0.1% external cream. **Family History:** Positive for heart, hypertension, gastrointestinal disorder, and malignant neoplasm. **Vital Signs:** Height: 4 feet 11 inches. BMI 36.8. Blood pressure 120/83. Heart rate 91. Respiration 18. Weight 182 lb. 3 oz. **Assessment:** 1) Multiple joint pain. 2) Chronic pain of left elbow. 3) Moderate major depression, single episode. **Plan:** 1) X-rays of the left elbow are ordered. 2) An orthopedic referral is given for her left elbow pain. 4) Labs are ordered.

**02/14/19 – Charles Taylor, M.D. – Healthcare Partners – X-ray of the Left Elbow. Indication:** History of chronic left elbow pain. **Impression:** Negative left elbow exam.

**02/14/19 – Healthcare Partners – Laboratory Report.** No abnormal values are noted.

**02/16/19 – Daisy Guevara, M.D. – Results Letter.** The patient is notified that her tests for Lupus (ANA), rheumatoid arthritis, CBC, chemistry panel, and uric acid level are normal, as well normal STD tests.

**03/15/19 – Deposition of Debra Sanchez (71 pages, full page format).**

P8 Ms. Sanchez stated she had taken Paxil in the morning and that Dr. Guevara had prescribed this medication, who is located at Healthcare Partners in Downey. MS Sanchez estimated that she has been taking this medication for three years.

P10 MS Sanchez also admitted taking Tylenol in the morning.

P13+ Ms. Sanchez testified that she drinks an adult beverage on occasion and very rarely. Ms. Sanchez testified when she has a drink, it is maybe a sweet mixed drink. She stated that she does not smoke and never has been a smoker.

P15+ Ms. Sanchez stated that she was on administrative leave the first week of January. Ms. Sanchez testified that her occupation was office coordinator at the hospital part of Keck. Her duties included filing papers, filing glass slides, answering phones, and sending tissues out on slides. Ms. Sanchez stated the heaviest lifting she would do was maybe 25 to 30 pounds. She answered further questions regarding the physical duties of her work.

P41+ Ms. Sanchez testified that she has not worked anywhere since January 17th. She did not have any outside employment when she worked for USC. She stated her family doctor has been Daisy Guevara since maybe 1999 or 2000. She state she did not remember who her doctor was before that time. She stated that Zelda Billingly was her ob-gyn when she was 20.

P44+ Ms. Sanchez stated that she has been hospitalized for childbirth and for gastric bypass in 2013. She does not recall who her doctor was. She stated she was in Torrance Memorial for her bypass. She was hired after her bypass. She testified that she has not had any other surgeries. She stated she has not been treated for ongoing medical conditions such as blood pressure, cardiovascular problems, or respiratory problems. She testified that she is in good health.

P46+ Other than a carpal tunnel problem, Ms. Sanchez stated she had never had any other job-related injuries. She has not had any athletic or recreational injuries, and no motor vehicle accidents that required medical attention. Other than her wrists, she testified she has not been treated for any other body parts. She stated she was treated for this problem a long time ago. She was told she had carpal tunnel in '93 or '94. Physical therapy resolved the problem completely.

P61+ Ms. Sanchez testified that she has seen her private doctor for her low back joint, her neck joint, both shoulders, her arms, and her ankles. She testified that her ankle started bother her when her shoulders, upper extremities, low back, and neck started bothering her. She also stated that both her knees bother her. She testified that this is from standing longer at the counter filing or carrying flats. She answers questions regarding the pain she has in her lower extremities.

P65+ Ms. Sanchez stated that she was advised to try ibuprofen and did take it. This was over-the-counter ibuprofen. She stated that she has not been hospitalized for the pain in these body parts. She testified that she is receiving unemployment. She received one check last week. She has been looking for other work.

P68+ Ms. Sanchez does not recall having filed a workers' compensation claim in the past.

**08/21/19 – Lawrence A. Feiwell, M.D. – Agreed Medical Examination. Date of Injury:** CT 02/08/18 to 02/07/19. **Chief Complaints:** Neck pain, bilateral shoulder pain, bilateral elbow pain left greater than right, bilateral wrist/hand pain, upper, mid and lower back pain, bilateral hip pain, bilateral knee pain, bilateral ankle/foot pain, as well as depression and anxiety. **History:** The patient is a pathology office coordinator, who began working for USC in March 2014, and alleges CT injuries. She developed anxiety and depression in 2017, and over time, developed pain in her neck, shoulders, elbows, wrists, hands, back, hips, knees, and ankles, which she attributes to her work activities. She reported her symptoms to her supervisor in 2018 but was not offered medical treatment. She saw her primary care physician, Dr. Daisy Guevara, and received evaluation, x-rays, and medications. Blood workup for lupus was done but was negative for lupus or rheumatoid arthritis. She continued working full duties and was referred to an orthopedic surgeon, which was scheduled, but her insurance was cancelled after she was laid off. She obtained legal counsel and filed a claim in February 2019, and continued working through 02/07/19, at which time she was laid-off and was not given a reason. She was referred for chiropractic care on 03/29/19, and received evaluations and x-rays, as well as physical therapy and chiropractic treatments. She continues to be off work. She denies prior injuries to the injured body parts. She reports developing pain in the wrists and hands in 1996, while

