RECORDS

Applicant/Plaintiff	**Floreen Rooks**
Case No.	SIF7024643, SIF10825285,SIF7024645
Defendant	Dveal Family & Youth Services
Date of Injury	11/10/2007
File/Claim Num	00
Date Published	11/25/2020
Records of Location Copied	**State Compensation Insurance Fund** 655 N Central Ave, 4th floor Glendale, CA 91203
Type of Records	Insurance Claims

Records delivered to: Control Num 21-21912-9 (386) C1

1 Customer

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Records Excerpt & Outline

(List of injuries, diseases and symptoms)
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Control No: 21-21912-9

Medical Record Excerpt & Outline

Patient Name	:	Floreen Rooks
WCAB #	:	SIF7024643, SIF10825285,SIF7024645
Social Security No.	:	000-00-0000
Date of Birth	:	06/20/49
Employer	:	Dveal Family & Youth Services
Records of	:	State Compensation Insurance Fund Glendale, CA
Date of Injury	:	11/10/2007

Date of Service	Page No.	Provider	Excerpt
11/16/07	75, 85		**WC Claim Form (DWC 1)** DOI: 11/10/07. Hx of injury: Employee fell onto ground and gravel and fractured right foot to prevent rolling car from entering into oncoming traffic.
11/20/07	239- 244, 255- 256, 259- 262, 281- 282	Hadley, Michael, M.D.-HealthCare Partners	**Dr's 1st Rept of Occupational Injury/Illness** Hx of injury: “Fell on to ground gravel and fractured right foot to prevent from rolling into oncoming traffic injured right foot”. CC: On 11/10/07 while trying to enter the vehicle that was moving even though it was parked she tripped on the ground and fell, she hit her left knee and she twisted her left ankle and also her right foot. Because of these injuries, patient developed her left ankle and also her right foot. Because of these injuries, patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment. While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. Patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility. Patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot. BP: 156/98. PMH: Patient states that she has a heart valve problem for many years and does

			use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. Allergies: She is allergic to PCN. Social habits: Tobacco use. Exam: Right foot revealed that there is moderate to marked tenderness prevent on the do sum. Patient patient does have impaired weightbearing secondary to pain and altered gait secondary to pain. Patient is ambulating with the aid of a cane. Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema. Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain. Preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending. Dx: Contusion, left knee. Fracture, right foot. Sprain, left ankle. Patient does have hardware in her left ankle and this may impact upon her rate of recovery. Tx: Motrin 800 mg. Tylenol. Tx plan: X-ray. Dispensed walker boot/Cam walker. Recommendation: Referral to orthopedic surgeon for evaluation and treatment. RTW/modified duty. Restrictions: No driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.
11/20/07	367	HealthCare Partners	**Radiology/Diagnostics** X-ray of Right Foot, Left Ankle and Left Knee. X-ray of Right Foot: Findings: There is minimally displaced comminuted fracture of the distal fourth metatarsal. In addition, there is a nondisplaced fracture of the shaft of the fifth metatarsal seen best in the oblique view. The remaining visualized osseous structures and joint spaces are intact. The fractures do not appear to extend into adjacent metatarsophalangeal joints. Impression: 1) Fractures of the fourth and fifth metatarsals as described above. 2) Abnormal report. X-ray of Left Ankle: Findings: There are post-operative findings of metallic plate and surgical screws in the distal fibula and two screws in the distal tibia in place. No acute fracture or dislocation is identified. There is significant degenerative narrowing of the ankle mortise. Impression: Post-operative findings in the distal tibia and fibula as described above. There is significant degenerative narrowing of the ankle mortise. X-ray of Left Knee: Impression: 1) Mild osteoarthrosis in the left knee. 2) Questionable 0.8 cm loose body.

12/20/07	326- 327, 344- 345, 351- 352	Saucedo, Thomas, M.D.	**Orthopedic Supplemental Rept (PR-2)** Patient has been under our care with a diagnosis of a fracture of her right fourth and fifth metatarsal. She has been using a Cars walker and indicates that her pain has steadily improved. Patient has also complained of pain and discomfort of her left knee and her left ankle, which she indicates has been improving subjectively since her last visit. Exam: Right foot: There is evidence of mild tenderness. There is mild swelling. Left knee: Reveals evidence of mild tenderness. Left ankle: Reveals evidence of mild tenderness in the anterolateral aspect of the ankle. X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture, overall good position. Dx: Healing right fourth and fifth metatarsal fracture. Left knee sprain. Left ankle sprain. Discussion: I will recommend that patient at this time continue off of work. I will encourage her to continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will be provided for her left knee and I will recommend that she weightbearing as tolerated with the assistive devices. I will maintain her off of work and I would like to see her back for f/u in four weeks' time, at which time x-rays will be taken to assess the healing fractures.
12/20/07	374	Health Care Partners	**Radiology/Diagnostics** X-ray of Right Foot. Clinical Indication: F/u fracture. Comparison: Comparison is made to prior radiographs of the right foot performed on 11/20/07. Findings: There are healing fractures involving the distal fourth metatarsal and the distal shaft of the fifth metatarsal. There is near anatomic alignment of the fourth metatarsal fracture. There is good anatomic alignment of the fifth metatarsal fracture. The rest of the examination is rather unremarkable. Impression: Healing fractures of the fourth and fifth metatarsals.
01/17/08	346- 348	Saucedo, Thomas, M.D.-Specialists	**Orthopedic Supplemental Rept (PR-2)** This patient has sustained a fracture of her right fourth and fifth metatarsals. He also has an injury to her left knee as well as her left ankle. She indicates that her right foot pain has steadily improved, however, she c/o pain especially of her left knee with swelling and effusion of the knee, difficulty with squatting, kneeling and climbing activities. She also c/o soreness of her left ankle. Exam: Right foot: There is evidence of tenderness over the dorsal aspect of the fourth and fifth metatarsal. Minimal swelling is noted. Left knee: Reveals evidence of notable swelling. There is a small effusion, medial joint line tenderness; she flexes the knee from 0 to 110 degrees with noticeable pain and discomfort. Positive McMurray's sign. Positive Apley's sign is noted.

			Left ankle: Reveals evidence of mildly diffuse medial and lateral malleolar area swelling. X-rays of the right foot was reviewed. Impression: Impression: 1) Healing right fourth and fifth metatarsal fracture. 2) Left knee internal derangement. 3) Left ankle sprain. Discussion: At this time, it is quite apparent that patient right foot fractures appear to be healing quite well. I will recommend that we continue conservative measures utilizing the twit walker to allow the fractures to heal. She will be given an appointment for four weeks, at which time x-rays will be repeated to assess the healing fracture consolidation with respect to her left knee, there is notable swellin3 and effusion of her left knee and findings consistent with a possible cartilage or meniscal tear; therefore an MRI of left knee will be requested and ordered at this point in time. I will continue her off work as a result of these injuries. With respect to her left ankle, I will recommend she continue on an aggressive exercise program, continua use of Tylenol for pain and discomfort, and I will see her back for fallow-up in four weeks' time to assess her progress.
01/17/08	366	Health Care Partners	**Radiology/Diagnostics** X-ray of Right Foot. Clinical Indication: F/u fracture. Comparison: Comparison is made to prior radiographs of the right foot performed on 12/20/07. Findings: There is continued healing of fractures involving the distal fourth and fifth metatarsals. The remaining visualized bony structures and joint spaces appear to be intact. Impression: 1) No significant interval changes. 2) There is continued healing of fracture involving the fourth and fifth metatarsalis.
02/21/08	316- 317, 336- 337, 342- 343, 356- 357, 360- 361	Saucedo, Thomas, M.D.-Specialists	**Orthopedic Supplemental Rept (PR-2)** As you are well aware, this patient has sustained a fracture of her right foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained a left ankle sprain and a left knee injury, and most recently her left knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her RLE and putting all of the weight on bet contralateral extremity, the pain has steadily gotten worse as a result of the initial injury as well as the underlying degenerative osteoarthritic changes from which patient already suffers. Exam: Right foot: There is evidence of mild tenderness. There is mild swelling. Left knee: Reveals evidence of medial joint line tenderness. There is notable swelling. There is notable effusion. Positive grind sign. Positive Apley sign. Positive McMurray's sign. X-rays of the right foot was reviewed. Impression: 1) Healing right fourth and fifth metatarsal fracture. 2) Left knee internal

			derangement. Discussion: It appears quite evident that this patient has developed an increased level of pain and discomfort of her left knee as a result of favoring her RLE. She initially incurred the injury of the left knee as well; however, it was certainly not as painful as it is now. I will recommend that an MRI of left knee be ordered at the soonest possible time, although this apparently has already been denied due to lack of the ability to communicate with my office; however, that appears to be erroneous since I am always available either by cell phone or in our office. If you deem it necessary to communicate with any review of service, I would be more than happy to do so. With respect to her right foot, it appears to be healing well and I an hopeful this will heal uneventfully. I would like to reexamine her in four weeks' time and I will continue her off of work until further progress is made.
02/21/08	355, 359	Saucedo, Thomas, M.D.-HealthCare Partners	**Referral Slip** Recommendation: MRI of left knee.
02/21/08	373	Health Care Partners	**Radiology/Diagnostics** X-ray of Right Foot. Clinical Indication: F/u fracture. Comparison: Comparison is made to prior radiographs of the right foot performed on 01/17/06. There is continued healing of fractures involving the distal fourth and fifth metatarsals. There is near anatomic alignment cf the fracture fragments of the fourth metatarsal fracture. Impression: Continued healing of fractures involving the fourth and fifth metatarsals.
03/19/08	368- 369, 371- 372	HealthCare Partners	**Radiology/Diagnostics** MRI of Left Knee. Clinical indications: Rule out internal derangement. No known surgery. Impression: 1) Tear, posterior born, medial meniscus (Grade III). 2) Early osteoarthritic changes of the medial compartment of the knee joint. 3) Knee joint effusion.
03/20/08	340- 341	Saucedo, Thomas, M.D.-Specialists	**Orthopedic Re-Examination** This patient has sustained a fracture of her right foot involving the fourth and fifth metatarsal and at this time indicates that she has no pain or discomfort. She also has no significant pain of her left ankle; however, she continues to complain of left knee pain. As a result, an MRI of left knee has been ordered. The MRI reveals evidence of a tear of the posterior aspect of the medial meniscus. There is also evidence of mild early osteoarthritic degenerative arthritic changes of the left knee probably in the medial compartment and a knee effusion. Exam: Left knee: Reveals evidence of notable swelling. There is tenderness. There is an effusion. There is positive Apley sign, positive McMurray's sign, and

			positive grind sign. She flexes the knee from 0 to 125 degrees with noticeable pain. Impression: 1) Left knee internal derangement with evidence of medial meniscus tear. 2) Right fourth and fifth metatarsal fracture, healed. 3) Left ankle sprain. Discussion: I will recommend that patient at this time continue off of work given her pain and discomfort of her left knee. I will request authorization and approval for surgery arthroscopically of her left knee, which will be done as an outpatient. I will maintain her off of work until further progress is made. I will see her back for f/u in 3-4 weeks time to assess her progress. With respect to her right foot and her left ankle, she can and has responded favorably to conservative measures. On this basis, she will be released to her previous level of occupation with no restrictions.
03/20/08	370	Health Scan Partners	**Radiology/Diagnostics** X-ray of Right Foot: Clinical Indication: F/u fracture. Impression: Continued healing of fourth and fifth metatarsal fractures.
04/17/08	338- 339	Saucedo, Thomas, M.D.-Specialists	**Orthopedic Supplemental Rept (PR-2)** Patient has been under our care. She has been treated for a fracture of her right foot. The fracture at this time has healed completely. She has no pain or discomfort. However, she does continue to complain of left knee pain primarily with activities of squatting, kneeling and climbing. She has minimal soreness and discomfort of her left ankle; otherwise, she notes pain increasing of the left ankle when she is required to stand for prolor.ged periods of time. Exam: Left knee: Reveals evidence of medial joint line tenderness. There is notable swelling. There is positive effusion, positive McMurray's sign, and positive Apley sign. Left ankle: Reveals evidence of limited ROM of the ankle. She dorsiflexes the ankle to 10 degrees. She plantar flexes the ankle to 25 degrees. Impression: 1) Healed right foot fourth and fifth metatarsal fracture. 2) Left knee internal derangement with evidence of medial meniscus tear. 3) Left ankle post-op degenerative osteoarthritic changes with limited ROM. Discussion: At this time, it is quite apparent that patient at this time is focusing primarily on her left knee injury. An MRI has revealed evidence of a medial meniscus tear and she will be scheduled for surgery arthroscopically of her left knee on 04/24/08. She understands the risks and benefits and wishes this to be done. We will treat her conservatively for her right foot as well as her left ankle. I will maintain her off of work. I will see her pre-operatively in my office on 04/23/08, at which time she will undergo pre-op evaluation and treatment before surgery on 04/24/08.

04/24/08	253- 254, 257- 258	Saucedo, Thomas, M.D.-Plaza Surgical Ctr	**Operative Rept** Pre-op Dx: Left knee internal derangement. Operation performed: 1) Left knee diagnostic and surgical arthroscopy. 2) Left knee partial medial and partial lateral meniscectomy. 3) Left knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, and lateral femoral and tibial plateau cartilage. Post-op Dx: 1) Evidence of left knee complex tear of the medial and lateral meniscus. 2) Evidence of cartilage tears of the patellofemoral groove, tears of the medial femoral condyle cartilage, lateral femoral condyle cartilage, medial tibial plateau and lateral tibial plateau. Clinical Indication: Patient was taken to the operating room, and under adequate laryngeal mask anesthetic, patient1s LLE was prepped and draped in the usual sterile manner. Patient was given 600 mg of Clindamycin on a prophylaxis basis.
05/09/08	318, 332- 334	Assoc Sports Therapy	CC: Patient c/o left knee. Recommendation: PT 3 x/week x 4 weeks. Disability Status: TTD. (There are illegible data on these pages)
05/26/08	386	Eastside Ortho Med Assoc	**Surgery Authorization Request** Dx: Medial meniscus tear. Internal derangement knee. Tx plan: Crutches, ice, therapy unit. Recommendation: Left knee arthroscopy.
06/06/08	318, 323- 325, 328- 331	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept (PR-2)** Patient has undergone arthroscopic surgery of the left knee. She indicates that her pain has improved significantly. She is now approximately six weeks since she underwent the surgery and has improved significantly with respect to the surgical procedure. She has also been in PT for the last four weeks and has responded favorably. Exam: Lower Extremities: On examination of her left knee there is evidence of mild tenderness. There is mild swelling. There is no gross erythema. There are well healed surgical arthroscopic portals. ROM is 0 to approximately 100 degrees. Impression: S/p left knee arthroscopy. Discussion: I will recommend that patient at this time continue on an aggressive PT program three times a week for the next four weeks as well as an aggressive home exercise program to continue to strengthen the extremity. She will continue on Vicodin for pain and discomfort. I will see her back for f/u in four weeks time and I am hopeful she will respond to conservative measures. In the meantime, I will recommend that she continue off of work until further progress is made. Recommendation: PT 3 x/week x 4 weeks.
06/18/08	382- 384	Assoc Sports Therapy	**PT Evaluation** Dx: Left s/p internal derangement. Exam: Left knee: Pain

			level 4-5/10. ROM: Flexion: 0-115 degrees. Strength: 4+/5. Tx plan: Continue current treatment plan. (There are illegible data on these pages)
07/11/08	319- 322, 354	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept (PR-2)** CC: 10 weeks with left knee pain. Exam: Left knee: ROM: 20-100 degrees. Dx: Left knee pain. Tx plan: Vicodin. PT 2 x/week x 4 weeks. Work status: Off work. Disability Status: TTD. (There are illegible dates on these pages)
08/08/08	306, 315	Assoc Sports Therapy	**Orthopedic Supplemental Rept (PR-2)** CC: 14 weeks with knee surgery. Dx: Left knee post-op. Tx plan: Vicodin. PT 3 x/week x 4 weeks. Disability Status: TTD. (There are illegible dates on these pages)
08/22/08	379- 380, 387- 393	Assoc Sports Therapy	Patient participated in PT sessions from 06/18/18 to 08/22/08 in an effort to decrease pain tenderness and increase ROM and strength.
08/28/08	314		**Orthopedic Supplemental Rept (PR-2)** CC: 16 weeks with knee f/u. 2 months severe electrical type pain. LLE external and LBP. Exam: Left knee: Well healed. Left IT band with pain. Dx: Pain with left knee. Tx plan: Continue Motrin. (There is illegible data on this page)
09/05/08	307- 313	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept (PR-2)** Patient has undergone arthroscopic surgery of the left knee on 04/24/08. Since then, she has been placed on an aggressive PT program, a home exercise program and at this point in time indicates that her pain has improved significantly. She does complain of some associated pain to her lower back and some radiculopathy of her LLE. Exam: Back: On examination of her back there is evidence of mild tenderness, there is mild swelling. She flexes forward for 90 degrees, extends to 35 degrees, and laterally bends to 35 degrees bilaterally. Lower extremities: On examination of her left knee there is evidence of well healed surgical arthroscopic incisions. She flexes the knee from 0 to 125 degrees. Impression: 1) S/p left knee arthroscopy. 2) Lumbosacral spine strain. 3) LLE radiculopathy. Discussion: Given this patient's overall findings, I would recommend that this patient be released to a work related position avoiding any prolonged periods of standing and walking, any squatting, climbing and pivoting type of activities. I will recommend that patient continue on a strengthening program on her own behalf for her LLE. I will also recommend that she continue use of Ibuprofen for pain and inflammation and I would like to re-examine her in four weeks time to assess her progress. I am hopeful that she will continue to improve and I will keep you informed as to her progress with supplemental reports.

10/10/08	284, 305		**Orthopedic Supplemental Rept (PR-2)** CC: Patient c/o swelling pain worse. Dx: Left knee f/u. DJD. Tx plan: Motrin 500 mg. Vicodin. HEP. F/u on 4 weeks. (There is illegible data on this page)
11/07/08	303- 304		**Orthopedic Supplemental Rept (PR-2)** CC: Left knee pain in the same. Meds Ibuprofen to get helps. Exam: Left knee: ROM: 15-100 degrees. Dx: Left knee pain with swelling. Left knee OA. Tx plan: Motrin 500 mg. Vicodin. Prilosec. HEP. F/u on 3 weeks. (There are illegible data on these pages)
12/05/08	245- 252	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic P and S Rept** Patient has been under our care. She underwent discomfort of her left knee. Arthroscopic surgery of her left knee on 04/24/07. At the time of surgery, she underwent a partial medial meniscectomy and an abrasive chondroplasty of the medial femoral condyle. Since then, she indicates that her pain has improved, however, not completely resolved. She indicates that she does have some mild. Exam: Lower extremities: On examination of her left knee there is evidence of well healed surgical arthroscopic portals. She flexes the knee from 0 to 125 degrees. Impression: 1) S/p left knee arthroscopy with partial meniscectomy. 2) S/p left knee abrasive chondroplasty. Discussion: At this time it is apparent that patient has essentially plateaued and may be considered P and S. She has reached a maximum level of improvement having undergone arthroscopic surgery and placed on a post-operative PT program. Work status: Given this patient's clinical presentation and findings, I will recommend that this patient be released to her previous occupation with no restrictions. Impairment rating: Based on the American Medical Association 5th Edition Guide to permanent impairment there is no loss of ROM noted, however, she did undergo a partial meniscectomy which corresponds to a 1% whole person impairment rating. Apportionment: Apportionment in this patient's case is apparently not indicated since patient denies any prior injuries of her involved knee. Subjective factors of disability: Her subjective complaints are rated in the range of intermittent minimal not exceeding that level. Objective factors of disability: Objectively, patient did undergo a partial meniscectomy as well as an abrasive chondroplasty and has responded favorably. Vocational rehabilitation: Vocational rehabilitation is also not indicated since this patient will be released to her previous occupation with no restrictions. Future medical care: Future medical care in this patient's case certainly is indicated given the nature of this

			patient's injury and the clinical findings and 1 would recommend that we grant her physician care, pharmacotherapy, PT and this would certainly provide her coverage should there be an aggravation or recurrence of the same similar symptoms as a result of the initial injury.
01/23/09	297- 302	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept (PR-2)** Patient underwent arthroscopic surgery of her knee on 04/24/08 at the Plaza Surgical Center. She underwent a partial medial and partial lateral meniscectomy with an abrasive chondroplasty of the patellofemoral groove, medial femoral condyle, and medial tibial plateau, lateral femoral and lateral tibial plateau. Since then, she was considered P and S on her visit of 12/05/08. In reviewing this patient's history, she denied any prior injuries noted of her left knee. However, she does give us an h/o having injured her left ankle in August of 2007. She was off of work for approximately four to five weeks, she informed us of this, and however, in reviewing the report by Dr. Ralph Gamberdella, it appears that in fact that she did sustain an ankle sprain which was treated by Dr. Gamberdella's associate Dr. Jung. As a result of having developed pain to her left knee was referred to Dr. Gamberdella. However, he does not note an acute traumatic event to the left knee other than pain. As a result of the pain, Dt Gamberdella awarded her a 7% lower extremity impairment raring based on the joint space narrowing of the knee and a 10% lower extremity impairment rating as a result of the patellofemoral joint space narrowing, a total of 17% which corresponds to a 7% whole person impairment rating. On this basis, it appears that in fact this patient does in fact have a preexisting underlying degenerative osteoarthritis of her knee with previous pain which apparently improved and/or resolved and at this time has had a recurrence of the same problem. I would apportion this to at least 50% present industrial injury of 11/10/07 would be apportioned to her prior injury of her left knee as noted by Dr. Gamberdella.
09/04/09	294- 296	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept (PR-2)** Patient has previously been under our care. She was last seen in this office on 12/05/08 and was considered P and S. Since then, patient has been declared P and S. She indicates that this past week she apparently was getting out of a friend's car when she attempted to do so she apparently twisted her left knee causing her to develop pain and discomfort of her left knee. She was concerned that she may have re-injured the knee and therefore sought medical attention under our care and supervision. She also indicates that she has not lost time

			from work. Wt: 213 lbs. Exam: General: Patient c/o left knee soreness. Lower extremities: On physica1 examination of her left knee reveals evidence of mild medial joint line tenderness. She flexes the knee from 0 to 125 degrees. X-rays taken today reveals evidence of mild medial joint space narrowing noted. Impression: 1) Left knee re-injury. 2) Left knee evidence of mild degenerative osteoarthritis. Discussion: I will recommend that patient at this time be provided with Motrin for pain and inflam4iatioa I am hopeful this will relieve her acute onset of this re-injury and it appear that she does not have anything mote severe than a strain of her involved left knee, I will recommend that she continue working with no restrictions and I will see her back for f/u should her symptoms not improve in the next four to six weeks time.
10/11/10	288- 293	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept (PR-2)** Patient has been under our care. She has been previously declared P and S with an injury to her involved left knee. However, she was also presented with pain and discomfort of her lower back with associated radiculopathy to her LLE. She indicates that this is a new problem and is quite concerned. Exam: Back: On physical examination of the lumbar spine there is mild tenderness. She flexes forward to 90 degrees, extends to 35 degrees, and laterally bends to 35 degrees bilaterally. Lower extremities: Left knee exam reveals evidence of mild diffuse medial collateral ligament tenderness. She flexes the knee from 0 to 125 degrees. Impression: 1) S/p left knee surgical arthroscopy. 2) Lumbosacral spine strain with LLE radiculopathy (new problem). Discussion: Patient at this time has noted some pain and discomfort of the lower back which appears to be a new problem. I have discussed with patient the fact that this is not a continued medical problem from a previous injury and therefore this should be seen and treated according to either a new industrial injury or nonindustrial injury depending on patient's presentation of the problem to the newly treating doctor. With respect to her left knee, she does have some tenderness over the media] collateral ligament area, however, there is no evidence of any acute injury, there is no evidence of loss of motor or sensory function, therefore these is no need for any acute ongoing medical care. Patient will be provided with the use of an anti- inflammatory medication as well as an analgesic medication to ameliorate her level of pain and discomfort of her left knee. I will keep you informed as to this patient's progress should she return on reexamination purposes.