working as a transcriptionist for Telecare La Casa Mental Facility. She received a settlement with vocational rehabilitation (amount of settlement unknown) and denies any residuals. **Past Medical History:** No medical illnesses are noted. **Surgical:** Gastric bypass 2-3 years ago. **Medication:** Paxil 40 mg. **Family History:** Positive for cancer, diabetes, and hypertension. **Social History:** She denies use of tobacco or consumption of alcoholic beverages. **Activities of Daily Living:** She reports difficulty getting restful sleep, and averages 3-4 hours of sleep per night and reports her lack of sleep is secondary to pain, anxiety, and depression. She feels depressed due to her work injury. She also reports difficulties with riding in a car, typing, reclining, walking, going up and down stairs, standing, grasping, gripping, sitting, and lifting. **Present Complaints:** Neck pain, bilateral shoulder pain, bilateral elbow pain left greater than right, bilateral wrist/hand pain, upper, mid and lower back pain, bilateral hip pain, bilateral knee pain, bilateral ankle/foot pain, as well as depression and anxiety. **Vital Signs:** Weight 183 pounds. Height 4 feet 10 inches. BMI 38.2. **Diagnoses:** 1) Osteoarthritis, cervical spine minimally symptomatic. 2) Asymptomatic osteoarthritis, thoracic spine. 3) Normal low back examination. 4) Normal hip examination. 5) Normal bilateral shoulder examination. 6) Normal right elbow examination. 7) Evidence of medical epicondylitis and cubital tunnel syndrome left elbow. 8) Mild evidence of carpal tunnel syndrome, bilateral wrists, and hands. 9) Advanced osteoarthritis, bilateral thumbs. 10) Normal left knee examination. 11) Complaints of parapatellar pain, right knee with symptoms of chondromalacia. 12) Normal ankle and foot examination. 13) Morbid obesity. 14) History of anxiety and depression. **Comment:** The patient reports she was able to perform her job duties through 02/07/19 and was laid-off. She sought treatment from her private physician and arthritis testing was performed. Her private medical records have not been sent for review. She has a significant history of morbid obesity and underwent gastric bypass surgery three years ago. She weighed 190 pounds at the time of her gastric bypass surgery and now weighs 183 pounds and is 4 feet 10 inches in height. **Status:** Maximum medical improvement. **Impairment Rating:** Assuming she has positive EMG and nerve conduction studies of the upper extremities, she would have a total of 13% WPI. She has no ratable impairment for the neck, thoracic spine, lumbar spine, hips, knees, ankles, or feet. **Causation:** She sustained a CT injury to her right knee and her left cubital tunnel, bilateral carpal tunnels and bilateral thumbs. Medical records are pending review and if she had a settlement for carpal tunnel syndrome and future medical care, the wrist findings would be due to a prior injury. Her left cubital tunnel could be the result of CT while working for USC. **Apportionment:** Deferred pending review of medical records. **Work Recommendations:** She can perform her usual and customary duties with no indication for TTD. **Future Medical Care:** EMG and nerve conduction studies of both upper extremities is recommended. She is a candidate for excision arthroplasties of both thumbs and depending on EMG/nerve conduction studies, may be a candidate for bilateral carpal tunnel release surgery and left cubital tunnel release surgery. No intervention is required for her knees, neck, thoracic or lumbar spine.

**09/11/19 – Eric Gofnung, D.C./Mayya Kravchenko, D.C. - Eric Gofnung Chiropractic Corp. – Primary Treating Physician's Comprehensive Permanent and Stationary Evaluation Report. Date of Injury:** CT 02/08/18 to 02/07/19. **Job Description:** The patient was employed with Keck USC Medical Center as a pathology office coordinator at the time of her injury. She last worked for Keck USC Medical Center on 01/10/19. There was no concurrent employment. **History of Injury:** She reports sustaining a work-related injury to her back, neck, shoulders/arms, elbows, and knees due to continuous trauma from 02/08/18 to 02/07/19. She has

seen by her primary care physician, Dr. Daisy Guevara, for an evaluation and x-rays of the knees were taken revealing fluid in one of her knees (she cannot recall which side) and was advised to apply hot and cold packs and wear Ace bandages, which only minimally improved her symptoms. She requested a new chair from her manager in 2018 but was not provided same. She had an aggravation of her arm and leg pain in late 2018 and was seen by Dr. Guevara for an evaluation and was taken off work for one week. She returned to her usual and customary job duty with pain and discomfort. In 2019, she returned for a follow up visit and was tested for Lupus and fibromyalgia, and had x-rays of the left arm done, which revealed no abnormalities. An orthopaedic evaluation was requested, but the patient has no insurance coverage and has not been able to see a specialist. She continued working with pain and discomfort until 01/10/19. She received chiropractic and physiotherapy and has not been able to return to work. She reports improvement with treatment at this facility but remains symptomatic. MRI of the cervical and lumbar spine have been recommended. **Current Complaints:** Neck pain, left elbow pain with numbness and tingling in the forearm, lower back pain, as well as sleep difficulty, anxiety, and depression. **Past Medical History:** No major medical illnesses are reported. **Injuries:** She sustained injury about 20 years ago to both hands, while working as a transcriber and was diagnosed with carpal tunnel syndrome, treated with evaluation and physical therapy, and attained full recovery. She denies any new injuries. **Medications:** She is taking "Axil" and over-the-counter Tylenol prn pain. **Surgeries:** Gastric bypass surgery in 2014. **Review of Systems:** Positive for trouble sleeping, muscle or joint pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress. **Activities of Daily Living:** She reports difficulty with self-care, communication, physical activities, hand activities, and travel, including riding in a car, bus, etc., driving a car, and restful night sleep pattern with a rating of 4/5. **Family History:** Positive for multiple myeloma, breast cancer, and heart attack. **Social History:** She consumes alcohol. She denies smoking. She does not exercise or participate in any sports activities. **Vital Signs:** Pulse 70. Blood pressure 130/70. Height 4 feet 11 inches. Weight 180 pounds. **Diagnostic Impressions:** 1) Cervical spine myofasciitis, cervical facet-induced versus discogenic pain. 2) Lumbar spine myofasciitis, lumbar facet-induced versus discogenic pain, bilateral sacroiliac joint dysfunction. 3) Left elbow epicondylitis, cubital tunnel syndrome, rule out. **Recommendations:** MRI of the cervical and lumbar spine are recommended. Further treatment will not decrease the patient's level of disability/impairment rating. The opinions of this examiner may change after review of the requested MRI of the cervical and lumbar spine in regard to impairment rating, apportionment and other important issues. **Causation:** Causation of the cervical spine, lumbar spine, and upper extremity injuries is felt to be industrially related and due to the continuous trauma injuries from 02/08/18 to 02/07/19, while working for Keck Medical Center. **Permanent and Stationary Status:** She is now permanent and stationary. **Work Restrictions:** Prophylactic work restrictions are recommended to include no lifting in excess of 15 pounds. No repeated or forceful use of hands for grasping, torquing, pulling, or pushing. No repeated bending or stooping. **Vocational Rehabilitation:** The patient is a qualified injured worker. **Impairment Rating:** Total whole person impairment is 14% (10% spinal impairment and 4% upper extremity impairment). **Apportionment:** Regarding the cervical spine, lumbar spine, and left elbow, 100% is apportioned to the CT injury and 0% to nonindustrial causes. **Future Medical Care:** Future medical care is indicated in the way of further chiropractic and physiotherapy for both medical and surgical needs. MRIs are recommended for the cervical and lumbar spines, and the patient may require orthopaedic consultation.

**11/19/19 – Lawrence A. Feiwell, M.D. – Supplemental Medical-Legal Evaluation.** The examiner reviews provided medical records and his prior AME dated 08/21/19. **Causation:** The patient's right knee complaints are nonindustrial due to a fall and her bilateral elbow complaints are also nonindustrial due to a fall. **Whole Person Impairment:** No evidence of nerve entrapment of the upper extremities was found on electrodiagnostic testing, and therefore, the rating for the ulnar nerve and carpal tunnel should be eliminated. Whole person impairment for each thumb is 6% resulting in 12% whole person impairment. **Apportionment:** Apportionment is 20% due to outside activities and 80% due to CT through 2019.

**03/26/20 – Workers' Compensation Appeals Board – Compromise and Release.** The applicant claims that while working for the University of Southern California as an office assistant, she sustained a cumulative injury from 01/20/18 to 02/01/19 with the injured body part listed as 841 stress. In addition, a cumulative injury is claimed to have occurred from 02/08/18 to 02/07/19, with injured body parts listed as 200 neck, 300 upper extremity, 420 back, 450 shoulder, 500 lower extremity, 320 wrists, and 340 fingers/thumbs. Earnings at the time of the injury are listed as $682.24. No temporary or permanent disability indemnity is paid. The parties agree to settle the claim by the payment of the sum of $40,000 with $6,000 requested as applicant's attorney's fee, which leaves a balance of $34,000.