01/26/11	285- 287	Saucedo, Thomas, M.D.-Eastside Ortho Med Assoc	**Orthopedic Supplemental Rept** Patient has been under our care having previously undergone arthroscopic surgery of her knee. Surgery was performed on 04/24/08. She indicates that she did well, however, she did have some residual soreness, this soreness has steadily become more pronounced. She denies any new injuries to her left knee. She denies any other problem to her left knee and indicates that she has continued to work with D'Veal Family Youth Svcs performing her work related activities. However, she does complain of increased pain of her left knee especially over the last few months. BP: 206/100. Exam: Lower extremities: On physical examination of the left knee there is evidence of notable medial joint line tenderness, there is notable swelling. There is an effusion. She has a positive McMurray sign and positive grind sign. There is notable pain and discomfort especially of the medial compartment of the knee. No gross laxity is noted. Motor and sensory function is intact distally. Diagnostic studies: X-rays of the left knee reveals evidence of Grade III medial compartment narrowing of the left knee with osteophyte formation noted primarily in the medial compartment. Impression: Left knee evidence of medial compartment degenerative osteoarthritis. Discussion: Given patient's clinical findings as well as the results of her x-rays it appears that she has extensive degenerative changes of the medial compartment of her left knee. This has progressively gotten worse since she had surgery three years ago and at this point in time it appears that the pain is quite unrelenting. I will recommend that she be treated conservatively at this point in time with the use of an anti-inflammatory medication as well as an intra-articular cortisone injection to minimize her pain and discomfort, this was provided. Patient noted immediate improvement of the pain and discomfort of the left knee. I will see her back for f/u in four weeks time. Should this patient's symptoms not improve or resolve significantly, she may require further intervention. This would entail a knee arthroplasty of her left knee. At this point in time I have discussed this in detail with patient and I will see her back for f/u to assess her progress in four weeks time. She will continue to work with no restrictions. I will keep you informed as noted.
03/17/11	263- 280	Fell Jr, Thomas W., M.D.	**Orthopedic Agreed Panel QME Evaluation** DOI: 08/09/07 and 11/10/07. Hx of injury: Patient first injury around August, 2007, when she slipped, fell and twisted her left ankle and her left knee. She was seen in an industrial clinic and treated with bracing for both of these as well as

			PT. While still healing from this injury, patient bad a second injury in November, 2007. She was picking up clients at work when she noticed that the car was rolling. She jumped in to pull up tension on the brake. In doing so, she fell striking her left knee on the ground and her right foot turned in. She had ongoing pain in the left knee and right ankle. She elevated and iced it. Because of the pain, she went to Kaiser emergency room where she was evaluated and had x-rays. She was told that she had two fractures of the right foot. She was placed in a Cam walker which she wore for a number of weeks. She then treated with Dr. Saucedo. As the right foot got better, she had persistent pain in the left knee. She had an MRI and eventually surgery of the left knee which helped the left knee. However, she has had residual ongoing symptoms of the left knee ever since the surgery. She was released in 2008 or so by Dr. Saucedo. She returned to him a couple of months ago because of pain in the left knee. At that time, she could not use the clutch of her car. Dr. Saucedo had told her that she would need to get a different kind of car because of the clutch, but she continued to use the clutch. He took x-rays of her knee and gave her a cortisone injection. She was off work for about a week. The injection helped a lot. However, she developed a skin burn from the topical used to freeze her knee prior to the injection. Dr. Saucedo told her she was bone on bone laterally and may need total knee replacement surgery in the future. Present complaints: The left ankle and left knee symptoms almost always occur together with any prolonged walking, climbing stairs, squatting, kneeling with cause swelling basically of the knee and then the ankle followed by pain. The ankle pain is medial and lateral. The left knee pain is diffuse peripatellar pain. The knee does not have any locking or buckling, but it has stiffness. Wt: 213 lbs. PMH: Prior injuries: Patient injured her left ankle a number of years ago, in the mid-90s. It was fractured medially and laterally- She had surgery. Ever since then she has had pain which became worse after the incident of August, 2007. Hypertension. Prior surgeries: Knee surgery for this injury. Prior left ankle surgery. Allergies: Penicillin. Social habits: Patient admits to smoking cigarettes and alcohol consumption. Meds: Patient is taking Lisinopril and Hydrochlorothiazide, Ibuprofen, Vicodin. Physician reviewed medical records. Exam: Left knee: Examination of the left knee reveals mild swelling as compared to the right. There are multiple well-healed arthroscopic portals. There is a 1.5 cm circular lesion on the superior medial aspect of the knee that is consistent with a first or second degree skin burn.

			There is tenderness over the anterior medial joint line and anterior lateral joint line with the anterior lateral joint line being tender. There is mild crepitus of the patellofemoral joint. There is moderate crepitus over the lateral joint. The left knee is in valgus when compared to the right. ROM of the left knee reveals extension to 0 degrees and flexion to 130 degrees. The left knee is stable to anteroposterior and mediolateral. Stressors taking into consideration the valgus deformity. Ankles/feet: Examination of the left ankle reveals mild swelling about the left ankle medially and laterally. There are well-healed medial and lateral scars. Diffuse tenderness is noted medially and laterally of the ankle. Pain with just the slightest motion of the ankle. ROM of the ankle reveals dorsiflexion is to 0 degrees and plantar flexion is to 5 degrees. ROM of the right ankle and foot shows dorsiflexion is to 15 degrees and plantar flexion is to 40 degrees. ROM is without pain. The right ankle is stable to yams and valgus stressors in the neutral and plantar-flexed positions. X-rays of the left ankle and X-rays were also obtained of the left knee were reviewed. Dx: 1) Sprain/strain of the left knee aggravating degenerative arthritis of the left knee. Status post arthroscopic partial lateral and medial meniscectomy 2) Sprain of the left ankle temporarily aggravating significant pre-existing arthritis of the left ankle. 3) Fracture of the right foot, fourth and fifth metatarsals healed. Discussion: This patient suffered two injuries, one on 08/09/07 and one on 11/10/07. Patient was doing well as far as her left knee was concerned even though she had pre-existing arthritis until she suffered the injury of August, 2007, and further injured it in November, 2007. With regards to the left ankle, it has always given her pain, well prior to the two work incidents. She suffered an injury to the left ankle back in the mid-90s and had ORIF. She had residual symptoms. She then sprained it and had temporary increased pain with the work incidents. However, I expect that most of the symptoms now are residuals of her arthritis given the fact that she has significant limitation of motion of the ankle. A sprained ankle would not cause this type of limitation of motion. She would have excessive motion. There is no instability of the ankle. Even the slightest motion of the ankle causes pain so all of the pain is coming from the ankle joint. Then I asked patient about that and mentioned the fact that I thought that the knee pain aggravated the arthritis and the ankle pain would probably be present absent the work injuries. She tended to agree that the arthritis of the knee was the one that was really aggravated by the work incidents and that the left knee really wasn't

			hurting her and the left ankle has always given her problems since the prior ankle surgery. She did suffer a right foot fractures in the 11/10/07 incident. However, the right foot fractures have healed completely with no residuals. Patient had a flare-up of symptoms that precipitated a lot of this, needing an injection which settled down her knee, but it is still symptomatic. Fortunately, individuals with valgus knees, that is, arthritis in the lateral aspect of the knee can tolerate a lot of arthritis without need for total knee replacement. Disability Status: Patient is at MMI from her injuries. AMA impairment: Using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:Right foot - The fracture is well healed without any impairment. Left ankle - The ankle is rated according to arthritis Table 17-31. This patient has 0 mm of joint space which is a 30% lower extremity impairment. Left knee - With regard to the left knee, she has approximately 2 mm of joint space on the left side. Using Table 17-31, this is a 20% lower extremity impairment. For the left knee, patient is also rated according to Table 17-33. Because she has partial medial and partial lateral meniscectomy, she has a 10% lower extremity impairment. This gives her a 30% lower extremity impairment for the left knee. Combining the 30% lower extremity impairment for the left knee with the 30% lower extremity impairment for the left ankle, using page 504 of the Guides, gives her a combined total of 51% lower extremity impairment which using Table 17-3, gives her a total of 20% whole person impairment. Future medical care: Left knee - Allowance should be made for repeat orthopedic visits for her left knee including but not limited to evaluations, x-rays, corticosteroid injections. For more lasting relief than the corticosteroid injections, viscous supplementation such Synvisc would be beneficial. Should the left knee symptoms become such that they interfere significantly interfere with her quality of life, then she would be a total knee replacement candidate. She is not a knee replacement candidate at this time, however, this could change in the next few years. X-rays findings are not indicative of the need for total knee replacement. Only the pain and its effect on the quality of living is an indication for a knee replacement. Left ankle - with regards to the left ankle, any further care of the left ankle would be treatment of her pre-existing arthritis of the left ankle, not the injury of August, 2007 or November, 2007. Right foot - None. Work status: She may do her present job without any formal restrictions. However in the open labor market, patient would be precluded from more

			than occasional squatting, kneeling, and precluded from any type of climbing and more than occasional use of stairs. Causation and Apportionment: With regards to her right foot, this was injured in the November 2007 work incident and 100% of any residual disability is due to the incident of November, 2007. With regards to the left knee, prior to the work incidents, she was asymptomatic in the left knee even though she had arthritis. She injured the left knee in both the 819/07 and the 11/10/07 work incidents. The arthritis appears to have gotten worse since the injuries. Based upon these records and examination today, I would apportion 20% to the pre-existing pathology and the remaining 80% to the aggravation of the pre-existing pathology, further sprain/strain and tears of the menisci as a result of the two work incidents of August and November, 2007. I cannot separate these two as to which one caused the tear of the meniscus and which one caused more injury to the knee; I put them together as one injury. With regard to the left ankle, while she has temporarily aggravated the left ankle in the 08/09/07 fall and 11/10/07 incident, she also had pre-existing arthritis from a prior injury that required surgery. At this point, any residual is 100% apportioned to the pre-existing arthritis. I think she had a temporary aggravation of the left ankle arthritis due to the sprains, but this settled back down. Patient's present complaints and need for treatment of the left ankle would be present absent the work injury. This is based upon the fact that she has significant limitation of motion of the ankle indicating severe arthritis. A sprain in the ankle would cause laxity and looseness of the ankle, not tightness of the ankle. This does not appear to be residual of the ankle sprain.
03/23/11	364- 365	Synergy Imaging Ctr	**Radiology/Diagnostics** X-ray of Left Knee. Clinical Indication: Evaluate for degenerative joint disease. Impression: Findings compatible with degenerative joint disease primarily involving the lateral compartment. X-ray of Left Ankle. Clinical Indication: DJD. Findings: The bones an notable for an old fracture involving the distal left fibula and medial malleolus with internal fixation. The lateral view reveals marked narrowing of The mortise joint spaces compatible with severe degenerative disease. The remainder of the bones is unremarkable. The soft tissues are notable for both medial and lateral soft tissue swelling. Impression: 1) Old fractures with internal fixation. 2) Severe degenerative disease of the mortise joint. 3) Soft tissue swelling.

11/07/20	349- 350, 353, 362	Health Care Partners Med Grp	**Referral Slip** Dx: Right foot. Soreness left ankle. Contusion left knee. Recommendation: Ortho evaluation and treatment. (There are illegible data on these pages)

Records Categories

Copy Service Paperwork	1
Start of Records	11
Claims	12
Reports	238
Doctor's Notes	283
Radiology/Diagnostics	363
General/Med	375

Copy Service Paperwork

SCI000001

Corrected Location Form

The current facility has indicated that we need to contact another location to obtain the requested records.

Date: 8/25/2020 **Employee:** Paulina Garcia

Injured Person: Floreen Rooks

Social Security #: _____ **Control #:** 21-21912-1

Current location: State Compensation Insurance Fund
PO Box 65005 , Pinedale, CA, 93650

Person contacted at facility: _____

Title: _____

Phone extension: _____

New location: State Compensation Insurance Fund
655 N Central Ave, 4th floor, Glendale, CA, 91203

Reason:

- [ ] New location is the **Agent for Service**
- [ ] Previous location was the **Agent for Service**
- [ ] New location is the **corporate office** where all records are kept
- [x] This company/facility has more than one location, the requested records are at the new address
- [ ] The facility has **moved** to a new address
- [ ] The previous facility was **purchased** by the new one
- [ ] The doctor is **deceased**, records are at a new location
- [ ] The doctor moved to a new facility and took records with him/her
- [ ] The physical address
- [ ]

Instructions: This form is to be filled out anytime we change facility locations. The form is to be kept with the Subpoena/Auth/Notice of Depo. and become part of the records or Certificate of No Records.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

Floreen Rooks
DOB: 06/20/49
AKA:
File: CLA: 05170360; DOL: 11/10/2007

Claimant/Applicant,

vs.

Dveal Family & Youth Services

Employer/Insurance Carrier/Defendant.

Case No. SIF7024643, SIF10825285,SIF7024645

(IF APPLICATION HAS BEEN FILED, CASE NUMBER MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using above case number or attaching a copy of subpoena)

Where no application has been filed for injuries on or after January 1, 1990 and before January 1, 1994, subpoena will be valid without a case number, but subpoena must be served on claimant and employer and/or insurance carrier.

See instructions below.*

The People of the State of California Send Greetings to: State Compensation Insurance Fund

WE COMMAND YOU to appear before A Deposition Officer – Med-Legal, LLC

at 955 Overland Ct, Suite 200, San Dimas, CA 91773,Phone 800-244-3495

on the 09/14/20 day of _____, at 10:00 o'clock AM., to testify in the above-entitled matter and to bring with you and produce the following described documents, papers, books and records.

See Attachment for a list of records to be produced subject to this subpoena, to make available for inspection and copying or transmit/transfer electronically.

(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 08/25/20

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Secretary, Assistant Secretary, Workers' Compensation Judge

WORKERS' COMPENSATION APPEALS BOARD SEAL

***FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990, AND BEFORE JANUARY 1, 1994**

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Government Code 68097.2, et seq.

DWC WCAB 32 (Side 1) (REV. 06/18)

HIPAA Compliant Request Control #: **21-21912-1**

Do not appear! Simply call (800) 244-3495 and somebody will copy the records for you at your office.

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. SIF7024643, SIF10825285,SIF7024645

STATE OF CALIFORNIA, County of Los Angeles

The undersigned states: That Med-Legal, LLC has been authorized to obtain records by

Natalia Foley, Esq Workers Defenders Law Group
That he /she is (one of) the attorney(s) of record / representative(s) for the applicant/defendant in the action captioned on the reverse hereof. That State Compensation Insurance Fund has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:
Based on the information and belief to resolve any dispute in the above referenced case.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

☐ That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. *(Check box if applicable and part of declaration below. See instructions on front of subpoena.)*

I declare under penalty of perjury that the foregoing is true and correct

Executed on 08/25/20 , at San Dimas, California.

Signature	955 Overland Court, Suite 200, San Dimas, CA 91773	(626) 653-5160
	Address	Telephone

Victor Landero, Operations

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Los Angeles

I, the undersigned, state that I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of Person Served	Date	Place

I declare under penalty of perjury that the foregoing is true and correct

Executed on_____, at_____, California.

_____
Signature

Control #: **21-21912-1**

DWC WCAB 32 (Side 2) (REV. 06/18)

Attachment

Re:

Patient/Applicant: Floreen Rooks Social Security #: 000-00-0000
AKA: D.O.B.: 06/20/49

Ordered By:

Natalia Foley, Esq
Workers Defenders Law Group
5753 E Santa Ana Cyn Rd Ste G #616
Anaheim, CA 92807

Records to produce:

Deponent's file #: CLA: 05170360; DOL: 11/10/2007
Exclusions (if any):

Date Range (if any):

For each injury alleged by the Applicant named on the Subpoena, produce the following:

A signed "Declaration of Custodian of Records" must accompany the records.

This notice of deposition includes a demand for all documents under your custody and control regarding the above claim number as described below for the applicant, herein claimant, listed on the notice of deposition.

This demand does not include privileged documents defined as:

1. Any documentation or correspondence between an attorney representing the deponent and any employee of the deponent.
2. Any documentation or correspondence between the designated spokesperson representing the employer and an attorney who represents that employer unless that documentation has been disclosed to a third party or an insurance company.
3. Any documents prepared by any attorney that are the attorney's impressions, conclusions, opinions or legal research or theories.
4. That portion of a report prepared by an investigator at the request of an attorney that contains the investigator's impressions, conclusions, opinions or theories.
5. Any surveillance video of claimant where the claimant's deposition has not been taken and the deponent intends to take the deposition of the claimant and that surveillance video has not been disclose to a third party or physician.

This demand includes:

1. The Employee's Claim for Workers' Compensation Benefits, DWC Form 1, showing the employer's date of knowledge of injury, the date the employer provided the form to the employee and the date the employer received the completed form from the employee.
2. All documentation of the date the employer provided a claim form to the employee or that the administrator has provided the claim form to the employee.
3. All Employer's Report of Occupational Injury or Illness, DLSR Forma 5020, or documentation of reasonable attempts to obtain it.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are not being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

4. All Doctor's First Report of Occupational Injury or Illness, DLSR From 5021, or documentation of reasonable attempts to obtain them.
5. All medical reports pertaining to the claim, or documentation of reasonable attempts to obtain them.
6. All orders or awards of the Workers' Compensation Appeals Board or the Rehabilitation Unit pertaining to the claim.
7. The application(s) for adjudication of claim filed with the Workers' Compensation Appeals Board.
8. All notices and correspondence related to the Qualified Medical Evaluation process required by Labor Code Section 4061 and 4062.
9. All documentation regarding the injured workers earnings and of reasonable attempts to obtain this information.
10. All documentation regarding the claimant's earning capacity, including documentation of any increase in earnings likely to have occurred but for the injury (such as periodic salary increases or increased earnings upon completion of training status) and of reasonable attempts to determine this information.
11. All notes (including email and computer notes) describing telephone conversations relating to the claim including the dates of calls, substance of calls, and identification of parties to the calls.
12. All correspondence (including Email) to and from all medical providers and medical examiners regarding all injuries or illnesses affecting this claim.
13. A copy of any and all records regarding applicant. All summaries or analysis of medical records prepared by any person other than attorneys.
14. All employment records, including personnel records, in all files wherever located, including supervisor files, accident or injury investigation files, personnel files, disciplinary files, and all employment records as defined by Labor Code section I198.5 in your possession or under your control.
15. All documents evidencing that claimant has chosen a pre-designated treating physician(s) before the occurrence of the injuries alleged in this matter.
16. All documents showing the employer has contracted with health care organizations to provide services and medical treatment to injured employees that include claimant.
17. All statements by any person whether a percipient witness to any alleged injuries or with any knowledge regarding any accidents or injuries to claimant whether written recorded or notes of the conversation.
18. All investigation reports involving any known, alleged or reported injuries by claimant.
19. All photographs or images of any scenes or locations or of any objects or equipment regarding any accident or know, alleged and reported injury to claimant.
20. All ergonomic studies of claimant's work area during the period of the alleged injury to claimant.
21. All photographs or images of claimant, including, but not limited to, those depicting any possible visible signs of injuries or disabilities or the lack thereof.
22. All films, movies, motion pictures, video tapes in any format or form purporting to depict claimant in any manner or activity whether depicting disability or lack of disability taken at anytime in the possession of deponent or under the control of deponent including any agent or investigators hired by deponent.
23. All documents including billing statements and reports regarding any surveillance of claimant by any agent or investigator hired by deponent, employer, insurance company or any agent of deponent, employer or insurance company. The documents are to show the name of the person conducting the surveillance, his or her employer, address of his or her employer, date, starting time of surveillance, and ending time of surveillance, minutes of filming or video taping, and any written notes or reports regarding the surveillance.
24. Any documents or records from any index, EDEX, or database of accidents, injuries, or workers' compensation claims attributed to or claimed by claimant, at any time.
25. All vocational rehabilitation documents or reports including job descriptions and job analysis prepared by any Qualified Rehabilitation Representative or vocational rehabilitation expert or nurse.
26. All documents, notes and reports by medical case managers involving this claim.
27. All documents showing proof of compliance with Title 8, California Code of Regulations section 9792.6 for any Utilization Review of any medical request by a physician in this matter.
28. If liability for the claim has not been accepted a copy of all investigation and medical evidence considered or relied upon as the basis for not accepting liability.
29. All documents showing all efforts by the employer to find modified or alternative work for the claimant.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are not being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

30. All documents showing all efforts by the employer to make reasonable accommodation for claimant's physical or mental disability.