**Weight/Medications Summary Extracted from Records**

| Date | Wt | Location | Medications |
|---|---|---|---|
| 07/25/05 | 185.6 | Daisy Guevara, M.D. | Keflex 500 mg and Fiorinal 1-2 tab Q6 hours prn |
| 04/03/06 | 176 lb. 1.6 oz | Gregory Ochoa, M.D. | Paxil 20 mg 1 tab q morning, Zithromax Z-pak 250 mg 2 tabs today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs Q8 hours prn, ibuprofen 600 mg 1 tab tid |
| 04/24/06 | 176 lb. 9.6 oz | Gregory Ochoa, M.D. | Zithromax Z-pak 250 mg 2 tab today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs q 8 hours prn, ibuprofen 600 mg 1 tab tid, Paxil 20 mg 1 tab every morning. Chloraseptic 1.4% gargle q 2 hours, loratadine 10 mg 1 tab daily, antipyrine-benzocaine 5.4-1.4 OT% solution 4 drops to right ear qid |
| 05/02/06 | 177 lb. 1.6 oz | Gregory Ochoa, M.D. | Paxil 20 mg 1 tab in the am, Zithromax Z-pak 250 mg 2 tabs today, then 1 tab daily thereafter, loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs q 6 hours prn, ibuprofen 600 mg 1 tab tid, Imitrex 100 mg 1 tab 1 time only, Chloraseptic 1.4% MT gargle q 2 hours, antipyrine-benzocaine 5.4-1.4% OT solution 4 drops to right ear qid |
| 09/14/06 | 181 lb. 11.2 oz | Daisy Guevara, | Paxil 20 mg 1 tab in the am, Zithromax Z-pak 250 mg 2 tabs today, then 1 tab daily thereafter, |

| | | | |
|---|---|---|---|
| | | M.D. | loratadine 10 mg 1 tab daily, Sudafed 30 mg 2 tabs q 6 hours prn, ibuprofen 600 mg 1 tab tid, Imitrex 100 mg 1 tab 1 time only, Chloraseptic 1.4% MT gargle q 2 hours, antipyrine-benzocaine 5.4-1.4% OT solution 4 drops to right ear qid, Mycelex OTC 1% external cream, Keflex 500 mg 1 cap q 6 hours |
| 08/01/07 | 188 | Florence Li Lee, N.P. | Paxil 20 mg 1 tab in the am, Mycelex OTC 1% external cream, Keflex 500 mg 1 cap po q6 hours, Imitrex 100 mg 1 tab 1 time only, Chloraseptic 1.4% gargle q 2 hours, loratadine 10 mg 1 tab daily, and ibuprofen 600 mg 1 tab tid, antipyrine-benzocaine 5.4-1.4% OT solution, and Sudafed 30 mg 2 tabs q 6-8 hours prn, Ortho Evra 150-20 mcg/24 hour 1 patch weekly for 3 weeks, then off 1 week |
| 06/26/08 | 192 lb. 11.2 oz | David Meacham, P.A. | Paxil 20 mg 1 tab in the am, Vandazole 0.75% vaginal gel. |
| 02/13/09 | 201 | Daisy Guevara, M.D. | Paxil 20 mg 1 tab in the am |
| 11/13/09 | 214 lb. 8 oz | Gregory Ochoa, M.D. | Paxil 20 mg 1 tab in the am, promethazine with codeine 6.25-10 mg /5 mL 1 tasp Q4-6 hours prn, loratadine 10 mg 1 tab daily prn, ibuprofen 600 mg 1 tab prn, Cepacol Sore Throat 10-4.5 mg |
| 04/05/10 | 209 | Prasad Chode, M.D. | paroxetine HCL 20 mg 1 tab in the am, loratadine 10 mg 1 tab prn, and ibuprofen 600 mg 1 tab prn, fluticasone propionate 50 mcg/act nasal spray |
| 09/09/10 | 197 | Gregory Ochoa, M.D. | paroxetine HCl 20 mg 1 tab in the am, Flonase 50 mcg/act nasal spray 1 spray each nostril bid prn, promethazine HCl 25 mg |
| 02/17/12 | 210 | Demetra Bastas-Braktkic, N.P. | Flonase 50 mcg/act 30 mg, Keflex 500 mg, paroxetine HCl 20 mg |
| 06/14/12 | 214 lb. 8 oz | Demetra Bastas-Braktkic, N.P. | paroxetine HCl 20 mg 1 tab in the am and Relpax 40 mg 1 tab 1 time only, repeat after 24 hours as needed, multivitamin |
| 06/22/12 | 215 | Daisy Guevara, M.D. | paroxetine HCl 20 mg 1 tab in the am, terconazole 0.4% vaginal cream, and Relpax 40 mg 1 tab 1 time only, repeat after 24 hours as needed, ibuprofen 600 mg 1 tab 3 times daily |
| 09/25/12 | 217 | Aileen Takahashi, M.D. | Paroxetine 20 mg daily |
| 01/16/13 | 217 | Maleah Grover- | phendimetrazine tartrate 35 mg 1 tab before meals, paroxetine HCl 20 mg 1 tab in the am |