Notice: For Subpoenas of claim files, you are to send the claim file directly to Med-Legal only. Sending the claim file to other than Med-Legal will be considered to be in non-compliance of the subpoena.

If any of the documents described above that are in your possession or control are not being produced then a detailed list of each withheld document must be included with the records production or listed on your declaration.

Where used, the terms "writing", "record", "document" and other words of similar meaning include (but are not limited to) electronically maintained image files, documents, notes, faxes, emails and other similar types of electronically held information. If the subpoenaed records exist in paper they are to be provided for inspection and copying. If the subpoenaed records exist electronically then they are to be provided either electronically through our Internet portal at upload.getrecords.com or on CD.

Case Name: Floreen Rooks v. Dveal Family & Youth Services

Case Number: SIF7024643, SIF10825285,SIF7024645

PROOF OF SERVICE BY MAIL

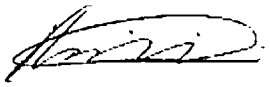
Notice of Copying , Deposition Notice

I declare that I am employed in the County of Los Angeles, over the age of 18 years and not a party to this action. My business address is: 955 Overland Court, Ste. 200 San Dimas, California 91773.

On 8/26/2020 I caused to be served, at my direction and following ordinary business practices, true copies of the document(s) referenced above for collection and mailing in a sealed envelope and addressed to the parties listed below. I am readily familiar with the business practices of Med-Legal, LLC for collection and processing of correspondence for mailing. The document was set for same day mail processing and collection, with postage fully paid, for delivery by the United States Postal Service or private delivery service following ordinary business practices.

SIBTF SACRAMENTO
160 PROMENADE CIRCLE, SUITE 350
SACRAMENTO CA 95834

I declare under penalty under the penalty of perjury under the laws of the State of California, the foregoing is a true and correct statement. Executed on 8/26/2020 at San Dimas, California.



/s/ Roderic B. Davis
Business Document Manager
Med-Legal, LLC
21-21912-1

APPLICANT/PLAINTIFF/PETITIONER: Floreen Rooks DEFENDANT/RESPONDENT: Dveal Family & Youth Services	CASE NUMBER: SIF7024643, SIF10825285,SIF7024645

PROOF OF SERVICE OF DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

1. I served this *Deposition Subpoena for Production of Business Records* by delivering a copy to the person served as follows:

eMail

___Personal Delivery ___Certified Mail ___Regular Mail ___Via ~~Facsimile~~

a. Person served (name): SCIF

b. Address where served: 655 N Central Ave, 4th floor Glendale, CA 91203

c. Date of delivery: 9/12/20 Time of delivery: _____

d. Deposition date is: ☑ 10/1/20 ☐ 09/14/20

e. (1) ☐ Witness fees were paid.
Amount: _____ $ 0 Check Number : 0

(2) ☐ Copying fees were paid.
Amount: _____ $ _____

f. Fee for service: _____ $ _____

2. I received this subpoena for service on (date): _____

3. Person serving:
   a. ☐ Not a registered California process server.
   b. ☐ California sheriff or marshal
   c. ☐ Registered California process server.
   d. ☑ Employee or independent contractor of a registered California process server.
   e. ☐ Exempt from registration under Business and Professions Code Section 22350(b).
   f. ☐ Registered professional photocopier.
   g. ☐ Exempt from registration under Business and Professions Code section 22451.

4. Name, address, telephone number, and, if applicable, county of registration and number:

955 Overland Ct. Suite 200, San Dimas, CA 91773,Phone 800-244-3495

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 9/12/20

► _____
(SIGNATURE)

(For California sheriff or marshal use only)
I **certify** that the foregoing is true and correct.

Date: _____

► _____
(SIGNATURE)

982(a)(15.2) [Rev. January 2000]

PROOF OF SERVICE
DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

Control Number: :21-21912-1

Records Order Form

08/25/20

Notice of Copying to:

SIBTF SACRAMENTO
160 PROMENADE CIRCLE, SUITE 350
SACRAMENTO, CA 95834

Case Information

Applicant: Floreen Rooks
Employer: Dveal Family & Youth Services
Case #: SIF7024643, SIF10825285,SIF7024645
DOI: 11/10/07 SS#: 000-00-0000
Claim #: Not Supplied by Carrier
Ordering party: Natalia Foley, Esq

Record Location: State Compensation Insurance Fund

Records of the Injured Worker are being produced at the above record location and delivered to the opposing party. You may receive copies of the records by selecting one of the following;

Title 8, CCR § 9982 Allowable Services. (A)... services for records relevant to an injured worker's claim, except services under a contract between the employer and the copy service provider.

☐ Electronic Set per Billing Codes WC026 or WC027
Fees set by § 9983 ***Fees for Copy and Related Services (f)(2)***
Number of Sets ____

☐ CD Set per Billing Codes WC026 or WC027
Fees set by § 9983 ***Fees for Copy and Related Services (f)(2)***
Number of Sets ____

Send records:

☐ Same as above

E-mail addresses required for the electronic sets:
_____@_____
_____@_____

☐ **Bill to My Office** (*Invoice will be sent to the address on this notice.*)

☐ **Bill to the Insurance Carrier**

_____ (Print your name)

_____ (Sign your name) **Control #: 21-21912-1**
(Signature required)

Med-Legal, LLC

Photocopy Reg #/County x-423/Los Angeles
Tax ID # 45-4424177
955 Overland Court, Suite 200, San Dimas, CA 91773, (800) 244-3495 FAX (800) 962-4896

Start of Records

SCI000011

Claims

SCI000012

INJURED NAME: Floreen Rooks CLAIM NUMBER: 05170360

DECLARATION

I hereby declare under penalty of perjury that the following statements are true, to the best of my knowledge and belief.

I am the custodian of records for State Compensation Insurance Fund. The records made available are all records called for in the attached Subpoena which State Compensation Insurance Fund is legally obligated to produce. All other records in State Compensation Insurance Fund's possession are privileged information.

SA Admin Support

_____

Signature

November 9, 2020

_____

Date

STATE COMPENSATION INSURANCE FUND

REQUEST FOR INFORMATION

Date: 10/13/2010

To: Dr Tomas Saucedo
Phone: 626-289-0178
Fax: 626-308-2083

Injured Employee Name: ROOKS, Floreen
Claim Number: 05170360
Tracking #: E000004811507
DOI: 11/10/2007 **DOB:** 06/20/1949

Dear Dr Saucedo:
Request: Omeprazole 20mg #30. Source Document: E-mail from Express Scripts with 10/11/10 date of service & received by SCIF adjuster on 10/12/10.
Prescription written by Dr Tomas Saucedo.

The request has been reviewed in accordance with State Fund's Utilization Review Program.

The following information is necessary to render a Utilization Review Decision and was not provided with the original request for authorization of treatment: ***please provide an updated PR-2 with medical necessity for dispensed medication on 10/11/10***

Any further consideration of this treatment request will require your submission of the requested information via facsimile (**FAX**) to the following telephone number:

FAX Number: (818) 550-6707

These requested documents should be prominently identified as "**UR Requested Information**" at the top of the page and include a copy of this **REQUEST FOR INFORMATION**. This additional medical information will be reviewed in accordance with State Fund's Utilization Review Program and the Utilization Review Regulations.

§ 9792.9. Utilization Review Standards—Timeframe, Procedures and Notice Content
(2) If appropriate information which is necessary to render a decision is not provided with the original request for authorization, such information may be requested within five (5) working days from the date of receipt of the written request for authorization to make the proper determination. In no event shall the determination be made more than 14 days from the date of receipt of the original request for authorization by the health care provider.

Thank you for your cooperation.
Ellen Abramsky, RN
Ellen Abramsky, RN
District Office Health Consultant
Los Angeles/Tri-County Claims, Glendale
PO Box 92622 Los Angeles, CA 90009-2622
Utilization Review Unit Fax: 818-550-6707

STATE COMPENSATION INSURANCE FUND

REQUEST FOR INFORMATION

Date: 10/13/2010

To: Dr Tomas Saucedo
Phone: 626-289-0178
Fax: 626-308-2083

Injured Employee Name: ROOKS, Floreen
Claim Number: 05170360
Tracking #: E00004811507
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Ellen Abramsky, RN
Ellen Abramsky, RN
District Office Health Consultant
Los Angeles/Tri-County Claims, Glendale
PO Box 92622 Los Angeles, CA 90009-2622
Utilization Review Unit Fax: 818-550-6707

TX RESULT REPORT

NAME :
TEL :
DATE :OCT.14.2010 08:43

SESSION	FUNCTION	NO.	DESTINATION STATION	DATE	TIME	PAGE	DURATION	MODE	RESULT
6387	TX	001	916263082083	OCT.14	08:43	001	00h00min19s	ECM	OK

STATE COMPENSATION INSURANCE FUND
655 N. CENTRAL AVENUE,
GLENDALE, CA 91203

FACSIMILE COVER SHEET
LOS ANGELES ADJUSTING CENTER
TELEFAX NUMBER IS:

(818) 291-7754

DELIVER TO:
NAME: Alicia
COMPANY: Dr. Tomas Saucedo
DATE: 10/5/10 TELEFAX NO: (626) 308-2083
AREA CODE

FROM: Yolanda Nielsen, Claims Representative
DEPARTMENT/SECTION: Los Angeles Adjusting Center
PHONE: (818) 291-7626
AREA CODE

MESSAGE: RE: Floreen Rooks, Claim# 05170360

This is to authorize Dr. Saucedo for an office visit regarding Injured Worker Floreen Rooks. For any further medical treatment, please fax your written request to (818) 550-6707.

Thanks.

THE TOTAL NUMBER OF PAGES, INCLUDING THIS COVER SHEET, ARE 1

SCIF 2070 (REV 4-91)

SESSION	FUNCTION	NO.	DESTINATION STATION	DATE	TIME	PAGE	DURATION	MODE	RESULT
0764	TX	001	9162630820B3	OCT.05	14:56	001	00H00M17S45	ECM	OK

NAME :
TEL :
DATE :OCT.05.2010 14:57

TX RESULT REPORT

COMPENSATION INSURANCE FUND
655 N. CENTRAL AVENUE, GLENDALE, CA 91203

LOS ANGELES ADJUSTING CENTER
TELEFAX NUMBER IS:
(818) 29 -7754

DELIVER TO: NAME: Alicia
COMPANY: Dr. Tomas Saucedo
DATE: 10/5/10 TELEFAX NO: (626) 308-2083
AREA CODE

FROM: Yolanda Nielsen, Claims Representative
DEPARTMENT/SECTION: Los Angeles Adjusting Center
PHONE: (818) 291-7626
AREA CODE

MESSAGE: RE: Floreen Rooks, Claim# 05170360

This is to authorize Dr. Saucedo for an office visit regarding Injured Worker Floreen Rooks. For any further medical treatment, please fax your written request to (818) 550-6707.
Thanks.

THE TOTAL NUMBER OF PAGES, INCLUDING THIS COVER SHEET, ARE 1

SCIF 2070 (REV 4-01)

8083

05T0360
LG Y Nielson
Claims 5
Rowena Marcelo

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BLVD STE 203
MONTERAPARK, CA 91754
OFFICE (626) 282-3577 FAX (626) 284-4276

FAX COVER SHEET

DATE: June 19, 2008

ATTN: Yolanda, Nielson

INS: State Comp 92622

FAX: (818) 291-7115

RE: Rooks Flippen

CLAIM #: 80283 DOI: 11-10-07

MESSAGE: **AUTHORIZATION REQUEST FOR PHYSICAL THERAPY**

Please Review request for Physical Therapy (2x4) Left Knee Post

Thank you

ENCLOSED, FOR YOUR REVIEW:

X PRESCRIPTION: (DATED) _____

_____ EVAL/REPORT;PROGRESS NOTE;RE-EVAL;(DATED) _____

X WORK STATUS SHEET: _____

X DOCTORS SUPPLEMENTAL REPORT: _____

FROM: Gladys Gomez

NUMBER OF PAGES 4
(INCLUDING COVER SHEET)

6/19/08

Y. Nielson Claims S Rowena Marcelo

BP - PIP -

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BLVD STE 203
MONTERAPARK, CA 91754
OFFICE (626) 262-3577 FAX (626) 284-4276

PAMELA SELEVICH
MAY 14 2008
LOS ANGELES CLAIMS

FAX COVER SHEET

DATE: May 13, 2008

ATTN: Yolanda Nielson

INS: State Comp 92622

FAX: (818) 291- 7115

RE: Rooks Floreen CL # 05170360; 05174168

CLAIM #: 80283 **DOI:** 11-10-07

MESSAGE: ***AUTHORIZATION REQUEST FOR PHYSICAL THERAPY***

Please review request for Physical Therapy 3x4 for left Knee
Thank you

ENCLOSED, FOR YOUR REVIEW:

X PRESCRIPTION: (DATED) _____

_____ EVAL/REPORT;PROGRESS NOTE;RE-EVAL:(DATED) _____

X WORK STATUS SHEET: _____

X DOCTORS SUPPLEMENTAL REPORT: _____

FROM: Sonia De La Torre

NUMBER OF PAGES_____
(INCLUDING COVER SHEET)

Health Care Partners 95-4526112

Patient Information
Occupational Medicine

Patient Information:

		Date	03/20/2008
Name	ROOKS,FLOREEN	Case #	80283
Address	1315 S. GLADYS AVE.	SSN	XXX-XX-8510
	SAN GABRIEL, CA 91776	DOB/Age	06/20/1949 / 58
Phone	(626) 573-1906	Sex	Female
Occupation	MARRIAGE FAMILY THERAPIST	MRN	32-295498

Employer Information:

Name	D'Veal Family & Youth Services	Service Contact	Agnes Mills
Address	P.O. Box 40255 Pasadena, CA 91114	Phone	(626) 296-8900
		Fax	(626) -
Phone	(626) 296-8900	Email	
Fax	(626) -	Pager	

Guarantor Information:

Name	State Comp 92622	Adjuster	Yolanda Nielsen ext.7026
Address	P.O. Box 92622 Los Angeles, CA 90009-2622	Phone	
Phone	(818) 291-7000		Fax# 818 241-7115
Fax	(818) 291-7301		
Contact	Glendale Office		

Case History:

Case #	Employer	Service/Sub-Type	DOI
80283	D'Veal Family & Youth Services	TX: Workers Comp	11/10/2007

PAMELA SELEVICH
MAY 14 2008
LOS ANGELES CLAIMS

FAX REQUEST
INFORMATION REQUIRED

April 08, 2008

To: Healthcare Partners Medical Group
Phone: 626-588-1990
Fax: 626-308-2083
ATTN: Jamie

From: Pebbles Draper, RN
Phone: (866) 459-0723
Fax: (866) 881-5412

Number of Pages Including cover sheet: 1

Employee: Floreen Rooks
Claim Number: 05170360
DOI: 11/10/2007
Employer/District Office: Glendale District Office

This is to notify you that additional information is necessary to process your request for 29850 - KNEE ARTHROSCOPY/SURGERY on the above mentioned employee. ***Please provide specific CPT codes for the surgery you are requesting so that I can review for the appropriateness of a polar unit.***

The Administrative Director of the State of California Division of Workers' Compensation has adopted regulations setting forth utilization review (UR) standards applicable to workers' compensation insurers and self-insured employers. Insurers and self-insured employers may engage in a case-by-case review of the medical treatment provided injured employees in order to improve care and manage costs. BC Life and Health Insurance Company ("BC Life" is an affiliate of Blue Cross of California, "BCC") has been selected by State Compensation Insurance Fund to administer these UR services. Further, if you are a BCC Prudent Buyer or Workers' Compensation Network Provider, you are subject to the terms of your Participating Provider Agreement.

Sincerely,
Pebbles Draper, RN
Medical Manager Lead
Office Hours Monday-Friday 8:00-5:30

cc: Adjuster: Yolanda Nielsen (electronically)
URC (electronically)

BC Life & Health Insurance Company

FAX REQUEST
INFORMATION REQUIRED

April 08, 2008

To: Healthcare Partners Medical Group
Phone: 626-588-1990
Fax: 626-308-2083
ATTN: Jamie

From: Pebbles Draper, RN
Phone: (866) 459-0723
Fax: (866) 881-5412

Number of Pages Including cover sheet: 1

Employee: Floreen Rooks
Claim Number: 05170360
DOI: 11/10/2007
Employer/District Office: Glendale District Office

This is to notify you that additional information is necessary to process your request for 29850 - KNEE ARTHROSCOPY/SURGERY on the above mentioned employee. ***Please provide specific CPT codes for the surgery you are requesting so that I can review for the appropriateness of a polar unit.***

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Sincerely,
Pebbles Draper, RN
Medical Manager Lead
Office Hours Monday-Friday 8:00-5:30

cc: Adjuster: Yolanda Nielsen (electronically)
URC (electronically)

SCIF RECD DTE 04/03/2008 BKGCAL 5 04/[illegible] 03:42 PM 027520 1 2

unit 5 Rowena Marcelo

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA

Eastside Orthopedic Medical Associates

Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

CATHY SELLITTO
APR 0 3 2008
GLENDALE LOC.

Fax Cover

Rush!!

Date: FAXED 4.2.08

RECEIVED
APR 0 2 2008
GLENDALE LOC.

Attn: Yolanda Nielsen

From: State Comp.

Fax: ~~(818) 241-7301~~ (818) 291-7115

Re: ROOKS, Floren CL# 05170810

Message: Attached is authorization request for left knee Arthroscopy. If you may have any questions please feel free to call

RECEIVED
APR 0 2 2008
GLENDALE LOC.

Thank you

PAUL LIANG
APR 0 4 2008
GLENDALE LOC.

FROM: ANGIE GONZALEZ
(WORK COMP COORDINATOR)
(626) 588-1990

number of pages 4
(including cover sheet)

8083

SCIF RECD DTE 02/08/2008 BKSCAN 4 02/08/2008 12:23 PM 017415 1 4

LC Yolanda Nelson Claims S

FEB-05-2008 16:06 HCP Ravena Marcelo

Fax Transmittal

HealthCare PARTNERS MEDICAL GROUP

DATE: 2/5/08

TO: UR Dept FROM: Ana Gomez

State Comp PHONE: (626) 582-7950

FAX #: 888 550-6707 FAX #: (626) 582-7928

TOTAL # OF PAGES (INCLUDING COVER SHEET): 4

IF YOU DO NOT RECEIVE THE NUMBER OF SHEETS INDICATED ABOVE, PLEASE CONTACT OUR OFFICE IMMEDIATELY. THANK YOU.

COMMENTS: re Floreen Rooks

CL# 0S170360

RECEIVED
FEB 05 2008
L.A. D.O. GLENDALE LOC.

CATHY SELLITTO
FEB 06 2008
GLENDALE LOC.

CONFIDENTIAL TRANSMISSION: YES_____ NO _____

A015 (5/03)

8083

5170360

Fax Transmittal

HealthCare PARTNERS MEDICAL GROUP

DATE: 12/17/07

TO: Yolanda Nielson FROM: Ana Gomez

PHONE: (626) 582-7950

FAX #: 707-646-2609 FAX #: (626) 582-7928

TOTAL # OF PAGES (INCLUDING COVER SHEET): 4

IF YOU DO NOT RECEIVE THE NUMBER OF SHEETS INDICATED ABOVE, PLEASE CONTACT OUR OFFICE IMMEDIATELY. THANK YOU.

COMMENTS: Re: Rooks, Floreen
CH# 05170360

CONFIDENTIAL TRANSMISSION: YES_____ NO_____

A015 (5/02)

8083

SCIF RECD DTE 11/15/2007 BKSCAN 3 11/15/2007 05:34 PM 016558 1 1

FROM : DUERL FAX NO. :6262968911 Nov. 13 2007 03:14PM P2

KAISER PERMANENTE

Documentation of Medical Impairment (DMI)

Rooks, Floren
05170360

CONFIDENTIAL MEDICAL INFORMATION: This form contains confidential medical information which is only to be accessed by those with legitimate need to know. This form may not be placed or maintained in a non-medical personnel file, but must be placed in a separate confidential occupational health file.

1. Patient Data:

DATE OF THE FORM VISIT/DISCHARGE: Month 11 Day 12 Year 2007 — Day / Evn / Night

LAST DAY WORKED: Month ___ Day ___ Year ___ — Medical Release for Return to Work only, patient not treated for this impairment.

DATE OF INJURY / DATE ILLNESS BEGAN: Month ___ Day ___ Year ___ — Telephone Consultation, patient not seen

DATE OF: Hospital Admit / Outpatient Surgery / EDC — Month ___ Day ___ Year 200_

Medical Record Number (If KP card is not available)
00-000876702

2248 0083 102283409

© copyright 1997, Kaiser Permanente

2. Diagnosis or Reason for Impairment:

a. Mark ONLY the DX(s) driving the Off Work/Activity Restriction(s) in Section 3.

Bunionectomy	01	Morton's Neuroma	02	Skin Infection: Bacterial (Abscess / Cellulitis etc.) - incl. I & D	03
Charcot's Arthropathy	04	Nail: ingrown - any tx inc. matrixectomy	05	Soft Tissue Mass: Ankle / Foot / Toe(s)	06
Diabetes: Includes gestational	07	Neurectomy	08	Sprain / Strain / Pain: LE / Hip / Knee / Ankle / Foot / Toe(s)	09
FX: Ankle / Foot excludes Toe(s)	10 (marked)	Plantar Fascia Release	11	Tendonitis / Synovitis / Bursitis / Shoulder Impingement	12
Hammer Toe Correction	13	Plantar Fasciitis: medical treatment	14	Ulcerations: Foot / Ankle	15

b. If DX (table) NOT found in 2a, print Code and Write description of the DX driving Off Work/Activity Restriction(s) in Section 3.

DMI Code (DMI group list on fly sheet): D___
OR
Diagnosis Code (ICD - see ECR)
OR
Procedure Code (CPT - see ECR)
AND
Written description for DX code above (2b)

PODIATRY

3. EMPLOYER INSTRUCTIONS — Recommended Impact on Work:

a. RETURN TO WORK TODAY — Patient can return to work today, without restrictions

b. OFF WORK Homebound (Example → 021) — Patient completely unable to work (Homebound) for a period of ___ Calendar Day(s) STARTING WITH Month ___ Day ___ Year 200_

c. ACTIVITY RESTRICTIONS (Example → 010) — Patient can return to work with restriction(s) as noted in Section 4 for a period of NA Calendar Day(s) STARTING AFTER or ON WITH Month 11 Day 12 Year 2007

d. PERMANENT CONDITION — Patient has reached maximum medical improvement. Restriction(s) listed are permanent. / Patient is permanently, totally disabled. (ex: anticipate he/she will never return to any work.)

4. Restrictions:

Climbing, Driving, Hand Motion (L R), ..., (L R), Sports, Standing, Walking — NO LIFTING OVER ___

Cannot Perform / MAX: Minutes Per Hour / MAX: Hours Per 8 hr. Shift

FOLLOW-UP PLAN:
TX Duration ___ wk(s)
Next Visit ___/___/___
Therapy ___ visits/wk ___ wk(s)

Comments (List applicable devices): Pt cannot drive because of right foot fractures

5. Clinician Resource Code:
DPMS / ID*DO Example → J0D0DE
DG LHM

Date Signed: Month 11 Day 12 Year 2007

Circle affiliated Medical Center Area

Clinician Signature

HB-5184 (1/98) CHART COPY

8083

SCI000026

SCIF RECD DTE 11/19/2007 BKSCAN 3 11/19/2007 02:29 PM 016670 3 2

FROM : DUEAL FAX NO. : 6262968911 Nov. 13 2007 04:18PM P2

KAISER PERMANENTE

CONFIDENTIAL MEDICAL INFORMATION: This form contains confidential medical information which is only to be accessed by those with legitimate need to know. This form may not be placed or maintained in a non-medical personnel file, but must be placed in a separate confidential occupational health file.

Rooks, Floreen
05170360

1. Patient Data: DATE OF THE FORM VISIT/DISCHARGE: Month 11 Day 12 Year 2007 — Day / Eve / Night

LAST DAY WORKED: Month / Day / Year — Medical Release for Return to Work only, patient not treated for this impairment.

DATE OF INJURY / DATE ILLNESS BEGAN: Month / Day / Year — Telephone Consultation, patient not seen

DATE OF: Hospital Admit / Outpatient Surgery / EDC — Month / Day / Year 200_

Medical Record Number (If KP card is not available)
00-00087167 02

2248 0083 10228340?

© copyright 1997, Kaiser Permanente

2. Diagnosis or Reason for Impairment

a. Mark ONLY the DX(s) driving the Off Work/Activity Restriction(s) in Section 3.

Bunionectomy	01	Morton's Neuroma	02	Skin Infection: Bacterial (Abscess / Cellulitis etc.) - incl. I & D	03
Charcot's Arthropathy	04	Nail: Ingrown - any tx inc. matricectomy	05	Soft Tissue Mass: Ankle / Foot / Toe(s)	06
Diabetes: includes gestational	07	Neurectomy	08	Sprain / Strain / Pain: LE / Hip / Knee / Ankle / Foot / Toe(s)	09
FX: Ankle / Foot includes Toe(s)	10 ✓	Plantar Fascia Release	11	Tendonitis / Synovitis / Bursitis / Shoulder Impingement	12
Hammer Toe Correction	13	Plantar Fasciitis: medical treatment	14	Ulcerations: Foot / Ankle	15

b. If DX bubble NOT found in 2a, print Code and Write description of the DX driving Off Work/Activity Restriction(s) in Section 3.

DMR Code (DMR group list on fly sheet): D
OR Diagnosis Code (ICD - see ECR)
OR Procedure Code (CPT - see ECR)
AND Written description for DX code above (2b)

3. EMPLOYER INSTRUCTIONS Recommended Impact on Work:

a. RETURN TO WORK TODAY — Patient can return to work today, without restrictions

b. OFF WORK (Homebound) Example → 021 — Patient completely unable to work (Homebound) for a period of ___ Calendar Day(s) STARTING WITH Month / Day / Year 200_

c. ACTIVITY RESTRICTIONS Example → 010 — Patient can return to work with restriction(s) as noted in Section 4 for a period of NA Calendar Day(s) STARTING AFTER OR WITH Month 11 Day 12 Year 2007

d. PERMANENT CONDITION — Patient has reached maximum medical improvement. Restriction(s) listed are permanent. / Patient is permanently, totally disabled. (ie: anticipate he/she will never return to any work.)

4. Restrictions

Climbing, Driving, Hand Motion L R, ... L R, Sitting, Standing, Walking ...

Cannot Perform / MAX: Minutes Per Hour / MAX: Hours Per 8 hr. Shift

FOLLOW-UP PLAN:
TX Duration ____ wk(s)
Next Visit ___/___/___
Therapy ___ visits/wk ___ wk(s)

Comments (List assistive devices): Pt cannot drive because of right foot fractures

5. Clinician Resource Code

Example → J10D0E

DGEHM

Date Signed: Month 11 Day 12 Year 2007

Circle affiliated Medical Center Area

Clinician Name (print): [illegible]
Clinician Signature: [illegible]

CHART COPY

PODIATRY

8083

DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or OME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(f))

Case Name: FLOREEN ROOKS (employee name) v. D' VEAL FAMILY AND YOUTH SERVICES (claims administrator name, or if none employer)

Claim No.: 05124168 AND 05170360

EAMS or WCAB Case No. (if any): _____

I, ANA J. VITERI (Print Name), declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: 4940 Van Nuys Blvd #302, Sherman Oaks CA 91403
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:
B	-04-15-11-	STATE COMPENSATION INSURANCE FUND P.O. BOX 92622 LOS ANGELES, CA 90009
B	-04-15-11-	FLOREEN. ROOKS 1315 S. GLADYS AVE. SAN GABRIEL, CA 91776

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 04-15-2011

Ana Viteri (signature of declarant)

ANA J. VITERI (print name)

STATE COMPENSATION INSURANCE FUND

HEALTH CONSULTANT UTILIZATION REVIEW ASSESSMENT

Date: 10/22/2010

To: Dr Tomas Saucedo
Phone: 626-289-0178
Fax: 626-308-2083

Injured Employee Name: ROOKS, Floreen
Claim Number: 05170360
Tracking #: E000004811507
DOI: 11/10/2007 **DOB:** 06/20/1949

Treatment Request: Prospective: Omeprazole 20mg #30
Source Document: E-mail from Express Scripts with 10/11/10 date of service & received by SCIF adjuster on 10/12/10. Prescription written by Dr Tomas Saucedo.

Accepted Body Part(s): right foot & left knee

Clinical Summary:
This is a 61 year old female marriage & family therapist who while working for D' Veal Family Youth Services reported a work comp injury. Hire date with company listed as 01/01/2005.

11/20/2007: Drs First report, Dr Michael Hadley, Healthcare Partners, El Monte:
Injury: file notes patient was getting into her car to stop it from rolling when she slipped on the ground & fell. She hit her left knee & left ankle & twisted her right foot.
She went to Kaiser for initial treatment & was told she had fracture of right foot, sprain to left ankle & bruise to left knee.
Xrays- fracture of right foot involving the 4th & 5th metatarsals with angulation present in the 4th metatarsal head. Xray of left ankle reveals presence of hardware but no acute findings (prior surgery/healed scar). Xray left knee unremarkable except for degenerative changes.

04/24/2008 left knee arthroscopy, Dr Saucedo-partial medial & partial lateral meniscectomy with an abrasive chondroplasty of the patellofemoral groove, medial femoral condyle, medial tibial plateau.

9/4/2009: Dr Saucedo,
Patient last seen 12/5/08 & was considered permanent & stationary. This past week she was getting out of a friends car when she apparently twisted her left knee causing pain & discomfort.
She felt she needed to be re-examined as she might have re-injured her left knee.
She is 5 feet 6 inches tall & weighs 213 lbs.
Impression: left knee re-injury & left knee evidence of mild degenerative osteoarthritis.
Patient started on Motrin for pain & inflammation.

10/5/2010- adjuster authorized re-evaluation with Dr Saucedo with confirmed appt set for 10/11/10.

Work status: unknown- none stated on 9/4/09 Dr Saucedo report.
Work restrictions provided: no [x]
ECF lists patient work status as: is employee still off work? - YES

Contact with requesting Provider:
Date: 10/22/2010 Time: 11:34 a.m. Results: The reviewer spoke with Dr. Saucedo and a peer-to-peer case discussion ensued. The determination was provided.

Analysis:
The injured worker is a 61 year-old female, who was employed as a marriage and family therapist, when she sustained an industrial injury on 11/10/2007, when she was getting into her car to stop it from rolling and she slipped on the ground & fell. She has been diagnosed with the following: 1. Left knee re-injury. 2. Mild degenerative osteoarthritis, left knee. The injured worker has been treated with Motrin. Omeprazole is a proton-pump inhibitor (PPI), and is indicated for the following: maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers, the treatment of pathological hypersecretory conditions (e.g., Zollinger-Ellison syndrome and systemic mastocytosis, the short-term treatment of active, benign gastric ulcer, maintenance therapy for gastric ulcer patients at reduced dosage after healing of acute ulcers, treatment of GERD, Erosive esophagitis, and/or for maintenance of healing of erosive esophagitis. The data submitted for review failed to document any of the stated indications for omeprazole. However, the **CA Medical Treatment Utilization Schedule (MTUS),** Chronic Pain Medical Treatment Guidelines, (page 68), regarding NSAIDs, GI symptoms & cardiovascular risk, set out the following risk factors for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that *H. Pylori* does not act synergistically with NSAIDS to develop gastroduodenal lesions. During the case discussion, Dr. Saucedo indicated that the injured worker has a prior history of gastritis and has been unable to tolerate any NSAIDs without either a PPI or an H-2 receptor antagonist. Based upon that information, this injured worker clearly has a risk factor for a gastrointestinal event. Therefore, the intervention in question meets evidence-based criteria for medical necessity.

Decision:
Authorize: Omeprazole 20 mg. #30.

Supporting references:

The CA Medical Treatment Utilization Schedule (MTUS) includes:
Chronic Pain Medical Treatment Guidelines/MTUS/Effective 7/18/09:
Pages 68-69:
NSAIDs, GI symptoms & cardiovascular risk

Recommend with precautions as indicated below.
Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. *Determine if the patient is at risk for gastrointestinal events:* (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant;

or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that *H. Pylori* does not act synergistically with NSAIDS to develop gastroduodenal lesions.

Recommendations

Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.)

Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44).

Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary.

Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)

Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia.

Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxyn plus low-dose aspirin plus a PPI.

Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. Cardiovascular risk does appear to extend to all non-aspirin NSAIDs, with the highest risk found for the Cox-2 agents. (Johnsen, 2005) (Lanas, 2006) (Antman, 2007) (Laine, 2007)

Use with Aspirin for cardioprotective effect:

In terms of GI protective effect: The GI protective effect of Cox-2 agents is diminished in patients taking low-dose aspirin and a PPI may be required for those patients with GI risk factors. (Laine, 2007)

In terms of the actual cardioprotective effect of aspirin: Traditional NSAIDs (both ibuprofen and naproxen) appear to attenuate the antiplatlet effect of enteric-coated aspirin and should be taken 30 minutes after ASA or 8 hours before. (Antman, 2007) Cox-2 NSAIDs and diclofenac (a traditional NSAID) do not decrease anti-platelet effect. (Laine, 2007)

Use of NSAIDs and SSRIs: The concurrent use of SSRIs and NSAIDs is associated with moderate excess relative risk of serious upper GI events when compared to NSAIDs alone. This risk was higher for non-selective NSAIDs when compared to Cox-2 selective agents (adjusted odds ratio of 1.77 and 1.33, respectively). (Helin-Salmivaara, 2007)

Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI.

Harry Eisenbach, M.D.
Name

Harry Eisenbach, M.D. 10/22/2010
Signature Date

UR Medical Consultant
Title

California M.D. License on file (818)662-4829
License No. Telephone

Occupational Medicine	Friday 8:30 AM – 5:00 PM
Specialty	Hours

EK Health Services, Inc. Independently Contracted Utilization Review Physician

COMPPARTNERS

Provider Notification Letter

Request for Auth #:0197512
Date: July 22, 2008

Prescribing physician: THOMAS SAUCEDO, M.D>
Fax number: 310-792-1207
Client: SCIF-CA UR (GLENDALE)
Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Medical Provider:

The 07/11/08 request for medical treatment for Floreen Rooks was received on 7/14/2008 and a decision was made on 7/18/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: **physical therapy, 2 times a week for 4 weeks for the left knee.**

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

- Nurse attempted to contact your office on 07/17/08
  A request for information letter was ☐ sent to you on N/A
- The physician reviewer attempted to contact you on 07/18/08 and the attempt was successful ☐ or not successful ☒

Our Physician Reviewer, Ronald Axtell, MD, has modified the request for authorization and the decision(s) is/are: **physical therapy six sessions over four weeks for the left knee.**
Attached is our Physician Reviewer's explanation of the reason(s) for the modification, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

Disclaimer: Denial or non-certification for all or part of the requested intervention is in no way intended to absolve the provider from his or her duty to adhere to any applicable practice standards. Medical necessity determinations are based on available

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Provider Notification Letter

Request for Auth #:0197512
Date: July 22, 2008

Prescribing physician: THOMAS SAUCEDO, M.D>
Fax number: 310-792-1207
Client: SCIF-CA UR (GLENDALE)
Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Medical Provider:

The 07/11/08 request for medical treatment for Floreen Rooks was received on 7/14/2008 and a decision was made on 7/18/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: **physical therapy, 2 times a week for 4 weeks for the left knee.**

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

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- A request for information letter was ☐ sent to you on N/A
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Physician Review Recommendation
Prepared for SCIF - Glendale

Patient Name:	Rooks, Floreen	**Claim/Policy #:**	05170360
CompPartners Case:	SC080718001	**DOI:**	11/10/07
Requester:	J. Moosmann	**Request #:**	0197512
Adjuster:	Y. Nielsen	**Case#:**	08000064020
State:	CA	**Date Referred:**	7/18/08
Review:	Expedited	**Date Completed:**	7/18/08

****

Reason for Referral: Determine the medical necessity for:
1. Request #0197512 – Physical therapy (PT) 2 times a week for 4 weeks for the left knee.

Recommendation: MODIFIED:
1. Request #0197512 - PT six sessions over four weeks for the left knee.

This recommendation is based on medical necessity; it does not guarantee payment or acceptance of additional body parts or injuries into this claim.

Guideline/Reference Used: Official Disability Guidelines, Treatment Index, 6th Edition (Web), 2008, Knee – Physical Therapy – Outlier Status.

Rationale: This 59-year-old male was injured on November 10, 2007, when he fell while trying to get into a moving parked vehicle. He suffered a right 4th and 5th metatarsal fracture and a left knee medial meniscus tear. The patient had a left knee arthroscopy on April 24, 2008, which involved a partial medial and partial lateral meniscectomies and an abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral and lateral femoral plateau cartilage. This surgery is slightly more extensive than the typical arthroscopy for which the Official Disability Guidelines recommends "12 visits over 12 weeks" postsurgery. The patient has been afforded 16 sessions of physical therapy to date. The most recent physical therapy summary note was faxed to this reviewer. The patient from May to June increased the extension by 5 degrees and flexion by 25 degrees, and decreased his pain level on June 18th to 4-5/10. The most recent left knee motion was 0 degrees to 120 degrees with strength listed 4+/5 and pain listed as 2-3/10. The patient continued to show progress and was doing a home exercise program. This patient would be an outlier to the typical guidelines because of the extent of the surgery and the age of the patient. Therefore, the modified determination will be for six additional sessions over four weeks for the left knee to bring about a transition to a home exercise program by the end of treatment.

If non-certification is secondary to lack of sufficient information, what information, or test result would be required? *Peer-to-peer case discussion.*

Reviewed Data:
1. Nurse UM Summary dated 7/17/08.
2. Fax Cover Sheet/Authorization Request dated 7/18/08, 7/11/08.
3. Progress Flow Sheet dated 7/16/08, 6/18/08, 5/22/08.
4. Progress Report dated 7/16/08, 6/18/0/8.
5. Therapy dated 7/11/08.
6. CompPartners Peer Reviewer Final Report dated 6/26/08.
7. Supplemental Summary Report dated 6/11/08.

JANET PATTERSON
JUL 22 2008
LA D.O. GLENDALE LOC.

8. Orthopedic Supplemental Report dated 6/6/08.
9. Operative Report dated 4/24/08.
10. Follow-Up dated 4/23/08

Requesting Provider/Telephone #: Tomas Saucedo, M.D./626-289-0178

Provider or Designee Contact: No **Appeal/reconsideration/disclaimer given:** Yes

Date/Time: 07/18/08 / 9:35 am PT **Name:** Angie G.
Content of Discussion: The doctor was seeing the patient. The nature of the call, a callback number, and the proposed modification were given.

Date/Time: 07/18/08 / 10:00 am PT **Name:** Angie G.
Content of Discussion: Dr. Saucedo agreed that the 6 sessions were reasonable.

Attestation of lack of conflict of interest: Yes.
This reviewer declares, under penalty of perjury, that the information contained in this report and its attachment, 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, this report accurately describes the information provided to me.

Peer Reviewer Name: Ronald Axtell, MD
Specialty: Family Medicine
Board Certified: Family Medicine effective through 12/31/2010
State/License #: CA A25374

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Provider Notification Letter

Request for Auth #:0197512
Date: July 22, 2008

Prescribing physician: THOMAS SAUCEDO, M.D>
Fax number: 310-792-1207
Client: SCIF-CA UR (GLENDALE)
Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Medical Provider:

The 07/11/08 request for medical treatment for Floreen Rooks was received on 7/14/2008 and a decision was made on 7/18/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: **physical therapy, 2 times a week for 4 weeks for the left knee.**

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

- Nurse attempted to contact your office on 07/17/08
- A request for information letter was ☐ sent to you on N/A
- The physician reviewer attempted to contact you on 07/18/08 and the attempt was successful ☐ or not successful ☒

Our Physician Reviewer, Ronald Axtell, MD, has modified the request for authorization and the decision(s) is/are: **physical therapy six sessions over four weeks for the left knee.**
Attached is our Physician Reviewer's explanation of the reason(s) for the modification, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

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JUL 22 2008
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information. You are entitled to a voluntary secondary review if the following box is checked:☒

The request for a secondary review must be submitted by the requesting physician and should be prominently identified as a "UR Appeal" at the top of the page and include a copy of the specific UR decision which you are appealing. In order for an appeal to be considered for review, the requesting physician must outline his or her reason for the appeal citing sources from a nationally recognized, evidence based medical treatment guideline, and/or giving the clinical reasons this specific patient's medical condition warrants care that falls outside of the ACOEM or other evidence based guidelines cited by this reviewer. Appeals received from parties other than the requesting physician, or appeals without such substantial supporting information, will not be considered.

To appeal this medical decision, the requesting physician submit in writing to the assigned Utilization Review Nurse on this claim by mail or fax @ (866) 724-3738 within 10 days. The appeal will be reviewed in accordance with State Fund's internal Utilization Review Appeals process. Participation in this process is entirely on a voluntary basis. If you wish to speak to the Physician Reviewer directly, please contact (949) 253-3111 between the hours of 8am-5pm PST so we may facilitate contact with the Physician Reviewer.

The payment decision for the proposed treatment will be made by the insurer or third party administrator, whichever is applicable.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely,

Judith Moosmann, RN/Utilization Review Nurse

JM,RN/eh

PHONE # (949) 253-3111 Ext 2846

Enc: Physician Peer Review Report
Request for Information Letter (if applicable)

cc: Yolanda Nielsen, Claims Examiner
Floreen Rooks; 1315 S. Gladys Ave. ; San Gabriel, CA 91776-3623

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SCIF RECD DTE 07/23/2008 BKSCAN 5 07/23/2008 03:50 PM 030330 13 5

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09/10/50 8/8 601 1000000000 3240722 20

NOTICE TO INJURED EMPLOYEE

All utilization review disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may receive recorded information by calling 1-800-736-7401 or you may contact the local state Information and Assistance office. A list of the local office numbers are provided below.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

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I&A Office	Phone Numbers
Anaheim	(714) 738-4038
Bakersfield	(661) 395-2514
Eureka	(707) 441-5723
Fresno	(559) 445-5355
Grover Beach	(805) 481-3296
Goleta	(805) 968-4158
Long Beach	(562) 590-5240
Los Angeles	(213) 576-7389
Oakland	(510) 622-2861
Oxnard	(805) 485-3528
Pomona	(909) 623-8568
Redding	(530) 225-2047
Riverside	(951) 782-4347
Sacramento	(916) 263-2741
Salinas	(831) 443-3058
San Bernardino	(909) 383-4522
San Diego	(619) 767-2082
San Francisco	(415) 703-5020
San Jose	(408) 277-1292
Santa Ana	(714) 558-4597
Santa Monica	(310) 452-1188
Santa Rosa	(707) 576-2452
Stockton	(209) 948-7980
Van Nuys	(818) 901-5367

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SCAN AS ONE DOCUMENT

July 15, 2008

Comppartners Inc
18881 Von Karman Avenue
Ste. 900
Irvine CA 92612

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear CompPartners

Requested Procedure: PT 2 x 4 to Lt knee

Source Document and Location: PTP Dr. Saucedo's PT Rx dated 7-11-08 received by scif UR Faxline on 7-14-08. Rx to be faxed to CP via manual fax.

Due Date: Target due by 7-21-08

Location of additional documents: Addt'l meds to be faxed to CP on ECF.