| | | | |
|---|---|---|---|
| | | McKay, M.D. | |
| 03/08/13 | 204 lb. 4 oz | Demetra Bastas-Braktkic, N.P. | paroxetine HCl 20 mg 1 tab in am, phendimetrazine tartrate 35 mg 1 tab, amoxicillin 500 mg, promethazine HCl 6.25 mg/5 mL or syrup |
| 06/11/13 | 200 lb. 7 oz | Daisy Guevara, M.D. | Paroxetine |
| 06/23/13 | | Aileen Takahashi, M.D. | Continue paroxetine 20 mg po daily and multivitamins. Hold Vitamin D and Vitamin A. Discontinue amoxicillin/clavulanate 825/125 Q12 hours and phentermine 37.5 mg. |
| 07/03/13 | 188 | Daisy Guevara, M.D. | Ursodiol 300 mg 1 cap bid, omeprazole 40 mg 1 cap daily, enoxaparin sodium 30 mg/0.3 mL solution, paroxetine HCl 20 mg 1 tab in the morning, amoxicillin-pot clavulanate 875-125 mg 1 tab Q12 hours, phendimetrazine tartrate 35 mg 1 tab before meals |
| 11/17/14 | 162 | Demetra Bastas-Braktkic, N.P. | Paroxetine HCL 20 mg 1 tab in am Miconazole 7.2% vaginal cream |
| 12/23/14 | 166.375 lbs. | Betty Fletcher, M.D. | Miconazole 7.2% vaginal cream, paroxetine HCl 20 mg 1 tab in am, Nystatin-triamcinolone 1% external cream, metronidazole 500 mg 1 tab bid |
| 01/02/15 | 166 | Jamshid Sheik, M.D. | Metronidazole 500 mg 1 tab bid, miconazole 7.2% vaginal cream, nystatin-triamcinolone 1% cream, paroxetine HCl 20 mg 1 tab in the am, ciprofloxacin HCl 500 mg 1 tab Q12 hours |
| 01/09/15 | | Aileen Takahashi, M.D. | B-12 tabs once daily, Biotin once daily, Cipro 500 mg 1 tab bid, multivitamin chew 2 tabs once daily, paroxetine HCL 20 mg 1 tab daily, vitamin D3 |
| 02/17/15 | 163 | Lori Zanini, R.D. | |
| 05/14/15 | 167 lb. 12.8 oz | Demetra Bastas-Braktkic, N.P. | Triamcinolone acetonide 0.1% external cream, fluconazole 100 mg 1 tab daily for 10 days, paroxetine HCl 20 mg 1 tab in the morning, melatonin 3 mg 1 tab at bedtime |
| 01/05/16 | 168 | Daisy Guevara, M.D. | melatonin 3 mg 1 tab at bedtime, paroxetine HCl 20 mg 1 tab daily, triamcinolone acetonide 0.1% external cream |
| 03/07/16 | 178 lb. 4 oz | Demetra Bastas-Braktkic, N.P. | Paroxetine HCl 20 mg 1 tab daily |
| 07/05/16 | 183 | Daisy Guevara, M.D. | prednisone 20 mg 1 tab for 7 days, promethazine-codeine 6.25-10 mg/5 mL oral syrup 1 tsp po 3x daily prn cough, amoxicillin-pot clavulanate 875-125 mg 1 tab bid after meals |

| | | | |
|---|---|---|---|
| 10/24/16 | 183 | Thiri Oo, M.D. | paroxetine HCL 20 mg 1 tab daily, triamcinolone acetonide 0.1% external cream, ibuprofen 800 mg 1 tab tid prn pain |
| 11/27/17 | 166 lb. 7 oz | Daisy Guevara, M.D. | Triamcinolone Acetonide 0.1% external cream, paroxetine HCl 40 mg 1 tab qday |
| 10/23/18 | 179 lb. 2 oz | Paula Bendigo, NP-C | Paroxetine HCl 40 mg 1 tab qday |
| 02/14/19 | 182 lb. 3 oz | Daisy Guevara, M.D. | Aleve, magnesium 200 mg 1 tab bid, Paroxetine HCl 40 mg 1 tab qday, sumatriptan succinate 50 mg 1 tab, triamcinolone acetonide 0.1% external cream |
| 08/21/19 | 183 | Lawrence A. Feiwell, M.D. | Paxil 40 mg |
| 09/11/19 | 180 | Eric Gofnung, D.C./Mayya Kravchenko, D.C. | "Axil", over-the-counter Tylenol prn pain |

**RESULTS OF LAB TESTING:**

CBC and blood chemistries were obtained.
Results are normal.

**IMPRESSION**:

1. Chronic migraines.
2. Anxiety/depression.
3. Obstructive sleep apnea with CPAP intolerance.

**DISCUSSION**:

1. **Chronic migraines**:

   The assessment of chronic migraines is beyond my expertise, and I will defer the assessment of this condition to a neurologist.