Sincerely

Paul Liang
Paul Liang
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

Enc: Utilization Review Referral Form
Associated Sport Therapy of 06/18/2008
Thomas Saucedo, M.D. of 06/06/2008
Thomas Saucedo, M.D. of 04/24/2008
Thomas Saucedo, M.D. of 04/23/2008
Thomas Saucedo, M.D. of 04/17/2008
Michael Vo, M.D. of 03/20/2008
Thomas Saucedo, M.D. of 03/20/2008
Mri Of Left Knee of 03/19/2008
Michael Vo, M.D. of 02/21/2008
Thomas Saucedo, M.D. of 02/21/2008
Thomas Saucedo, M.D. of 02/21/2008
Michael Vo, M.D. of 01/17/2008
Thomas Saucedo, M.D. of 01/17/2008
Michael Vo, M.D. of 12/20/2007
Thomas Saucedo, M.D. of 12/20/2007
Thomas Saucedo, M.D. of 12/20/2007
Michael Hadley, M.D. of 11/20/2007
Michael Vo, M.D. of 11/20/2007

Back | Transmit

#05170360
LD Yolanda Nelsen
Unit 5 Rowena Marcelo

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BLVD STE 203
MONTERAPARK, CA 91754
OFFICE (626) 282-3577 FAX (826) 284-4276

FAX COVER SHEET

SCAN AS ONE DOCUMENT

DATE: JUL 11 2008

ATTN: Yolanda Nelson

INS: State Comp

FAX: (818) 291-7115

RE: Rook, Floren

CLAIM #: 80283 **DOI:** 11 10 07

MESSAGE: ***AUTHORIZATION REQUEST FOR PHYSICAL THERAPY***

Please review request for Physical Therapy 2X4 for Lt knee.

Thank you,

ENCLOSED, FOR YOUR REVIEW:

- ✓ PRESCRIPTION: (DATED) JUL 11 2008
- ✓ EVAL/REPORT;PROGRESS NOTE;RE-EVAL:(DATED) _____
- ✓ WORK STATUS SHEET: _____
- ✓ DOCTORS SUPPLEMENTAL REPORT: _____

FROM: Sonia De La Torre

NUMBER OF PAGES 6
(INCLUDING COVER SHEET)

MYRA GUEVARA
JUL 14 2008
LOS ANGELES CLAIMS

COMPPARTNERS

Provider Notification Letter

Request for Auth #:0195096
Date: June 28, 2008

SCAN AS ONE DOCUMENT

Prescribing physician: Tomas Saucedo, MD
Fax number: 626-582-7953
Claim Number: 05170360
Employee: Floreen Rooks
Date of injury: 11/10/2007

Dear Medical Provider:

The 06/06/2008 request for medical treatment for Floreen Rooks was received on 6/19/2008 and a decision was made on 6/25/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: Physical Therapy, 3 times per week for 4 weeks for the left knee.

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

Nurse attempted to contact your office on 06/25/2008
A request for information letter was ☐ sent to you on N/A and a copy is attached
The physician reviewer attempted to contact you on 06/25/2008 and the attempt was successful ☒ or not successful ☐

Our Physician Reviewer, John R. Coon, MD, has modified the request for authorization and the decision(s) is/are: Physical Therapy, 4 sessions for the left knee. Attached is our Physician Reviewer's explanation of the reason(s) for the modification, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

Disclaimer: Denial or non-certification for all or part of the requested intervention is in no way intended to absolve the provider from his or her duty to adhere to any applicable practice standards. Medical necessity determinations are based on available information. You are entitled to a voluntary secondary review if the following box is checked:☒

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specific patient's medical condition warrants care that falls outside of the ACOEM or other evidence based guidelines cited by this reviewer. Appeals received from parties other than the requesting physician, or appeals without such substantial supporting information, will not be considered.

To appeal this medical decision, the requesting physician submit in writing to the assigned Utilization Review Nurse on this claim by mail or fax @ 951-244-1708 within 10 days. The appeal will be reviewed in accordance with State Fund's internal Utilization Review Appeals process. Participation in this process is entirely on a voluntary basis. If you wish to speak to the Physician Reviewer directly, please contact 951-244-0403 between the hours of 8am-5pm PST so we may facilitate contact with the Physician Reviewer.

The payment decision for the proposed treatment will be made by the insurer or third party administrator, whichever is applicable.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely,

Michele Forslund, RN

Utilization Review Nurse
Phone: 951-244-0403
Completed by: Erlita Oliver - Assistant

Enc: Physician Peer Review Report
Request for Information Letter (if applicable)

cc: Yolanda Nielsen, Claims Examiner
Floreen Rooks; 1315 S. Gladys Ave. ; San Gabriel, CA 91776-3623
Sports Therapy Associates Inc; 1545 Bayshore Hwy ; Burlingame, CA 94010

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If you want further information, you may receive recorded information by calling 1-800-736-7401 or you may contact the local state Information and Assistance office. A list of the local office numbers are provided below.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

I&A Office	Phone Numbers
Anaheim	(714) 738-4038
Bakersfield	(661) 395-2514
Eureka	(707) 441-5723
Fresno	(559) 445-5355
Grover Beach	(805) 481-3296
Goleta	(805) 968-4158
Long Beach	(562) 590-5240
Los Angeles	(213) 576-7389
Oakland	(510) 622-2861
Oxnard	(805) 485-3528
Pomona	(909) 623-8568
Redding	(530) 225-2047
Riverside	(951) 782-4347
Sacramento	(916) 263-2741
Salinas	(831) 443-3058
San Bernardino	(909) 383-4522
San Diego	(619) 767-2082
San Francisco	(415) 703-5020
San Jose	(408) 277-1292
Santa Ana	(714) 558-4597
Santa Monica	(310) 452-1188
Santa Rosa	(707) 576-2452
Stockton	(209) 948-7980
Van Nuys	(818) 901-5367

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E-MAIL: MAIL@COMPPARTNERS.COM TOLL FREE 1-877-YOURHCO

COMPPARTNERS

ACCREDITED
INDEPENDENT REVIEW
ORGANIZATION

Physician Revlaw Recommendation
Prepared for SCIF - Glendala

Patient Name:	Rooks, Floreen	**Claim/Policy #:**	05170360
CompPartners Case:	SC080625015	**DOI:**	11/10/07
Requester:	M. Forslund	**Request #:**	195096
Adjuster:	Y. Nielsen	**Case #:**	08000064020
State:	CA	**Date Referred:**	6/25/08
Review:	Expedited	**Date Completed:**	6/26/08

****

Reason for Referral: Determine the medical necessity for:
Request # 195096: PT 3x4 left knee.

Recommendation:
Request # 195096: **MODIFIED** - Physical therapy four sessions for the left knee.

Gnideline/Reference Used: 1. ACOEM Guidelines do not apply. 2. Official Disability Guidelines, Treatment Index, 6th Edition, 2008 Knee - Physical Therapy.

This 59-year-old female sustained an industrial injury on November 10, 2007, when she fell while trying to get into a moving vehicle. The claimant's diagnosis is status post fourth and fifth metatarsal fractures and status post left knee arthroscopy on April 24, 2008. Provided for review was an operative report dated April 24, 2008, with a preoperative diagnosis of left knee internal derangement. The procedure performed was a left knee diagnostic and surgical arthroscopy to include partial medial and lateral meniscectomies, abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral, and tibial plateau cartilage. The most current evaluation provided for review was a PR-2 conducted by the requesting physician, Tomas Saucedo, M.D., dated June 6, 2008. At that time the claimant was noted to be six weeks post arthroscopic knee surgery and was demonstrating improvement and had been attending physical therapy for the previous four weeks. The left knee examination noted diffuse mild tenderness with swelling and well healed surgical arthroscopic portals. Range of motion of the left knee was noted to be 0-100 degrees. Treatment recommendations were for continuation of an aggressive physical therapy program three times a week for four additional weeks as well as an aggressive home exercise program. As per the nurse UM summary, the claimant has received 12 sessions of physical therapy with the current request for 12 additional sessions. Following meniscal surgeries the Official Disability Guidelines support 12 visits of physical therapy over 12 weeks. In a lengthy case discussion with Dr. Saucedo, it was noted that this claimant had very complex tears of both the medial and lateral menisci and her recovery was delayed due to the complexity of the underlying pathology. In agreement with Dr. Saucedo there will be a modification for four additional sessions of physical therapy following which the claimant should be able to continue and complete her rehabilitation through an independent home exercise program.

If non-certification is secondary to lack of sufficient information, what information or test result would be required? Not applicable.

Reviewed Data:
1. Nurse UM Summary dated 6/25/08.
2. Physical Therapy Progress Report dated 6/18/08.
3. Orthopedic Supplemental Report/Letter dated 6/6/08, 4/17/08, 2/21/08.
4. Prescription Treatment dated 6/6/08.
5. Orthopedic Supplement Summary Report dated 6/6/08.

6. Operative Report dated 4/24/08.
7. Right Foot X-ray dated 3/20/08.
8. Orthopedic Re-Examination Letter dated 3/20/08.
9. Left Knee MRI dated 3/19/08.

Requesting Provider/Telephone #: Tomas Saucedo, M.D./626-289-0178

Provider or Designee Contact: Yes **Appeal/reconsideration/disclaimer given:** Yes

Date/Time: 06/25/08 11:15am PT **Name:** Angie G.

Content of Discussion: A case discussion ensued with Dr. Saucedo and the determination was provided and agreed upon.

Attestation of lack of conflict of interest: Yes.
This reviewer declares, under penalty of perjury, that the information contained in this report and its attachment, 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, this report accurately describes the information provided to me.

Peer Reviewer Name: John R. Coon, MD
Specialty: General Practice
State/License #: CA A25456

REVIEW DETERMINATION

April 15, 2008

Healthcare Partners Medical Group
3144 Santa Maria Avenue
El Monte, CA 91733-1316

REVIEW DATE: 4/15/2008

EMPLOYEE:	Florsen Rooks
CLAIM#:	05170360
REFERENCE#:	08000094192
DOI:	11/10/2007

LOCATION:	Outpatient
REVIEW TYPE:	Prospective
SERVICE TYPE:	Surgical Procedure
District Office:	Glendale District Office

A Physician Advisor has reviewed this request and made the recommendation(s) listed on the attached "Physician Advisor Review".

SERVICE(S)	*PROCEDURE DESCRIPTION*	*FROM*	*TO*	*QTY*
Requested:	Polar Unit/Cold Therapy Unit Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee			1 unit 1 unit 1 unit
Certified:	Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee	4/15/2008	6/15/2008	1 unit 1 unit
Not Certified:	Polar Unit/Cold Therapy Unit	4/15/2008		1 unit

Physician Advisor: Thomas Grogan, MD
Ph#: (310) 828-5441

Specialty: 450 - ORTHOPEDIC SURGERY
Hours: 8:00-4:30 M-F

The Administrative Director of the State of California Division of Workers' Compensation has adopted regulations setting forth utilization review (UR) standards applicable to workers' compensation insurers and self-insured employers. Insurers and self-insured employers may engage in a case-by-case review of the medical treatment provided injured employees in order to improve care and manage costs. BC Life and Health Insurance Company ("BC Life" is an affiliate of Blue Cross of California, "BCC") has been selected by **State Compensation Insurance Fund** to administer these UR services. Further, if you are a BCC Prudent Buyer or Workers' Compensation Network Provider, you are subject to the terms of your Participating Provider Agreement.

BC Life used the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines in reaching this decision. Additional guidelines may include the McKesson Care Enhanced Review Manager Guidelines, as well as Blue Cross of California Medical Policy. A copy of the relevant portion of the criteria applied in this case is attached for your reference.

Per California Labor Code 139.3, "it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion

COMPPARTNERS

Provider Certification Letter

Date: May 19, 2008
Auth Number:
0191182

Prescribing Physician: Thomas Saucedo MD
Fax number: 626-582-7953

Claim Number: 05170360
Employee: Floreen Rooks
Client: SCIF-CA UR (GLENDALE)
Date of Injury: 11/10/2007

Dear Medical Provider:

The 5/9/08 request for medical treatment for Floreen Rooks was received on 5/14/08 and a decision was made on 5/19/08. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program:

Your request for (PT 3x4 left knee) is certified.

Approved facility: Insurer to determine
Units: 12
Dates of Service: 5/19/2008 to 7/18/2008

This notification does not guarantee acceptance of causality or compensability nor does it guarantee payment which remains the responsibility of the insurer.

If you need to discuss this certification please call me at the following telephone number: 951-244-0403
This certification is valid for 60 days from the date of this notice.
Sincerely,
Michele Forslund, RN / Utilization Review Nurse

cc: Claims Adjuster - Yolanda Nielsen

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REVIEW DETERMINATION

April 15, 2008

Healthcare Partners Medical Group
3144 Santa Maria Avenue
El Monte, CA 91733-1316

REVIEW DATE: 4/15/2008

EMPLOYEE:	Floreen Rooks
CLAIM#:	05170360
REFERENCE#:	08000094192
DOI:	11/10/2007

LOCATION:	Outpatient
REVIEW TYPE:	Prospective
SERVICE TYPE:	Surgical Procedure
District Office:	Glendale District Office

A Physician Advisor has reviewed this request and made the recommendation(s) listed on the attached "Physician Adviser Review".

SERVICE(S)	*PROCEDURE DESCRIPTION*	*FROM*	*TO*	*QTY*
Requested:	Polar Unit/Cold Therapy Unit Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee			1 unit 1 unit 1 unit
Certified:	Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee	4/15/2008	6/15/2008	1 unit 1 unit
Not Certified:	Polar Unit/Cold Therapy Unit	4/15/2008		1 unit

Physician Advisor: Thomas Grogan, MD
Ph#: (310) 828-5441

Specialty: 450 - ORTHOPEDIC SURGERY
Hours: 8:00-4:30 M-F

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Per California Labor Code 139.3, "it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion

BC Life & Health Insurance Company

REVIEW DETERMINATION

April 15, 2008

Healthcare Partners Medical Group
3144 Santa Maria Avenue
El Monte, CA 91733-1316

REVIEW DATE: 4/15/2008

EMPLOYEE:	Floreen Rooks
CLAIM#:	05170360
REFERENCE#:	08000094192
DOI:	11/10/2007

LOCATION:	Outpatient
REVIEW TYPE:	Prospective
SERVICE TYPE:	Surgical Procedure
District Office:	Glendale District Office

A Physician Advisor has reviewed this request and made the recommendation(s) listed on the attached "Physician Advisor Review".

SERVICE(S)	*PROCEDURE DESCRIPTION*	*FROM*	*TO*	*QTY*
Requested:	Polar Unit/Cold Therapy Unit Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee			1 unit 1 unit 1 unit
Certified:	Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee	4/15/2008	6/15/2008	1 unit 1 unit
Not Certified:	Polar Unit/Cold Therapy Unit	4/15/2008		1 unit

Physician Advisor: Thomas Grogan, MD
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therapy, outpatient surgery or diagnostic imaging goods or services whether for treatment or medical legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral." The prohibition shall not apply to an outpatient surgical center where the referring physician obtains a service preauthorization from the insurer or self-insured employer after disclosure of the financial relationship.

Per California Labor Code 4604.5, for injuries occurring on or after January 1, 2004, an injured worker shall be entitled to no more than 24 chiropractic and 24 physical therapy and 24 occupational therapy visits per industrial injury. This letter is not to be misconstrued as the written authorization from the insurance carrier for additional services beyond the 24 visits.

This certification is valid for 60 days. Extension or changes in the treatment plan will require additional certifications. This certification is based on the information provided, and is of medical necessity only and is not a guarantee that payment will be made. Payments are based on the employee's injury being accepted as a compensable claim. Payment could also be limited for a number of other reasons (For example: if the information submitted with your claim differs from that given by phone, or if the employer or Workers' Compensation Carrier determines that the condition is not payable.)

If this Injured Worker is in a Medical Provider Network (MPN), medical treatment for the Injured Worker may be required to be provided by a MPN provider. For further information, you may contact the Division of Workers' Compensation website at www.ca.gov, or the claims administrator.

PROVIDER APPEALS

You may telephone the undersigned within ten (10) business days to initiate an expedited appeal; or you may submit within thirty (30) days a letter in writing requesting a standard appeal and submit pertinent clinical information in support of your request, which will be reviewed by another Physician Advisor.

All correspondence regarding this certification should be addressed to the attention of the Nurse Case Manager listed below.

Pebbles Draper, RN
Nurse Case Manager
(866) 459-0723

OFFICE HOURS: MON-FRI 8:00-5:30

CC:
Yolanda Nielsen, CE (electronically)
URC, (electronically)

Attachments
Physician Advisor Review
Criteria: BC Policy # MED.00066

BC Life & Health Insurance Company

REVIEW DETERMINATION

April 15, 2008

Floreen Rooks
1315 S Gladys Avenue
San Gabriel, CA 91776

REVIEW DATE: 4/15/2008

EMPLOYEE:	Floreen Rooks
CLAIM#:	05170360
REFERENCE#:	08000094192
DOI:	11/10/2007

LOCATION:	Outpatient
REVIEW TYPE:	Prospective
SERVICE TYPE:	Surgical Procedure
District Office:	Glendale District Office

A Physician advisor has reviewed this request and made the recommendation(s) listed on the attached "Physician Advisor Review"

SERVICE(S)	*PROCEDURE DESCRIPTION*	*FROM*	*TO*	*QTY*
Requested:	Polar Unit/Cold Therapy Unit Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee			1 unit 1 unit 1 unit
Certified:	Crutches 29877 - ARTHROSCOPY, KNEE, CHONDROPLASTY Left Knee 29881 - ARTHROSCOPY, MENISCECTOMY Left Knee	4/15/2008	6/15/2008	1 unit 1 unit
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PROVIDER APPEALS INFORMATION

The provider may telephone the undersigned within ten (10) business days to initiate an expedited appeal, or may submit within thirty (30) days a letter in writing requesting a standard appeal and submit pertinent clinical information in support of the request, which will be reviewed by another Physician Advisor.

INJURED WORKER INFORMATION

Any dispute with this determination shall be resolved in accordance with the provisions of Labor Code 4062. **If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of the utilization review decision in accordance with Labor Code 4062.** You must meet this deadline even if you are participating in the claims administrator's internal review appeal process. The 20-day time limit may be extended for good cause or by mutual agreement of the parties.

You may also file an Application for Adjudication of Claims and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408.

If you want further information, you may contact the local state Information and Assistance office by calling the Information and Assistance office closest to you. (See below), or you may receive recorded information by calling 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fees will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Pebbles Draper, RN
Medical Manager Lead
(866) 459-0723

OFFICE HOURS: MON-FRI 8:00-5:30

Attachments
Physician Advisor Review
Criteria: BC Policy # MED.00066

INFORMATION & ASSISTANCE UNIT – DISTRICT OFFICES

Anaheim 92801-1162 1661 N. Raymond Avenue Room 202 (714) 738-4000	Riverside 92501-3337 3737 Main Street Suite 300 (951) 782-4269	Santa Ana 92701-4033 28 Civic Center Plaza Suite 451 (714) 558-4121
Bakersfield 93301-1929 1800 30th Street Suite 100 (661) 395-2723	Sacramento 95825-2403 2424 Arden Way Suite 230 (916) 263-2735	San Jose 95113 100 Paseo de San Antonio Room 241 (408) 277-1246
Eureka 95501-0481 100 "H" Street Suite 202 (707) 445-6518	Salinas 93906-2204 1880 North Main Street Suite 100 & 200 (831) 443-3060	Santa Rosa 95404-4771 50 "D" Street Suite 420 (707) 576-2391
Fresno 93721-2280 2550 Mariposa Street Suite 4078 (559) 445-5051	Pomona 91768-2653 732 Corporate Center Drive (909) 623-4301	Stockton 95202-2314 31 East Channel Street Room 344 (209) 948-7759
Goleta 93117-5551 6755 Hollister Avenue Suite 100 (805) 968-0258	Redding 96001-2740 2115 Civic Center Drive Suite 15 (530) 225-2845	Van Nuys 91401-3370 6150 Vao Nuys Blvd. Suite 105 (818) 901-5367 x3501
Grover Beach 93433-2261 1562 W. Grand Avenne (805) 481-4912	San Bernardino 92401-1411 464 W. Fourth Street Suite 239 (909) 383-4341	San Diego 92108-4424 7575 Metropolitan Drive Suite 202 (619) 767-2083
Long Beach 90802-4304 300 Oceangate Street Suite 200 (562) 590-5001	San Francisco 94102-7014 455 Golden Gate Avenue 2nd Floor (415) 703-5011	Oakland 94612-1402 1515 Clay Street, 6th floor (510) 622-2866
Los Angeles 90013-2329 320 W. 4th Street 9th floor (213) 576-7335	Marina del Rey 90292 4720 Lincoln Blvd 2nd Floor (310) 482-3820	Oxnard 93036-8293 220 E Gonzales Road Suite 100 (805) 485-3528

PHYSICIAN ADVISOR:	Thomas Grogan, MD
PATIENT:	Rooks, Florine
CLAIM NUMBER:	5170360
CASE NUMBER:	8000094192
DATE OF DICTATION:	04/14/08
NURSE:	Pebbles Draper, R.N.

REASON FOR REFERRAL: Evaluate the necessity of polar care unit following surgery.

SUMMARY OF REVIEW: I spoke to Jamie in the office of Dr. Tomas L. Saucedo at 626-588-1990. Dr. Saucedo will not be in the office until the 16th. I explained to Jamie that we do not approve the polar care unit and will recommend use of conventional cold application. She understands and will inform Dr. Saucedo.

SPECIFIC RECOMMENDATION: Do not approve the polar care unit per the MED policy 00066. Alternatively, the patient should be using conventional means of cold application.

Board Certification: Fellowship Trained Orthopedic
License Number: G46906

DISCLOSURE: 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. Further, I have not violated the provisions of Labor Code Section 139.3.

TG/smy/rmc D: 04/14/08 T: 04/15/08

[redacted]

Medical Policy

[redacted]

Subject: Cooling Devices in the Outpatient Setting

Policy #: MED.00066	**Current Effective Date:**	11/13/2006
Status: Reviewed	**Last Review Date:**	09/14/2006

[redacted]

Description/Scope

Continuous cooling devices can be broadly subdivided into those providing passive cold therapy and those providing active cold therapy using a mechanical device. The policy addresses both passive and active cooling devices.

Policy Statement

Not Medically Necessary:

The use of active or passive cooling devices is considered **not medically necessary** in the postoperative care of patients undergoing musculoskeletal surgery.

Investigational/Not Medically Necessary:

Other applications of passive cooling devices, including but not limited to their use for nonoperative musculoskeletal injuries, are considered **investigational/not medically necessary**.

The use of active cooling devices with additional pneumatic compression is considered **investigational/not medically necessary**, for all indications, including, but not limited to, the post operative care of patients.