2. **Anxiety/depression**:

   The assessment of her anxiety/depression is beyond my expertise, and I will defer this to the appropriate specialist.

3. **Sleep disorder**:

   Ms. Debra Sanchez has a long-standing history of snoring and obesity. This preceded her employment at USC by many years. It is my opinion that her condition of OSA was

preexisting. This was formally diagnosed in 2014/2015, after which she was given a CPAP machine. She was intolerant of therapy and is currently not using it. Her Epworth sleepiness score is 12, which implies moderate sleepiness. As discussed above, she is unable to use a CPAP machine.

**Impairment Rating:**

Using the AMA Guides to the Evaluation of Permanent Impairment Fifth Edition, Page 317, Table 13-4, it is my opinion that she has Class 2 Impairment of the Whole Person, 12%, due to sleep and arousal disorders. She has moderate daytime sleepiness and difficulty with self-care and some activities of daily living are diminished. She reports that she is sleepy all day long, and after 5:00 pm, she cannot wait to get into bed. She has no difficulty with self-care, but is tired and sleepy all day long. She has difficulty with memory and recollection. She has become irritable over time, as well.

**Causation:**

The causation of her OSA is nonindustrial and secondary to her long-standing obesity.

**Apportionment**:

As per SB 899 and Labor codes 4663 and 4664, and mindful of the Escobedo and Benson decisions, apportionment to causation of impairment/disability is considered. Apportionment may be considered to employment with Keck USC Hospital. At that time, her Paxil dose was doubled, due to stress. Stress, in her case, was also due to her mother's illness, as well as her employment. It would be reasonable to apportion 90% to preexisting and 10% apportionment to stress associated with her employment.

**Future Medical Care:**

She would benefit from ongoing therapy with a CPAP device, and ongoing weight loss.

I have been asked to specifically answer the following questions:

1. On the day of my evaluation, does the worker have a permanent impairment of any body part in my specialty?

   The worker has a permanent disability due to obstructive sleep apnea/sleep disorder.

2. Is the worker's condition P&S as of today?

   The condition is P&S as of today.

3. Impairment Rating:

   Impairment rating, discussed above, is 12%.

4. Work Restrictions:

   Ms. Sanchez should avoid working with machinery or instruments that may cause bodily harm if she was to have a period of sleepiness while operating this equipment. She should avoid work that requires her to drive long distances, as she has a tendency to feel sleepy on long drives.

5. Does the worker have a preexisting condition?

   It is my opinion that Ms. Sanchez had preexisting OSA/sleep disorder prior to her employment with Keck USC.

6. Was the preexisting condition permanent and stationary at the time of her last employment?

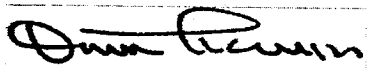
   It is my opinion that the preexisting condition was P&S at the time of her last employment and could have rated as PPD at the time the worker suffered the subsequent industrial injury. It is my opinion that the subsequent injury is not within the scope of my specialty and is orthopaedic in nature.

7. I am asked to also apportion preexisting condition and subsequent injury and post subsequent injury, and this has been done in the discussion on apportionment above.

   The subsequent industrial injury did not rate to 35% disability without modification for age and occupation, and the preexisting disability did not affect the upper or lower extremity or eye, and also did not affect the opposite or corresponding part.

Thank you for asking me to see and evaluate Ms. Debra Sanchez. I will be available for review of medical records or to produce supplemental reports at the request of parties concerned.

Thank you,



Syed O. Tirmizi, M. D. FCCP
Diplomate, American Board of Internal Medicine
Diplomate, American Board of Internal Medicine, Pulmonary Disease
Diplomate, American Board of Internal Medicine, Critical Care Medicine
Diplomate, American Board of Internal Medicine, Sleep Medicine
Diplomate, American Board of Sleep Medicine
Qualified Medical Evaluator #945518 State of California

**Sanchez, Debra** DOB: **05/29/1966** **Patient Report**

Patient ID: Age: **55** Account Number: **04275310**

Specimen ID: **168-629-0856-0** Sex: **Female** Ordering Physician:

labcorp

Ordered Items: **CBC, Platelet, No Differential**

Date Collected: **06/16/2021** Date Received: **06/18/2021** Date Reported: **06/18/2021** Fasting: **Not Given**

## CBC, Platelet, No Differential

| Test | Current Result and Flag | Previous Result and Date | Units | Reference Interval |
|---|---|---|---|---|
| WBC[01] | 5.3 | | x10E3/uL | 3.4-10.8 |
| RBC[01] | 4.42 | | x10E6/uL | 3.77-5.28 |
| Hemoglobin[01] | 13.8 | | g/dL | 11.1-15.9 |
| Hematocrit[01] | 42.7 | | % | 34.0-46.6 |
| MCV[01] | 97 | | fL | 79-97 |
| MCH[01] | 31.2 | | pg | 26.6-33.0 |
| MCHC[01] | 32.3 | | g/dL | 31.5-35.7 |
| RDW[01] | 12.9 | | % | 11.7-15.4 |
| Platelets[01] | 253 | | x10E3/uL | 150-450 |

**Disclaimer**
The Previous Result is listed for the most recent test performed by Labcorp in the past 3 years where there is sufficient patient demographic data to match the result to the patient.