Rationale

The standard postoperative treatment of musculoskeletal surgeries consists of icepacks and various types of compressive wraps. Therefore, to document the medical necessity of passive cooling devices, randomized controlled trials are required that demonstrate that passive cooling devices provide a greater likelihood of benefit compared to conventional ice packs when used in the outpatient setting. Both the ice packs and the passive cooling devices are essentially designed to provide cold therapy, with the primary difference being that water recirculation is more convenient with passive cooling devices. Therefore, to document a benefit beyond convenience, the trial design must control the number of exchanges of ice bags and episodes of water recirculation. In contrast, active cooling devices are designed to provide a steady low temperature, which might provide a unique benefit compared to the more variable temperature achieved with ice packs or passive cooling devices. Benefit is typically focused on pain control and swelling. The discussion below focuses only on randomized studies.

Passive Cooling Devices

Schroder and Passler compared the CryoCuff® device to traditional ice therapy in 44 inpatients that had undergone repair of the anterior cruciate ligament (ACL) (Schroder, 1994). Those receiving ice therapy received an ice bag three times per day postoperatively, while the CryoCuff group used the device. While those randomized to the CryoCuff group reported significant decreases in pain, swelling and analgesic use, it was not reported how frequently the cold water was recirculated in the device. Additionally, the inpatient setting is not relevant to this policy, particularly since in this German study, patients were hospitalized for 14 days. Whitelaw and colleagues reported on the results of a trial that randomized 102 patients undergoing knee arthroscopy in the outpatient setting to receive either a CryoCuff device or traditional ice therapy (Whitelaw, 1995). The number of exchanges of ice packs and water recirculation was not reported. There was no significant difference in average pain assessment, while those in the CryoCuff group reported decreased pain medication compared to the control group. Healy and colleagues reported that the CryoCuff device provided no benefit to pain control or swelling compared to ice packs in a randomized trial of 76 patients (105 knees) undergoing total knee arthroplasty (Healy, 1994). No data was provided on the number of ice pack exchanges, although the water was recirculated in the CryoCuff device every one

ECF

COMPPARTNERS

ACCREDITED
INDEPENDENT REVIEW
ORGANIZATION

Physician Review Recommendation
Prepared for SCIF - Glendale

Patient Name:	Rooks, Floreen	**Claim/Policy #:**	05170360
CompPartners Case:	SC080228015	**DOI:**	11/10/07
Requester:	J. Moosmann	**Request #**	0179808
Adjuster:	Y. Nielsen		
State:	CA	**Date Referred:**	2/28/08
Review:	Reconsideration	**Date Completed:**	2/29/08

****

Reason for Referral: Determine the medical necessity for:
Request #0179808 – MRI of the left knee.

Recommendation: CERTIFIED –
Request #0179808 – MRI of the left knee.

This recommendation is based on medical necessity; it does not guarantee payment or acceptance of additional body parts or injuries into this claim.

Guideline/Reference Used: American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition, Chapter 13, Page 348-350. "MRI indicated when:
1. Significant inability to bear weight or ambulate greater than 4-6 weeks.
2. Presence of locking or catching of the knee.
3. Objective evidence of ligamental injury on physical exam.'

Rationale: The patient is a 58-year-old female with the date of injury of November 10, 2007. The mechanism of injury was a fall on gravel, with a resultant fracture of the foot. The diagnoses were fractured fourth and fifth metatarsals, degenerative narrowing of the ankle mortise, and mild osteoarthritis of left knee. The patient was diagnosed with a sprain at the Kaiser Emergency Room. The patient was given a Cam Walker and a knee immobilizer for the left knee. The patient was seen on November 10, 2007, with the note not indicating the treating physician. The patient complaining of mild discomfort in left ankle, left knee, but there was significant right foot discomfort. The patient had a prior history of left ankle fracture that was treated operatively in 1992. On that date, physical examination noted impaired weight bearing secondary to pain and altered gait secondary to pain. The patient was ambulating with the aid of a Cam Walker. The left ankle noted an old healed surgical scar, trace tenderness, and edema acutely. The left knee noted valgus tenderness anteriorly with trace edema. Full flexion was noted but painful. The patient was to be referred to an orthopedic surgeon. Dr. Saucedo then noted a plan of treatment for this patient and on December 20, 2007, the fourth and fifth metatarsals fractures were noted to be healing in an overall good position. The patient was recommended to continue off work and was to continue using the CAM walker. A knee immobilizer was provided for the left knee, and the patient was to weight bear as tolerated with assistive devices. The January 17, 2008, report by Dr. Saucedo noted the patient complained of pain, especially in the left knee with swelling and effusion and difficulty squatting, kneeling, and climbing. The patient's physical examination noted tenderness to the dorsal aspect of the fourth and fifth metatarsals, minimal swelling was noted, motor and sensory function were intact. Left knee examination noted swelling and medial joint line tenderness. Range of motion was 0 to 110 degrees, with no evidence of pain and

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TELEPHONE: 949 253-3111 FACSIMILE: 949 253-4081
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discomfort, a positive McMurray, and a positive Apley's sign. He felt the fractures of the foot were healing quite well. The patient was to continue conservative measures with the Cam Walker for weeks. The patient was to return in four weeks. An MRI was felt to be indicated and was ordered. On February 21, 2008, a PR-2 by Dr. Saucedo indicated continued medial joint line tenderness with effusion, positive grind, Apley, and McMurray tests. The MRI was again recommended. The patient had greater than four to six weeks since the injury with ongoing positive physical findings of effusion, positive McMurray, positive Apley, and positive grind test, all indicative of a probable internal derangement. The patient had been treated with a knee immobilizer, and therefore, at this time, this reviewer does feel that in line with the ACOEM Guidelines, the patient does have objective findings of internal derangement, and the MRI is indicated since there was difficulty bearing weight at greater than four to six weeks.

If non-certification is secondary to lack of sufficient information, what information, or test result would be required? *See above rationale.*

Reviewed Data:

1. Nurse UM Summary dated 2/28/08.
2. Orthopedic Supplemental Report/Letter dated 2/21/08, 12/20/07, 1/17/08
3. CompPartners Peer Reviewer Final Report dated 2/11/08.
4. Right Foot X-Rays dated 1/17/08, 12/20/07, 11/20/07.
5. Referral Slip dated 1/17/08.
6. PR-1 dated 11/20/07.

Requesting Provider/Telephone #: Thomas Saucedo, M.D./626-582-7989

Provider or Designee Contact: No. **Appeal/reconsideratinn/disclaimer given:** Yes.

Time/Date: 2:44 p.m. CT/February 28, 2008 **Name:** Anna G.
Content of discussion: Anna G. indicated the physician was not available. The determination, disclaimer, and appeals were given.

Attestation of lack of conflict of interest: Yes.
This reviewer declares, under penalty of perjury, that the information contained in this report and its attachment, 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, this report accurately describes the information provided to me.

Peer Reviewer Name: Glenn Smith, DO
Specialty: Orthopedic Surgery
State/License #: OK 1667
TX E3458
CA 20A9245

CORPORATE OFFICE
18881 VON KARMAN AVENUE, SUITE 900, IRVINE, CA 92612
TELEPHONE: 949 253-3111 FACSIMILE: 949 253-4081

REVISED DATES

COMPPARTNERS

Provider Certification Letter(Reconsideration)

Date: March 03, 2008
Auth Number: 0179808

Prescribing Physician: SAUCEDO, TOMAS, MD
Fax number: 310-792-1207
Claim Number: 05170360
Employee: Floreen Rooks
Client: SCIF-CA UR (GLENDALE)
Date of Injury: 11/10/2007

Dear Medical Provider:

The 02/25/08 reconsideration request for medical treatment for Floreen Rooks was received on 2/25/2008and a decision was made on 2/29/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program:

Your reconsideration request for an MRI of the left knee, is CERTIFIED, by Peer Reviewer Glenn Smith, DO.

Approved facility: Insurer To Determine
Units: 1
Dates of Service: 2/25/2008 to 4/25/2008

This notification does not guarantee acceptance of causality or compensability nor does it guarantee payment which remains the responsibility of the insurer.

If you need to discuss this certification please call me at the following telephone number: (949) 253-3111 Ext 2846

This certification is valid for 60 days from the date of this notice.

Sincerely,

Judith Moosmann, RN / Utilization Review Nurse

JM.RN/eh

cc: Claims Adjuster - Yolanda Nielsen

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FEB-25-2008 14:56 6265827928 HCP LB Yolanda Nielsen unit 5 Rowena Marcelo 6265827928 P.01

Fax Transmittal

HealthCare PARTNERS MEDICAL GROUP

SCAN

DATE: 2/25/08

TO: UR Dept FROM: Ana Gomez

PHONE: (626) 582-7950

FAX #: 818-550-6707 FAX #: (626) 582-7928

TOTAL # OF PAGES (INCLUDING COVER SHEET): 4

IF YOU DO NOT RECEIVE THE NUMBER OF SHEETS INDICATED ABOVE, PLEASE CONTACT OUR OFFICE IMMEDIATELY. THANK YOU.

COMMENTS: Re: Brooks Florence

SCAN CL# 05170360

SCIF-SA RECEIVED FEB 25 2008 LA GLENDALE LOC.

CONFIDENTIAL TRANSMISSION: YES_____ NO _____

A016 (5/03)

8083

CompPartners

Provider Notification Letter

Request for Auth #:0179808
Date: February 12, 2008

Prescribing physician: THOMAS SAUCEDO
Fax number: 310-792-1207
Client: SCIF-CA UR (GLENDALE)
Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Medical Provider:

The 01/17/08 request for medical treatment for Floreen Rooks was received on 2/5/2008 and a decision was made on 2/8/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: **an MRI of the left knee.**

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

- Nurse attempted to contact your office on 02/08/08
  A request for information letter was ☐ sent to you on /NA
  The physician reviewer attempted to contact you on 02/08/08 and the attempt was successful ☒ or not successful ☐

Our Physician Reviewer, David Poder, DO, has denied the request for authorization of the following service(s)/item(s): an MRI of the left knee.
Attached is our Physician Reviewer's explanation of the reason(s) for the denial, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

Disclaimer: Denial or non-certification for all or part of the requested intervention is in no way intended to absolve the provider from his or her duty to adhere to any applicable practice standards. Medical necessity determinations are based on available

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information. You are entitled to a voluntary secondary review if the following box is checked:☒

The request for a secondary review must be submitted by the requesting physician and should be prominently identified as a "UR Appeal" at the top of the page and include a copy of the specific UR decision which you are appealing. In order for an appeal to be considered for review, the requesting physician must outline his or her reason for the appeal citing sources from a nationally recognized, evidence based medical treatment guideline, and/or giving the clinical reasons this specific patient's medical condition warrants care that falls outside of the ACOEM or other evidence based guidelines cited by this reviewer. Appeals received from parties other than the requesting physician, or appeals without such substantial supporting information, will not be considered.

To appeal this medical decision, the requesting physician must submit in writing to the assigned Utilization Review Nurse on this claim by mail or fax @ (866) 724-3738 within 10 days. The appeal will be reviewed in accordance with State Fund's internal Utilization Review Appeals process. Participation in this process is entirely on a voluntary basis. If you wish to speak to the Physician Reviewer directly, please contact (949) 253-3111 between the hours of 8am-5pm PST so we may facilitate contact with the Physician Reviewer.

The payment decision for the proposed treatment will be made by the insurer or third party administrator, whichever is applicable.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely,

Judith Moosmann, RN/Utilization Review Nurse
JM,RN/eh
PHONE # (949) 253-3111 Ext 2846
Enc: Physician Peer Review Report
Request for Information Letter (if applicable)

cc: Yolanda Nielsen, Claims Examiner
Floreen Rooks; 1315 S. Gladys Ave. ; San Gabriel, CA 91776-3623

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JANET PATTERSON
FEB 22 2008
L.A. D.O. GLENDALE LOC.

8083

CompPartners

NOTICE TO INJURED EMPLOYEE

All utilization review disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may receive recorded information by calling 1-800-736-7401 or you may contact the local state Information and Assistance office. A list of the local office numbers are provided below.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

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I&A Office	Phone Numbers
Anaheim	(714) 738-4038
Bakersfield	(661) 395-2514
Eureka	(707) 441-5723
Fresno	(559) 445-5355
Grover Beach	(805) 481-3296
Goleta	(805) 968-4158
Long Beach	(562) 590-5240
Los Angeles	(213) 576-7389
Oakland	(510) 622-2861
Oxnard	(805) 485-3528
Pomona	(909) 623-8568
Redding	(530) 225-2047
Riverside	(951) 782-4347
Sacramento	(916) 263-2741
Salinas	(831) 443-3058
San Bernardino	(909) 383-4522
San Diego	(619) 767-2082
San Francisco	(415) 703-5020
San Jose	(408) 277-1292
Santa Ana	(714) 558-4597
Santa Monica	(310) 452-1188
Santa Rosa	(707) 576-2452
Stockton	(209) 948-7980
Van Nuys	(818) 901-5367

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CompPartners
Physician Review Recommendation
Prepared for SCIF - Glendale

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Patient Name:	Rooks, Floreen	**Claim/Policy #:**	05170360
CompPartners Case:	SC080208033	**DOI:**	11/10/07
Requester:	J. Moosmann	**Request #**	0179808
Adjuster:	Y. Nielsen		
State:	CA	**Date Referred:**	2/8/08
Review:	Expedited	**Date Completed:**	2/11/08

****

Reason for Referral: Determine the medical necessity of:
1. Request #0179808 – MRI of the left knee.

Recommendation: NON-CERTIFIED:
1. Request #0179808 – MRI of the left knee.

Guideline/Reference Used: ACOEM Guidelines, 2nd Edition, Chapter 13.

Rationale: The patient is a 58-year-old female who fell onto the ground after fracturing her right foot on November 10, 2007. The diagnoses are status post fractures of fourth and fifth metatarsal of the right foot and left knee sprain. A doctor's first report of occupational illness or injury, dated November 20, 2007, indicated that this patient had a right foot fracture and a left knee contusion. X-rays of the right foot revealed a fracture involving the fourth and fifth metatarsal bone. Examination of the left knee revealed full flexion with pain and trace edema. X-rays of the knee in three view showed mild degenerative changes. No joint effusion was seen. On December 20, 2007, Dr. Saucedo saw this patient who stated that he had some pain and discomfort in her left knee, but had improved subjectively since her previous visit. On physical examination of the left knee; there was only mild tenderness, no swelling, no spasm, and no gross effusion noted. There was also no laxity. However, on January 17, 2008, approximately one month later, a PR-2 report from Dr. Saucedo indicated that now the patient had notable swelling in her left knee. There was small amount of effusion, medial joint tenderness. Flexion of the knee was from 0-110 degrees with no reducible pain and discomfort. McMurray's and Apley's signs were both positive. There therefore appeared to be a great deal of discrepancy between these two reports. A case discussion with Dr. Saucedo was unsuccessful, and it was unclear if this patient has had any conservative management to the left knee. According to the ACOEM Guidelines, 2nd Edition, Chapter 13; an MRI is indicated when there is a significant inability to bear weight or ambulate greater than 4-6 weeks, the presence of locking or catching of the knee, objective evidence of ligament injury on physical examination. From reviewing this medical record, it does not appear that the patient had met any of these criteria, and without a case discussion with Dr. Saucedo to discuss the discrepancy in his report, this reviewer will have to non-certify this request, which is not supported by the ACOEM Guidelines in any event.

If non-certification is secondary to lack of sufficient information, what information, or test result would be required? *N/A*

Reviewed Data:
1. Nurse UM Summary dated 2/8/08.
2. Orthopedic Supplemental Report Letter dated 1/17/08, 12/20/07.
3. Referral Slip dated 1/17/08.
4. Right Foot X-Ray dated 1/17/08, 12/20/07, 11/20/07.
5. PR-1 dated 11/20/07.

S:\SCIF Reviews\February 2008\Rooks, Floreen SC080208033.doc

Requesting Provider/Telephone #: Thomas Saucedo, M.D./626-582-7989
Provider or Designee Contact: Yes. **Appeal/reconsideration/disclaimer given:** Yes.

Time/Date: 4:00 pm PT / 2/8/08 **Name:** Voicemail of Dr. Saucedo's office
Content of discussion: The final determination and appeal were given to the voicemail of Dr. Saucedo's office.

Attestation of lack of conflict of interest: Yes.
This reviewer declares, under penalty of perjury, that the information contained in this report and its attachment, 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, this report accurately describes the information provided to me.

David J. Poder DO

Peer Reviewer Name: David Poder, DO
Specialty: General Practice
State/License #: CA 20A4153

CompPartners

Provider Notification Letter

Request for Auth #:0179808
Date: February 12, 2008

Prescribing physician: THOMAS SAUCEDO
Fax number: 310-792-1207
Client: SCIF-CA UR (GLENDALE)
Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Medical Provider:

The 01/17/08 request for medical treatment for Floreen Rooks was received on 2/5/2008 and a decision was made on 2/8/2008. The request of the following services has been reviewed in accordance with Comp Partners' Utilization Review Program: **an MRI of the left knee.**

All available documentation has been reviewed. In an attempt to obtain additional relevant information:

- Nurse attempted to contact your office on 02/08/08
  A request for information letter was ☐ sent to you on /NA
  The physician reviewer attempted to contact you on 02/08/08 and the attempt was successful ☒ or not successful ☐

Our Physician Reviewer, David Poder, DO, has denied the request for authorization of the following service(s)/item(s): an MRI of the left knee.
Attached is our Physician Reviewer's explanation of the reason(s) for the denial, which includes the criteria or guidelines used in the decision and the clinical reason(s) regarding medical necessity.

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The payment decision for the proposed treatment will be made by the insurer or third party administrator, whichever is applicable.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely,

Judith Moosmann, RN/Utilization Review Nurse
JM,RN/eh
PHONE # (949) 253-3111 Ext 2846
Enc: Physician Peer Review Report
Request for Information Letter (if applicable)

cc: Yolanda Nielsen, Claims Examiner
Floreen Rooks; 1315 S. Gladys Ave. ; San Gabriel, CA 91776-3623

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NOTICE TO INJURED EMPLOYEE

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You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

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Goleta	(805) 968-4158
Long Beach	(562) 590-5240
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Pomona	(909) 623-8568
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San Jose	(408) 277-1292
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Santa Rosa	(707) 576-2452
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State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información grabada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee - complete this section and see note above. ***Empleado - complete esta sección y note la notación arriba.***

1. Name. *Nombre.* FLOREEN ROOKS Today's Date. *Fecha de Hoy.* 11/16/07
2. Home Address. *Dirección Residencial.* 315 S. Gladys Ave.
3. City. *Ciudad.* San Gabriel State. *Estado.* CA Zip. *Código Postal.* 91776
4. Date of Injury. *Fecha de la lesión (accidente).* 11/10/07 Time of Injury. *Hora en que ocurrió.* 10:30 a.m. p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* Injury occured at 335 E. Altadena Drive, Altadena, CA 91001 while picking up a client.
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Fell onto ground/gravel and fractured right foot to prevent rolling car from entering into oncoming traffic.
7. Social Security Number. *Número de Seguro Social del Empleado.* 130-38-2610
8. Signature of employee. *Firma del empleado.* Floreen Rooks

Employer - complete this section and see note below. ***Empleador - complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* D'Vera
10. Address. *Dirección.* 1845 N. Fair Oaks Ave - Suite 2100 - Pasadena
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 11-13-07
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 11-13-2007
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* State Compensation Insurance Fund
15. Insurance Policy Number. *El número de la póliza de Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.*
17. Title. *Título.* Director of HR 18. Telephone. *Teléfono* 626-296-8900

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☒ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

STATE COMPENSATION INSURANCE FUND

8083

D'VEAL FAMILY AND YOUTH SERVICES
1845 NORTH FAIR OAKS AVENUE., STE #2600
PASADENA, CALIFORNIA 91103
(626) 296-8900 – PHONE / (626) 296-8911 – FAX

CONFIDENTIAL INFORMATION

FACSIMILE TRANSMITTAL SHEET

TO: Yolanda Nielsen,Adjuster	FROM: AGNES MILLS
COMPANY: State Fund	DATE: 03/18/2010
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER: 3
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:

X URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

SENDING OUT THE FOLLOWING:

Copy of Original claim for Rooks dated 11/10/2007.

COMMENTS OR NOTE:

05170360

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1
UNREPRESENTED
(Please print or type)

05124168

Request date (Required): 3/1/2010 Date of Injury (Required): 8/9/2007 11/10/2007 Claim Number (Required): 05170360

Specialty Requested *(Required)*: MOS
(use 3 letter code only)

Requesting party *(Check one box only)*:
- [x] Unrepresented Injured Employee
- [ ] Claims Administrator, if none, Employer
- [ ] Defense Attorney

Reason QME panel is being requested *(Check one box only)*:
- [ ] § 4060 (compensability exam)
- [x] § 4061 (permanent impairment or disability dispute)
- [ ] § 4062 Injured employee only (medical treatment determination, UR dispute or other 4062 reason)
- [ ] § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)
- [ ] §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request:

Answer each question below:

Has this claim been denied? [ ] Yes [x] No Has any body part in this claim been accepted? [x] Yes [ ] No

If yes, indicate the date of the denial _____

Did notice to injured employee state employer requests an evaluation to determine compensability? *(Attach copy of notice)* [ ] Yes [x] No

Does dispute involve an MPN : [ ] Continuity or Transfer of Care [x] Permanent Disability, Future Medical, UR decision [ ] Diagnosis/Treatment ?

Employee Information

First Name: FLOREEN P. Middle Initial: S. Last Name: ROOKS

Street Address : 1315 S. Gladys Avenue

City: San Gabriel State: CA Zip Code: 91776 Daytime Phone No: (626) 354-4900

If you now live out of state, list the California city and zip code of your residence when injured: N/A

If you never resided in California, list the California zip code in which you would like to be evaluated: N/A

Employer and Claims Administrator Information

Employer: DIVEAL FAMILY & YOUTH SERVICES

Claims Administrator Name: State FUND

Adjustor name: Yolanda L. Nielsen

Street Address or P.O. Box: P.O. Box 92622.