**Icon Legend**
⚠ Out of reference range ■ Critical or Alert

**Performing Labs**
01: SO - LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA, 92128-4108 Dir: Jenny Galloway, MD
For inquiries, the physician can contact Branch: 800-859-6046 Lab: 858-668-3700

Patient Details
**Sanchez, Debra**

Phone:
Date of Birth: **05/29/1966**
Age: **55**
Sex: **Female**
Patient ID:
Alternate Patient ID:

Physician Details

**Medical Group of Culver**
**4340 OVERLAND AVE, CULVER CITY, CA, 90230**

Phone: **310-559-4411**
Account Number: **04275310**
Physician ID: **TIRMIZI**
NPI:

Specimen Details
Specimen ID: **168-629-0856-0**
Control ID: **U3104275310**
Alternate Control Number:
Date Collected: **06/16/2021 1230 Local**
Date Received: **06/18/2021 0000 ET**
Date Entered: **06/18/2021 0202 ET**
Date Reported: **06/18/2021 1007 ET**
Rte: **00**

**Omar Tirmizi, MD Laboratory**
4340 Overland Avenue
Culver City, CA 90230
Tel: 310-556-0702 Fax: 310-556-8464
Laboratory Director: Omar Tirmizi, MD

Patient: **Sanchez, Debra**
PID: 05291966SD
DoB: 5/29/1966 Age: 55 Sex: F
Pt.Alt.ID:

Accu#: 01968
Dr: Omar Tirmizi MD
Location:
Ref.ID:

Drawn: 6/16/2021 9:52
Recvd: 6/22/2021 9:52
Print: 7/12/2021 12:23
FINAL

Fasting: N

| TEST | NORMAL | ABNORMAL | UNITS | RANGE |
|---|---|---|---|---|
| **CHEMISTRY** | | | | |
| SODIUM | 139 | | mEq/L | 135-145 |
| POTASSIUM | 4.4 | | mEq/L | 3.6-5.0 |
| CHLORIDE | 101 | | mEq/L | 97-107 |
| CO2 | 24 | | mg/dL | 21-31 |
| ANION GAP | 18 | | mEq/L | 7-34 |
| GLUCOSE | 89 | | mg/dL | 70-110 |
| BUN | 13 | | mg/dL | 7-18 |
| CREATININE | 0.7 | | mg/dL | 0.4-1.4 |
| BUN/CREA RATIO | 18.6 | | Ratio | 8.0-36.0 |
| eGFR | 86.9 | | mL/min | >60 |
| CALCIUM | 9.4 | | mg/dL | 8.5-10.4 |
| TOTAL PROTEIN | 8.0 | | mg/dL | 6.2-8.5 |
| ALBUMIN | 4.3 | | g/dL | 3.5-5.3 |
| GLOBULIN | 3.70 | | g/dL | 2.0-4.5 |
| A/G RATIO | 1.16 | | Ratio | 0.60-2.20 |
| ALK PHOSPHATASE | | 147 H | IU/L | 35-123 |
| AST (SGOT) | | 59 H | IU/L | 5-34 |
| ALT (SGPT) | | 65 H | IU/L | 4-36 |
| TOTAL BILIRUBIN | 0.7 | | mg/dL | 0.2-1.2 |
| MAGNESIUM | 1.7 | | mEq/L | 1.6-2.6 |
| IRON | 103 | | ug/dL | 65-170 |
| UIBC | 191 | | ug/dL | 126-382 |
| TIBC | 294 | | ug/dL | 250-450 |
| **LIPID STUDIES** | | | | |
| CHOLESTEROL | 197 | | mg/dL | 115-200 |

Note: Cholesterol recommended range:
Desirable Cholesterol - < 200 mg/dl
Borderline-High Cholesterol - 200 - 239 mg/dl
High Cholesterol - > 400 mg/dl

| | | | | |
|---|---|---|---|---|
| TRIGLYCERIDES | 108 | | mg/dL | 44-148 |
| HDL CHOLESTEROL | 77 | | mg/dL | 30-85 |

Note: HDL values greater than or equal to 35 mg/dl are considered desirable, and values greater than or equal to 60 mg/dl are considered to offer some protection against Coronary Heart Disease. Values below 35 mg/dl are considered to be a significant independent risk factor for Coronary Heart Disease.