City: Los Angeles State: CA Zip Code: 90009 Phone No. (818) 291-7626

8083

Claim Number: 05170360

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received a QME panel before?	☐ Yes	☒ No	☐ Unknown
If yes, did the employee ever see any QME from that panel?	☐ Yes	☐ No	☐ Unknown
If yes, has that claim been settled or resolved?	☐ Yes	☐ No	☐ Unknown

If yes, name of QME seen: _____ Specialty: _____

Date of Injury: _____ Body parts _____ Date of Exam: _____

Panel Number (If known): _____ Is that QME available now: ☐ Yes ☐ No ☐ Unknown

The completed form must be mailed to:
Division of Workers' Compensation-Medical Unit
P.O. Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date: March 1, 2010

FLOREEN S. ROOKS
Print Name of Requestor

Floreen S. Rooks
Signature of Injured Employee

Note: Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form

STATE COMPENSATION INSURANCE FUND

IN REPLY REFER TO:

November 15, 2007

Floreen Rooks
1317 1/2 S Gladys Ave
San Gabriel CA 91776

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Floreen Rooks

Please list below the medical treatment(s) you have received during the last 10 years, sign the enclosed medical release permit(s) and return this form and the medical release permit(s) to this office WITHIN 10 DAYS. The permit(s) and the information below will aid us in the adjustment of this claim.

Doctors or Medical Facilities	Address or Location	Part of Body Treated or Type of Treatment	Approx. Date of Treatment
Kaiser	1011 Baldwin Pk	right foot	11/12/07
Dr. Norris	420 W. Las Tunas San Gabriel, CA	left ankle, knee + hip	8/2007
Dr Le			
Dr. Gambardella	301 North Lake Pasadena, CA	Knee	9/2007
Dr. Jung	same add ↑	Ankle	9/2007
Julia Gomez	145 N. Sierra Pasadena	Knee	9/2007
Dr. Norris	420 W. Las Tunas San Gabriel, CA	left ankle	2005

List any other names you may have used in the last 10 years.

1. _____

2. _____

Sincerely

1

Please note

My address is

1315 S Gladys Ave
San Gabriel, CA 91776

NOT

1317 1/2

Thank you
Loree Parker

STATE COMPENSATION INSURANCE FUND

IN REPLY REFER TO:

FLOREEN ROOKS
1317 1/2 S GLADYS AVE
SAN GABRIEL, CA 91776

Date: 11/19/2007
Claim No: 05170360
Adj Code: LG

** NOTICE OF PHARMACY CLAIMANT HANDBOOK MAILING **
THIS IS A SYSTEM GENERATED NOTICE

Please note that an Express Scripts Pharmacy Claimant Handbook was mailed out to the above injured employee.

Printed on the front inside cover of this handbook is SCIF's standard introductory letter that contains general information about the program. The following is the full text of the introductory letter:

"State Compensation Insurance Fund and Express Scripts, a Pharmacy Benefit Management Company have teamed up to provide a program to simplify the prescription process for your work-related injury.

Prescription Drug ID Card

If you have an accepted work-related injury with authorized pharmaceutical medical benefits, please detach the Prescription Drug ID Drug Card from the back cover of this pamphlet and take it to any Express Scripts' participating pharmacy. Many of the pharmacies participating in this program are open 24 hours a day, 7 days a week.

Through this program, the chances of you paying any out of pocket expense for prescription medicine will be greatly reduced. The pharmacy will be paid directly by Express Scripts. The pharmacist will receive authorization to fill your approved prescription much faster than before, thus reducing the amount of time spent waiting at the pharmacy for your prescription.

To locate a pharmacy in your neighborhood, you can call Express Scripts at the customer service number below, refer to the list of pharmacies in this handbook, or access Express Scripts' Pharmacy Locator at www.express-scripts.com/custom/scif.

Please remember to present the card to the pharmacist when you fill a prescription.

Please note that if you are treating with Kaiser Permanente for your work-related injury, please continue to utilize a Kaiser Permanente Pharmacy to fill your prescriptions.

If you have any questions, feel free to call Express Scripts Customer Service Representatives at 1-888-201-5389. They are available 24 hours a day, 7 days a week."

For questions relating to the Pharmacy Benefit Program, please contact State Fund's Claims Rehabilitation Department by calling 323-266-5110 or by mail at P. O. Box 92503 Los Angeles CA 90009-2503.

STATE COMPENSATION INSURANCE FUND

AUTHORIZATION FOR THE RELEASE OF ALL MEDICAL INFORMATION (IN COMPLIANCE WITH CIVIL CODE SECTION 56 et. seq.)

CLAIM NO: 05170360

INJURED'S NAME: Floreen Rooks

I, Floreen Rooks, hereby authorize _____ to deliver, disclose, and release all information concerning medical care rendered to me, including diagnosis, x-rays, x-ray interpretation, laboratory and pathological tests, medical history obtained, medical reports of medical examination (both inpatient and outpatient), pre-operative reports, operative reports and billings or charges for all or part of said services to:

STATE COMPENSATION INSURANCE FUND

And/or its authorized representatives including but not limited to attorneys, claims adjusters, investigators, and consulting physicians.

I understand that the medical information to be furnished pursuant to this medical release may be used by State Compensation Insurance Fund only in a manner relating to any claim made by me or on my behalf for workers' compensation benefits in which State Compensation Insurance Fund is the workers' compensation insurance carrier or in any manner specifically authorized by law.

This medical release shall be valid for a period of two years from the date hereof and will then expire without any further notice or condition.

I understand and have been informed that I have a right to receive a copy of this authorization and I hereby acknowledge receipt of a true copy of this medical release.

A carbon copy, photostatic copy or facsimile copy of this true medical release shall be as valid as an original of same.

(Signed) Floreen Rooks

Dated 11/16/07

Information regarding workers' compensation HIPAA exclusion.

8083

STATE COMPENSATION INSURANCE FUND

AUTHORIZATION FOR THE RELEASE OF ALL MEDICAL INFORMATION (IN COMPLIANCE WITH CIVIL CODE SECTION 56 et. seq.)

CLAIM NO: 05170360

INJURED'S NAME: Floreen Rooks

I, Floreen Rooks (Name of Applicant), hereby authorize (List all doctors, hospitals and/or medical facilities)

Kaiser
1011 Baldwin Park Blvd.
Baldwin Park, CA 91706

to deliver, disclose, and release all information concerning medical care rendered to me, including diagnosis, x-rays, x-ray interpretation, laboratory and pathological tests, medical history obtained, medical reports of medical examination (both inpatient and outpatient), pre-operative reports, operative reports and billings or charges for all or part of said services to:

STATE COMPENSATION INSURANCE FUND

And/or its authorized representatives including but not limited to attorneys, claims adjusters, investigators, and consulting physicians.

I understand that the medical information to be furnished pursuant to this medical release may be used by State Compensation Insurance Fund only in a manner relating to any claim made by me or on my behalf for workers' compensation benefits in which State Compensation Insurance Fund is the workers' compensation insurance carrier or in any manner specifically authorized by law.

This medical release shall be valid for a period of two years from the date hereof and will then expire without any further notice or condition.

I understand and have been informed that I have a right to receive a copy of this authorization and I hereby acknowledge receipt of a true copy of this medical release.

A carbon copy, photostatic copy or facsimile copy of this true medical release shall be as valid as an original of same.

Floreen Rooks — Signature

11/16/07 — Date

Name and relationship of party signing if other than applicant

SCIF 3439 (REV. 9-07)

ORIGINAL - SCIF
COPY - INJURED

1207

STATE COMPENSATION INSURANCE FUND

AUTHORIZATION FOR THE RELEASE OF ALL MEDICAL INFORMATION (IN COMPLIANCE WITH CIVIL CODE SECTION 56 et. seq.)

CLAIM NO: 05176360

INJURED'S NAME: Bo Floreen Rooks

Information regarding workers' compensation HIPAA exclusion.

State Compensation Insurance Fund acknowledges the Health Insurance Portability and Accountability Act (HIPAA) requirements medical providers must follow to protect patients' privacy. Workers' compensation is specifically excluded from HIPAA regulations. Because the federal government excluded workers' compensation from HIPAA, we do not anticipate a change in how we obtain medical information from medical providers.

Under Title 45 of the Code of Federal Regulation (CFR), Part 164.512, Section (1), a medical provider may disclose protected health information to State Fund as authorized by and to the extent necessary to comply with laws relating to California's workers' compensation. The law reads as follows:

> "1) **Standard: disclosures for workers' compensation.** A covered entity may disclose protected information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

In addition, the Public Health Service Act, Title 42 of the United States Code, Part C, Section 300gg-91(c)(1) "Definitions", states that workers compensation is listed as an excepted benefit and therefore exempt from HIPAA.

SCIF 3439 (REV. 9-07)

ORIGINAL - SCIF
COPY - INJURED

1207

8083

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oir información grabada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor ("felony").

Employee - complete this section and see note above. *Empleado - complete esta sección y note la notación arriba.*

1. Name. *Nombre.* FLOREEN BOOKS — Today's Date. *Fecha de Hoy.* 11/16/07
2. Home Address. *Dirección Residencial.* 315 S. Gladys Ave.
3. City. *Ciudad.* San Gabriel — State. *Estado.* CA — Zip. *Código Postal.* 91776
4. Date of Injury. *Fecha de la lesión (accidente).* 11/10/07 — Time of Injury. *Hora en que ocurrió.* 1020 a.m. p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* Injury occured at 355 E. Altadena Drive, Altadena, CA 91001 while picking up a client.
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Fell onto ground/gravel and fractured right foot to prevent rolling car from entering into oncoming traffic.
7. Social Security Number. *Número de Seguro Social del Empleado.* 130-38-2610
8. Signature of employee. *Firma del empleado.* Floreen Books

Employer - complete this section and see note below. *Empleador - complete esta sección y note la notación abajo.*

9. Name of employer. *Nombre del empleador.* D'Vel
10. Address. *Dirección.* 1845 N. Fair Oaks Ave. Suite 2100 Pasadena
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 11-13-07
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 11-13-2007
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* State Compensation Insurance Fund
15. Insurance Policy Number. *El número de la póliza de Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.*
17. Title. *Título.* Director of HR — 18. Telephone. *Teléfono* 626-296-8900

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☒ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

STATE COMPENSATION INSURANCE FUND

8083

NAME :
TEL :
DATE :FEB.04.2000 23:24

SESSION	FUNCTION	NO.	DESTINATION STATION	DATE	TIME	PAGE	DURATION	MODE	RESULT
0215	TX	001	91818996048	FEB.04	23:23	000	00h00min00s	G3	NO ANSWER
			000F:REDIAL ALL FAIL						

TX RESULT REPORT

COMPENSATION INSURANCE FUND

Novsmber 23, 2010

Thomas Fall, Jr., M D
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number: 05170360
Employee: Floreen Rocks
Date of Injury: 11/10/2007

Dear Thomas Fall, Jr., M.D.

Thank you for agreeing to examine Floreen Rocks on January 6, 2011 at 11:00 a.m. as the Agreed Panel Qualified Medical Evaluator.

You are being asked to examine Floreen Rocks because there exists a dispute with the findings of the medical determination, regarding the following:

a. Permanent and stationary status
b. The extent and scope of medical treatment
c. The employee's preclusion or likely preclusion from engaging in her usual occupation
d. The level of permanent disability
e. The existence of new and further disability

BACKGROUND:

Floreen Rocks sustained an injury to her foot (right), knee (left) on November 10, 2007 while employed by D'Veal Family & Youth Services as a therapist.

MEDICAL RECORDS:

Medical record(s) enclosed for your review.

Please list all medical and non-medical records that you review in preparing your report pursuant to Section 10606(d) of the California Code of Regulations (CCR). Please dispose of the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

PLEASE ADDRESS THE FOLLOWING QUESTIONS IN YOUR REPORT:

1. A detailed medical and employment history, including any outside activities.

TX RESULT REPORT

COMPENSATION INSURANCE FUND

IN REPLY REFER TO:

November 23, 2010

Thomas Fell, Jr., M.D.
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Thomas Fell, Jr., M.D.

Thank you for agreeing to examine Floreen Rooks on January 6, 2011 at 11:00 a.m. as the Agreed Panel Qualified Medical Evaluator.

You are being asked to examine Floreen Rooks because there exists a dispute with the findings of the medical determination, regarding the following:

a. Permanent and stationary status
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c. The employee's preclusion or likely preclusion from engaging in her usual occupation
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PLEASE ADDRESS THE FOLLOWING QUESTIONS IN YOUR REPORT:

1. A detailed medical and employment history, including any outside activities.

Mailing Address: P.O. Box 93822 • Los Angeles, CA 90009-3822

COMPENSATION INSURANCE FUND

IN REPLY REFER TO:

November 23, 2010

Thomas Fell, Jr., M.D.
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

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c. The employee's preclusion or likely preclusion from engaging in her usual occupation
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e. The existence of new and further disability

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Medical record(s) enclosed for your review.

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PLEASE ADDRESS THE FOLLOWING QUESTIONS IN YOUR REPORT:

1. A detailed medical and employment history, including any outside activities.

Mailing Address: P O Box 92622 • Los Angeles, CA 90009-2622

COMPENSATION INSURANCE FUND

IN REPLY REFER TO:

November 23, 2010

Thomas Fell, Jr., M.D.
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

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You are being asked to examine Floreen Rooks because there exists a dispute with the findings of the medical determination, regarding the following:

a. Permanent and stationary status
b. The extent and scope of medical treatment
c. The employee's preclusion or likely preclusion from engaging in her usual occupation
d. The level of permanent disability
e. The existence of new and further disability

BACKGROUND:

Floreen Rooks sustained an injury to her foot (right), knee (left) on November 10, 2007 while employed by D'Veal Family & Youth Services as a therapist.

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Medical record(s) enclosed for your review.

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1. A detailed medical and employment history, including any outside activities

Mailing Address: P O Box 92622 • Los Angeles, CA 90009-2622

COMPENSATION INSURANCE FUND

IN REPLY REFER TO

November 23, 2010

Thomas Fell, Jr , M D
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number 05170360
Employee Floreen Rooks
Date of Injury: 11/10/2007

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You are being asked to examine Floreen Rooks because there exists a dispute with the findings of the medical determination, regarding the following

a Permanent and stationary status
b The extent and scope of medical treatment
c. The employee's preclusion or likely preclusion from engaging in her usual occupation
d The level of permanent disability
e The existence of new and further disability

BACKGROUND

Floreen Rooks sustained an injury to her foot (right), knee (left) on November 10, 2007 while employed by D'Veal Family & Youth Services as a therapist

MEDICAL RECORDS:

Medical record(s) enclosed for your review.

Please list all medical and non-medical records that you review in preparing your report pursuant to Section 10606(d) of the California Code of Regulations (CCR) Please dispose of the records in a manner that ensures medical confidentiality or return them to State Fund for disposal

PLEASE ADDRESS THE FOLLOWING QUESTIONS IN YOUR REPORT:

1 A detailed medical and employment history, including any outside activities.

Mailing Address: P O. Box 92622 • Los Angeles, CA 90009-2622

SESSION	FUNCTION	NO.	DESTINATION STATION	DATE	TIME	PAGE	DURATION	MODE	RESULT
0763	TX	001	9162630820B3	OCT.05	14:58	001	00h00m1n13s	ECM	OK

DATE :OCT.05.2010 14:59
TEL :
NAME :

TX RESULT REPORT

COMPENSATION INSURANCE FUND
555 N CENTRAL AVENUE
GLENDALE, CA 91203

LOS ANGELES ADJUSTING CENTER
TELEFAX NUMBER IS:
(818) 291-7754

DELIVER TO: NAME: Alicia
COMPANY: Dr. Tomas Saucedo
DATE: 10/5/10 TELEFAX NO: (626) 308-2083
AREA CODE

FROM: Yolanda Nielsen, Claims Representative
DEPARTMENT/SECTION: Los Angeles Adjusting Center
PHONE: (818) 291-7626
AREA CODE

MESSAGE: RE: Floreen Rooks, Claim# 05170360

This is to authorize Dr. Saucedo for an office visit regarding Injured Worker Floreen Rooks. For any further medical treatment, please fax your written request to (818) 550-6707.
Thanks.

THE TOTAL NUMBER OF PAGES, INCLUDING THIS COVER SHEET, ARE 1

SCIF 2070 (REV. 4-91)

Floreen Rooks

1315 S. Gladys Avenue

San Gabriel, CA 91776

September 18, 2008

State Compensation Insurance Fund

PO Box 92622

Los Angeles, CA 90009-2622

Fax: 707 646-2609

To Whom It May Concern:

This letter is to request your consideration for a Permanent Disability Advance in the amount of $2720. Since my return to work on September 15, 2008, I was informed by my employer, D'Veal Family and Youth Services, that my health insurance during my disability for 10 months had been paid. Consequently, the agency is requesting monthly repayments of $260 over a ten month period. In addition, I have to pay my current premiums at $280 monthly, which will result in a financial hardship.

Currently, I'm on Modification Work Status. However, this situation is causing significant stress and anxiety. Furthermore, the indicated rate of reduction in salary will render me unable to afford my monthly living expenses in-particular my rent, which has recently been substantially increased.

Thank you for your consideration in this matter.

Sincerely,

Floreen Rooks

Claim Number: 05170360

MED HEALTH SERVICES, INC.

Sherman Oaks	Beverly Hills	Arcadia	Palmdale	Paramount
4940 Van Nuys Blvd.#302	50 N. La Cienega Blvd.#205	630 W. Duarte Road #203	819 Auto Center Drive	16444 Paramount Blvd.#204
Sherman Oaks, CA 91403	Beverly Hills, CA 90211	Arcadia, CA 91007	Palmdale, CA 93551	Paramount, CA 90723
(818)990-4497	(323)966-4566	(626)447-8870	(661)266-0993	(562)408-2247

FACSIMILE COVER SHEET

To : Yolanda Nielsen

Fax# : 7076462609

Date Sent : 1/11/11

Total Number of Pages (Including Cover Sheet): 1

From : Shannon - Dr. Fell

Memo : Regarding - Yolanda Nielsen
Claim # - 05170360+05124168

If there are any problems with this transmission, please call (818) 990-4497 or fax to (818) 990-6045. Fax responses must be no more than 20 pages in length.

please note,
patient did not show for her panel QME evaluation w/ Dr. Fell on 1/6/11 @ 11am, do you want to r/s patient, please contact our office,
Thank you
(818) 990 4497

Medicals to 2

MED HEALTH SERVICES, INC.

Appts

Sherman Oaks
4940 Van Nuys Blvd.#302
Sherman Oaks, CA 91403
(818)990-4497

Beverly Hills
50 N. La Cienega Blvd.#205
Beverly Hills, CA 90211
(323)966-4568

Arcadia
830 W. Duarte Road #203
Arcadia, CA 91007
(626)447-8870

Palmdale
819 Auto Center Drive
Palmdale, CA 93551
(661)266-0993

Paramount
16444 Paramount Blvd.#204
Paramount, CA 90723
(562)408-2247

FACSIMILE COVER SHEET

To : Yolanda Natsea - SCIF

Fax# : 707-646-2609

Date Sent : 11-15-10

Total Number of Pages (Including Cover Sheet): 2

From : Dr Fell's Office

Memo : Re-Floreen Rooks
Claim # 05170360

If there are any problems with this transmission, please call (818) 990-4497 or fax to (818) 990-6045. Fax responses must be no more than 20 pages in length.

EXAM CONFIRMATION MEMO: THE ABOVE NOTED PATIENT IS SCHEDULED FOR A QME EXAMINATION IN THE Arcadia OFFICE ON 1/6/11 @ 11AM. WITH DR. Thomas Fell MD.

PLEASE SEND MEDICALS AT LEAST ~~ONE~~ 2 WEEKS IN ADVANCE TO THE SHERMAN OAKS OFFICE.

THANK YOU.

QME/AME APPOINTMENT NOTIFICATION FORM (Form 110)

EMPLOYEE INFORMATION

CLAIMANT'S NAME: FLOREEN ROOKS

STREET ADDRESS: 1315 S. GLADYS AVE ALHAMBRA, CA 91776

TELPHONE NO: (626)573-1906 SOCIAL SEC#: 130-38-8570

DATE OF INJURY: 11/10/07 PANEL #: 1193683 CLAIM NO: 05170360

EMPLOYER INFORMATION

EMPLOYER'S NAME: D-VEAL SERVICES

EMPLOYERS ADDRESS:

INSURER OR CLAIMS ADMINSTRATOR INFORMATION

INSURANCE CO: STATE COMPENSATION INS. FUND

INS COMPANY ADDRESS: P.O. BOX 92622

LOS ANGELES, CA 90009

ADJUSTER'S NAME: YOLANDA NIELSEN PHONE NO: (818)291-7626

APPOINTMENT INFORMATION

Date of Appt Call: 11/15/10 **DATE OF APPT & TIME:** **01/06/11** **11:00am**

LOCATION OF APPOINTMENT: MED HEALTH SERVICES
630 W. DUARTE RD, SUITE 203
ARCADIA, CA 91007
(626) 447-8870

CERTIFIED INTERPRETER REQUIRED (language) ø

COPY OF THIS FORM SENT TO: Employee ✓ Claims Admin ✓ Def. Attorney ___ App. Attorney ___

Signature of QME T. Fell MD

NAME OF QME: **THOMAS W FELL, JR., MD.**

ADDRESS/TELEPHONE: (mail all records & info for QME to):
MED HEALTH SERVICES, INC. (818) 990-4497
4940 Van Nuys Blvd, Suite 302, Sherman Oaks, CA 91403

Note of Claims Administrator: Please forward DEU form 101 "Request for Summary Rating" & all medical records prior to exam to QME. Also provide employee with DEU Form 100 "Employees Disability Questionaire" prior to exam.