| | | | | |
|---|---|---|---|---|
| CHOL/HDL RATIO | 2.56 | | Ratio | <5.60 |
| LDL (Calc.) | 98 | | mg/dL | 60-130 |

Note: Recommended Range
Desirable - <130 mg/dl
Borderline High - 130 - 159 mg/dl
High Risk - > 150 mg/dl

LDL (Caculated) is not valid if Triglycerides result is > 400 mg/dl.

| | | | | |
|---|---|---|---|---|
| VLDL (Calc.) | 22 | | mg/dL | 0-40 |
| **THYROID STUDIES** | | | | |

**Omar Tirmizi, MD Laboratory**
4340 Overland Avenue
Culver City, CA 90230
Tel: 310-556-0702 Fax: 310-556-8464
Laboratory Director: Omar Tirmizi, MD

| | | | | | |
|---|---|---|---|---|---|
| Patient: | Sanchez, Debra | Accn#: | 01968 | Drawn: | 6/16/2021 9:52 |
| PID: | 0529196680 | Dr: | Omar Tirmizi MD | Recvd: | 6/22/2021 9:52 |
| DoB: | 5/29/1966 Age: 55 Sex: F | Location: | | Print: | 7/12/2021 12:23 |
| Pt.Alt.ID: | | Ref.ID: | | FINAL | |

Fasting: N

| TEST | NORMAL | ABNORMAL | UNITS | RANGE |
|---|---|---|---|---|
| TSH | 1.02 | | mIU/L | 0.34-5.60 |
| T3, FREE | 3.2 | | pg/mL | 2.5-3.9 |
| T4, FREE | 1.04 | | ulU/ml | 0.3-3.0 |
| SPECIAL CHEMISTRY | | | | |
| FERRITIN | 36.4 | | ng/mL | 11.0-306.8 |
| FOLIC ACID | | 21.4 H | ng/mL | 3.00-17.00 |
| VITAMIN B-12 | 524 | | pg/mL | 180-914 |
| VITAMIN D | 48.7 | | ng/mL | 30-100 |

Note: Vitamin D 25-OHD3 indicates both endogenous production and supplementation. 25-OHD2 is an indicator for exogenous sources, such as diet or supplementation. Therapy is based on measurement of Total 25-OHD, with levels <20 ng/ml indicative of Vitamin D deficiency, while levels between 20 ng/ml and 30 ng/ml suggest insufficiency. Optimal levels are >or = 30 ng/ml.

| | | | | |
|---|---|---|---|---|
| HEMOGLOBIN A1c % | 5.5 | | % | 4.3-6.0 |

Note: Consistent with Diabetes:
3 - 6% in non-diabetics
6 - 8% in controlled diabetics
20% or higher - poorly controlled diabetics
The following HgbA1C ranges may be used for interpretation of results. However, factors such as duration of diabetis, adherence to theraphy and the age of the patient should also be consedered in assesing the degree of blood glucosecontrol. These values are for non-pregnant individuals. Action suggested depends on individual patient circumstances. Such action may include enhanced diabetis self-management education, co-management with diabetis team, referral to an endocrinologist, change in phamacological theraphy, initiation or increased self-monitoring of blood glucose, or more frequent contact with the patient.

| | | | |
|---|---|---|---|
| CARDIAC STUDIES | | | |
| CK | 106 | mg/dL | 0-160 |
| hsCRP | 0.1 | mg/L | 3.00 |

The American Heart Association and U.S. Centers for Disease Control and Prevention have defined risk groups as follows: Low risk: less than 1.0 mg/L. Average risk: 1.0 to 3.0 mg/L. High risk: above 3.0 mg/L

| | | | |
|---|---|---|---|
| PHOSPHORUS | 3.4 | mg/dL | 2.5-4.8 |
| URIC ACID | 4.2 | mg/dL | 2.1-7.2 |

***State of California***

***DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT***

**AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))**

**Case Name:** Debra Sanchez *(employee name)* v UNIVERSITY OF SOUTHERN CALIFORNIA *(claims administrator name, or if none employer)*

**Claim No.:** SIF11924493 **EAMS or WCAB Case No. (*if any*):** ADJ11924493

I, STEVI HIX *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: 1680 PLUM LANE, REDLANDS CA 92374
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A — depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.

B — placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C — placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D — placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E — personally delivering the sealed envelope to the person or firm named below at the address shown below.

| Means of service: *(For each addressee, enter A – E as appropriate)* | Date Served: | Addressee and Address Shown on Envelope: |
|---|---|---|
| A | 07/16/21 | SIBTF 160 Promenade Circle Sacramento, CA 95834 |
| A | 07/16/21 | Defendants Law Group 8018 Santa Ana Canyon Rd., Suite 100.215 Anaheim Hills, CA 92808 |
| | | |
| | | |

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 07/16/2021

Stevi Hix
*(signature of declarant)*

STEVI HIX
*(print name)*

QME Form 122
Rev. February 2009