STATE OF CALIFORNIA - IMC Form 110 (substitute)

State of California **DIVISION OF WORKERS' COMPENSATION** Department of Industrial Relations

INJURED WORKER INFORMATION

Panel #: 1193683

Date Request Received: 10/13/2010 Date Mailed: 10/20/2010 No. of Req: 1
Claim No(s): 05124168, 05170360
Date(s) of Injury: 08/09/2007, 11/10/2007

Employee: **FLOREEN ROOKS**
1315 S GLADYS AVE
SAN GABRIEL, CA 91776
Employer: DIVEAL FAMILY AND YOUTH SERVICES

To: **YOLANDA NIELSEN**
SCIF CMS MONTEREY PARK
PO BOX 92622
LOS ANGELES, CA 90009

SELECTED QUALIFIED MEDICAL EVALUATOR PANEL:

PHYSICIAN'S NAME	ANANT RAM, MD
ADDRESS	430 S GARFIELD AVE STE 418 ALHAMBRA, CA 91801-3877 Tel No.: (800) 242-0880
SPECIALTY	Orthopaedic Surgery
YEARS IN PRACTICE	Twenty-Nine
PHYSICIAN'S EDUCATION	SN MEDICAL COLLEGE AGRA INDIA, AGRA INDIA, Degree awarded in 1960
PHYSICIAN'S TRAINING	SURGERY-MAIMONEDES MEDICAL CENTER, BROOKLYN, NY, 1977-1978 SURGERY-METHODIST HOSPITAL,BROOKLYN,NY,1978-1979 ORTHOPAEDIC-KINGS COUNTY HOSPITAL,BROOKLYN,NY,1979-1980 ORTHOPAEDIC-KINGS COUNTY HOSPITAL,BROOKLYN,NY,1981-1982
PHYSICIAN'S NAME	THOMAS W. JR. FELL, MD
ADDRESS	630 W DUARTE RD STE 203 ARCADIA, CA 91007 Tel No.: (626) 447-8870
SPECIALTY	Orthopaedic Surgery
YEARS IN PRACTICE	Thirty-Seven
PHYSICIAN'S EDUCATION	NEW JERSEY COLLEGE OF MEDICINE, NEWARK, NEWARK, NJ Degree awarded in 1969
PHYSICIAN'S TRAINING	ORTHOPEDIC SURGERY-NORTH CAROLINA MEMORIAL HOSPITAL, CHAPEL HILL, NC, 1969-1970 ORTHOPAEDIC-NORTH CAROLINA MEMORIAL HOSPITAL,CHAPEL HILL,NC,1971-1974
PHYSICIAN'S NAME	DAVID R. JOHNSON, MD
ADDRESS	10301 GARVEY AVE STE 100 EL MONTE, CA 91733-2180 Tel No.: (800) 242-0880
SPECIALTY	Orthopaedic Surgery
YEARS IN PRACTICE	Fifty
PHYSICIAN'S EDUCATION	LOMA LINDA UNIVERSITY MEDICAL SCHOOL, LOMA LINDA, CA Degree awarded in 1961
PHYSICIAN'S TRAINING	ROTATING-WHITE MEMORIAL HOSPITAL, LOS ANGELES, CA, 1961-1962 GENERAL SURGERY-GLENDALE SANITARIUM & HOSPITAL,GLENDALE,CA,1962-1963 ORTHOPEDIC SURGERY-WHITE MEMORIAL HOSBITAL,LOS ANGELES,CA,1964-1965 ORTHOPEDIC SURGERY-WHITE MEMORIAL HOSPITAL,TAMPA,FL,1966-1968 ADULT RECONSTRUCTIVE-RANCHO LOS AMIGOS/USC,CA,1968-1970

STATE COMPENSATION INSURANCE FUND

January 7, 2009

Dr. Tomas Saucedo
3144 Santa Anita Ave, Module A
El Monte, CA 91733

RE: Floreen Rooks/ Claim Number 05170360

Dear Dr. Saucedo:

We have received the permanent and stationary report dated 12/5/08.

In the apportionment section, you have indieated that there are no prior injuries regarding the left knee.

Attached is a permanent and stationary report dated 11/26/07 from Dr. Ralph Gambardella regarding a previous injury on the left knee.

Please submit to State Fund a supplemental report addressing the apportionment regarding the left knee resulting from both injuries.

Thank you for your immediate attention and cooperation.

Sincerely,

Yolanda Nielsen

Yolanda Nielsen
Claims Representative
Los Angeles/Tri-County Claims
(818) 291-7626

Enc. Medicals

FAX: 707-646-2609
ATTN: Yolanda L. Nielsen

05170360

Social Security Administration
Consent for Release of Information

Form Approved
OMB No 0960-0566

TO: Social Security Administration

FLOREEN ROOKS 6-20-49 130-38-8510
Name Date/Birth Social Security #

I authorize the Social Security Administration to release information or records about me to:

Name	Address
NuQuest/Bridge Pointe	P.O. Box 91561,9 Longwood, FL 32791-5619 (P) 866-658-7161 (F) 407-389-0199

I want this information released because:
To determine if my case meets the CMS review threshold in order to protect Medicare's interests under the Medicare Secondary Payer Statute.

(There may be a charge for releasing information)

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parent's name)
____ Monthly Social Security benefit amount
____ Monthly Supplemental Security Income payment: amount
____ Information about benefits/payments I received from All Dates to ____
____ Information about my Medicare claim/coverage from All Dates to ____
____ Medical records
____ Record(s) from my file (specify)
__X__ Other (specify) **Verify Social Security entitlement status, date of SS entitlement or date of application, date of denial, date of appeal, status of appeal, basis for entitlement (disability or age), name of representative payee if assigned, number of eligible work quarters, if quarters adequate for Social Security benefits, Medicare status, date of entitlement for Medicare A and B.**

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: Floreen Rooks
(Show signatures, names and address of two people if signed by mark)

Date: 8/4/2011 Relationship: self

Form SSA-3288 (3-2005) EF (3-2005)

05170360

CMS/Medicare Authorization for Release of Information

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, FLOREEN ROOKS, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my accident, injury and/or settlement to the individual(s) and/or firm(s) listed below. I also hereby authorize NuQuest/Bridge Pointe to register me under the "myMedicare.gov" website to obtain from said website conditional payment information related to my workers' compensation claim. This authorization for release is for my current accident, injury, or claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

- ☐ Claimant's attorney _____ (name and/or firm)
- ☐ Employer's attorney _____ (name and/or firm)
- ☐ Other _____ (name and/or firm)
- ☒ MSA Vendor NuQuest/Bridge Pointe (name and/or firm)

Claimant's Signature

8/4/2011
Date Signed

8/9/07 & 11/10/07
Date of Injury

130-38-8510
Social Security Number or Health Insurance Claim Number

STATE COMPENSATION INSURANCE FUND

Date: 02/11/2011

IN REPLY REFER TO

Floreen Rooks
1315 South Gladys Avenue
San Gabriel, CA 91776

Claimant: FLOREEN ROOKS
Claim No: 05170360
Adj Code: LG

** NOTICE OF PHARMACY CLAIMANT HANDBOOK MAILING **
THIS IS A SYSTEM GENERATED NOTICE

Please note that an Express Scripts Pharmacy Claimant Handbook was mailed out to the above injured employee.

Printed on the front inside cover of this handbook is SCIF's standard introductory letter that contains general information about the program. The following is the full text of the introductory letter:

"State Compensation Insurance Fund and Express Scripts, a Pharmacy Benefit Management Company have teamed up to provide a program to simplify the prescription process for your work-related injury.

Prescription Drug ID Card

If you have an accepted work-related injury with authorized pharmaceutical medical benefits, please detach the Prescription Drug ID Drug Card from the back cover of this pamphlet and take it to any Express Scripts' participating pharmacy. Many of the pharmacies participating in this program are open 24 hours a day, 7 days a week.

Through this program, the chances of you paying any out of pocket expense for prescription medicine will be greatly reduced. The pharmacy will be paid directly by Express Scripts. The pharmacist will receive authorization to fill your approved prescription much faster than before, thus reducing the amount of time spent waiting at the pharmacy for your prescription.

To locate a pharmacy in your neighborhood, you can call Express Scripts at the customer service number below, refer to the list of pharmacies in this handbook, or access Express Scripts' Pharmacy Locator at www.express-scripts.com/custom/scif.

Please remember to present the card to the pharmacist when you fill a prescription.

Please note that if you are treating with Kaiser Permanente for your work-related injury, please continue to utilize a Kaiser Permanente Pharmacy to fill your prescriptions.

If you have any questions, feel free to call Express Scripts Customer Service Representatives at 1-888-201-5389. They are available 24 hours a day, 7 days a week."

For questions relating to the Pharmacy Benefit Program, please contact State Fund's Claims Rehabilitation Department by calling 323-266-5110 or by mail at P. O. Box 92503 Los Angeles CA 90009-2503.

cc: Glendale - A Legal

LEGAL DEPARTMENT
655 North Central Avenue • Glendale, CA 91203-1400
(818) 291-7100
Mailing Address: P.O. Box 92622 • Los Angeles, CA 90009-2622

SCIF 19190

8083

STATE COMPENSATION INSURANCE FUND

Date: 02/11/2011

IN REPLY REFER TO

Floreen Rooks
1315 South Gladys Avenue
San Gabriel, CA 91776

Claimant: FLOREEN ROOKS
Claim No: 05170360
Adj Code: LG

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Date: 02/11/2011

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Claimant: FLOREEN ROOKS
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(818) 291-7100
Mailing Address: P.O. Box 92622 • Los Angeles, CA 90009-2622

SCIF 19190

8083

NUQUEST BRIDGE POINTE®

ONE SOURCE FOR MEDICARE SECONDARY PAYER COMPLIANCE

October 14, 2011

State Fund-CA
Attn.: Yolanda Nielsen
P.O. Box 92622
Los Angeles, CA 90009-2622

Claimant: Floreen Rooks
Claim No.: 05170360, 05124168
Date of Loss: 11/10/07, 08/09/07
Our File Nn.: 29858

This file was referred to NuQuest/Bridge Pointe for the purpose of completing a Medicare Set-Aside Allocation. We have received the benefit status information from the Social Security Administration office for Floreen Rooks.

Social Security and Medicare Benefit Status

Based on the information provided, it has been determined that **Floreen Rooks has not applied for Social Security Disability** benefits as of 10/14/11.

Medicare Reporting and Conditional Payment Identification

- **Not appropriate at this time**

We strongly recommend re-verifying the claimant's Social Security Disability benefit statns, prior to finalizing settlement of the case. Should Floreen Rooks become enrolled in Medicare prior to the finalization nf the settlement, it is required that State Fund-CA report the details nf the case to Medicare in order to notify them nf the above listed date of injury and as well as to initiate a Medicare conditional payment identification.

Need for Review by The Centers for Medicare and Medicaid Services (CMS)

- **Not appropriate at this time**

Based on the current information provided, CMS review of a proposed Medicare Set-Aside allocation cost projection is not appropriate at this time as this case currently does not meet the belnw review thresholds established by The CMS.

CMS Review Thresholds

1. A Medicare beneficiary at the time of settlement and the total settlement* is greater than $25,000
   OR
2. Not a Medicare beneficiary at the time of settlement but if there is a reasonable expectation that Medicare enrollment will occur within 30 months of the settlement *AND* the total settlement* exceeds $250,000.00

The CMS review thresholds are CMS workload review thresholds only, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law. Therefore, Medicare's interests must always be considered and protected when settling any workers' compensation case; even if CMS review thresholds are not met.

Please advise our nffice if yon would like us to complete a Medicare Set-Aside allocatinn and submit the proposed MSA to The CMS for approval.

Documentation Needed to Complete a MSA Allocation Report

- All medical records for the last 2 years of treatment (if treatment was limited, last 5 years)
- Medical claims and indemnity payment history for the last 2 years of medical treatment/receipt of indemnity benefits (if treatment was limited, last 5 years)
- Last 2 years of prescription drug history or pharmacy bills

Information can be forwarded via any of the following methods: 1) mail to the address below, 2) fax to 407-389-0299, 3) upload directly to our system via any screen of the online referral application at www.nqbp.com, or 4) request free, on-site copy service by calling 866-858-7161 and select option 2 for a Service Coordinator

NuQuest / Bridge Pointe
P.O. Box 915619
Longwood, FL 32791-5619

***The computation of the total settlement amount must include, but is not limited to, wages, attorney fees, all future medical expenses, and repayment of any Medicare conditional payments, and that payout totals for all annuities to fund the above expenses should be used rather than cost or present values of any annuities. Also note that any previously settled portion of the above listed claim must be included when the computing the total settlement amount.**

If you should require assistance, please do not hesitate to contact the Service Coordinator listed below.

Thank you for the opportunity to service your Medicare Set-Aside needs.

Lisa Cooper

Extension 4866
Direct Fax Number: (321) 460-5166

NUQUEST BRIDGE POINTE®
ONE SOURCE FOR MEDICARE SECONDARY PAYER COMPLIANCE

Proposed WC Medicare Set-Aside Allocation Report

Report Date: 02/17/2012
Report Prepared For: State Fund-CA/Yolanda Nielsen
Report Prepared By: Nancy Leone, RN, MSN, CCM, MSCC

Identifying Information

Claimant:	**Floreen Rooks**	**Case Type:**	Workers' Compensation
Date of Birth:	06/20/1949	**State of Jurisdiction:**	California
Date of Injury:	11/10/2007	**Claim #:**	05170360
	08/09/2007		05124168
Rated Age:	**68 Years**	**Life Expectancy:**	**16 Years**

MSA Recommendation:

Total Proposed MSA Amount:	**$27,621.00**
Future MSA Medical Treatment Amount:	$27,621.00
Future MSA Prescription Drug (Medicare Part D) Amount:	$0.00

Medical Record/Document Review

This file was referred by **Yolanda Nielsen** from **State Fund-CA** for the purpose of completing a **Medicare Set-Aside allocation** cost projection. A review of provided documentation including medical records has been completed. The following is our opinion and recommendations in regard to the Medicare Set-Aside allocation in this case.

ICD-9 Diagnoses *Related* to This Claim

- 719.46 Left knee pain

ICD-9 Diagnoses Disputed/Denied

- None

Pre-existing or Co-Morbid Conditions *Unrelated* to This Claim

- Smoker one pack daily
- Obesity 5'6" 213 pounds (BMI: 34.4)
- Hypertension
- Surgical history: open reduction and internal fixation (ORIF) of left ankle fracture (early 1990s)

Life Expectancy Information	
DOB:	06/20/1949
Actual Age:	62 Years
Rated Age:	68 Years Determination of Rated Age by Medical Underwriting utilizes a statistical methodology matching characteristics of individual medical histories to long-term mortality and/or survival rates of individuals with similar medical history characteristics.
Life Expectancy:	16 Years (Rounded to the nearest whole number) (Life table for total population: United States, 2007)
Source:	Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, National Center for Health Statistics, Division of Data Services, Hyattsville, MD, 20782. United States Life Tables, 2007, National Vital Statistics Reports, Volume 59, Number 9, September 28, 2011

If Floreen Rooks's case meets the CMS review thresholds and CMS approval of the Medicare Set-Aside arrangement is required; please provide all rated ages that you may have knowledge of, generated any time on or after the Date of Incident for Floreen Rooks. Per the CMS memorandum dated 05/14/2010, this information is required to be provided with a Medicare Set-Aside proposal to CMS. If this information is not received by NuQuest/Bridge Pointe upon submission of the Medicare Set-Aside arrangement, it will be assumed that this information does not exist.

Description of Initial Injury/Illness and Initial Treatment

Floreen Rooks is a 62 year old woman who was working as a marriage and family therapist when she sustained a twisting injury to her left knee and ankle in an industrial accident on 8/9/2007. She subsequently sustained injuries to her left knee, left ankle and right foot when she slipped and fell while trying to stop her car from rolling in a second industrial accident on 11/10/2007. She was treated conservatively for right foot fractures and following failure of conservative treatment she underwent left knee arthroscopic surgery on 4/24/2008.

Key Treatment Events

- 9/4/2009 through 1/26/2011 Tomas Saucedo M.D., orthopedic surgeon: He reported that Ms. Rooks was deemed permanent and stationary on 12/5/2008. He recommended medication for flare-up of left knee pain. On 10/11/2010 he reported new complaint of low back pain [this appears to be nonindustrial as this is the first report of this complaint] which he opined was a new problem. On 1/26/2011 he reported left knee joint steroid injection with immediate relief of symptoms. He opined that future treatment may include a total knee arthroplasty.
- 3/17/2011 Thomas W. Fell Jr. M.D., orthopedic surgeon [agreed panel qualified medical evaluation (PQME)]: He reported current medications included Lisinopril, Hydrochlorothiazide, Ibuprofen and Vicodin. He provided diagnoses of sprain/strain of left knee aggravating degenerative arthritis status post arthroscopic surgery; left ankle sprain temporarily aggravating significant pre-existing arthritis and fracture of right foot metatarsals. He opined that right foot fractures healed with no residuals. He opined that she had achieved maximum medical improvement (MMI). He opined that future care for left knee would include orthopedic visits with corticosteroid injections, viscosupplementation such as Synvisc and total knee replacement should her symptoms interfere with her quality of life. He opined that any future care for left ankle would be for pre-existing arthritis and not her industrial accident and no further care was indicated for right foot.

Anticipated Future MSA Medical Treatment

Ms. Rooks is medically stable. Based upon the interventions reflected in available medical records, recommendations for future treatment, and Medicare allowable services/items, provisions for future treatment related to the compensable injury will include the following:

- Physician services: Orthopedic surgery visits
- Surgeries/procedures: Left knee joint steroid injections, Synvisc injections, total knee arthroplasty
- Therapies: Postoperative physical therapy and intermittent physical therapy for home exercise program and exacerbations
- Diagnostic testing: X-rays, MRIs

Per California Statute, Sections 133, 4603.5 and 5307.3, Labor Code. Reference: Sections 4062, 4600, 4600.4, 4604.5 and 4610, Labor Code; the American College of Occupational and Environmental Medicine's Occupational Medicine (ACOEM) Practice Guidelines were utilized for this review to determine if anticipated future medical treatment followed these guidelines.

Current Prescription Drug Utilization (Medicare Part D)

- None Prescribed

Anticipated Future MSA Prescription Drug Utilization (Medicare Part D)

In compliance with the May 14, 2010 CMS memorandum, Drug Reviews are being completed by Progressive Medical to determine if off-label usage is supported by the compendia for inclusion in the MSA.

Dr. Fell indicated that Ms. Rooks was taking oral medication however there is no documentation in Dr. Saucedo's office notes of an ongoing need for medication and there is no documentation of any prescription medication refills in the medical payouts or prescription medication claims detail since 10/11/2010. Therefore no prescription medication is anticipated in the future.

Complications

While it is impossible to accurately predict the nature and frequency of complications, the historical nature and frequency of complications specific to this case have been considered in the preparation of this report.

Proposed Consideration of Medicare's Interests

Proposed Medicare Set-Aside Allocation Amount

$27,621.00 is our proposed total Medicare Set-Aside allocation amount; which includes $27,621.00 for future medical treatment and $0.00 for future prescription drug treatment (Medicare Part D). These amounts are to be designated for future illness/injury related medical needs related to the claim being settled that are of the type otherwise covered by Medicare for Floreen Rooks's life expectancy.

See attached Medicare Set-Aside Cost Projection for detailed breakdown of the recommended amount.

Additional Recommendations

The projections contained in the proposed Medicare Set-Aside allocation are based upon the good faith professional judgment of NuQuest/Bridge Pointe, its employees or agents based on the information available to NuQuest/Bridge Pointe as of the time the report was completed.

Should you have any questions or need assistance, please feel free to contact your assigned Service Coordinator listed below at 866-858-7161 and select option 2.

Service Coordinator: Lisa Cooper, lcooper@nqbp.com
Direct Fax Number: (321) 460-5166

Attachments:
MSA Cost Projection

cc:
Yolanda Nielsen/State Fund-CA Fax: (707) 646-2609

Medicare Set-Aside Cost Projection

Claimant: Floreen Rooks
Date of Injury: 11/10/2007, 8/9/2007
Life Expectancy (rounded to the nearest whole number): 16
State of Jurisdiction: California
Method of Calculating Costs: Workers' Compensation (WC) Reimbursement Schedule
Method of Calculating Prescription Drug Costs (Medicare Part D): N/A
Date of Report: 2/17/2012

Service Description	CPT Code	Service Frequency	Occurring Every x Years	Over Total # of Years	Price Per Service Frequency	Total
[illegible]						
Physician Services						
Orthopedic surgeon: routine	99213	1.00	1.00	16.00	$56.93	$910.88
Physician Services Sub-Total						$910.88
Surgeries/Procedures						
Left knee joint steroid injections	20610 J1030	1.00	1.00	3.00	$49.62	$148.86
Left knee Synvisc injections	20610 J7322	1.00	1.00	3.00	$60.63	$181.89
Left total knee replacement	27447	1.00	1.00	1.00	$20,000.00	$20,000.00
Surgeries/Procedures Sub-Total						$20,330.75
Therapies						
Postoperative physical therapy following total knee replacement	97110 97530	24.00	1.00	1.00	$99.63	$2,391.12
Intermittent physical therapy	97110 97530	6.00	1.00	3.00	$99.63	$1,793.34
Therapies Sub-Total						$4,184.46
Diagnostic Testing						
Left knee x-rays	73564	1.00	1.00	16.00	$55.81	$892.96
Left knee MRI	73722	1.00	1.00	2.00	$650.99	$1,301.98
Diagnostic Testing Sub-Total						$2,194.94
Total Future MSA Medical Treatment						$27,621.00
Future MSA Prescription Drugs (Medicare Part D)						
Drug Name and Dosage	***NDC***	***Amount per Month***	***Months per Year***	***Total # of Years***	***Price Per Unit***	***Total***
None anticipated						$0.00
Total Future Prescription Drugs (Medicare Part D)						$0.00
MSA Grand Total (Total MSA Medical Treatment and Total MSA Prescription Drugs)						$27,621.00

Generic equivalents are used when available for calculating prescription drug costs. Per CMS protocol, the following calculation formula was used: '# of years' divided by 'Every X Years' multiplied by 'Frequency' multiplied by 'Price per Service' = Total

Nancy Leone RN, MSN, CCM, MSCC
Medical Cost Projection Specialist

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (Initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
		earnings
		temporary disability
		jurisdiction
		apportionment
		employment
		injury AOE/COE
		serious and willful misconduct
		discrimination (Labor Code §132a)
		statute of limitations
		future medical treatment
		other ALL ISSUES
		permanent disability 24% LT ANKLE/LT KNEE
		self-procured medical treatment, except as provided in Paragraph 7
		vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

INJURED WORKER IS NOT RECEIVING MEDICARE BENEFITS AT THIS TIME AND IS CURRENTLY CONTINUALLY WORKING FULL TIME WITH DVEAL FAMILY & YOUTH SERVICES SO THERE IS NO NEED FOR A MEDICARE SET ASIDE ALLOCATION REPORT AT THIS TIME.
SETTLEMENT BASED ON PANEL QME REPORT OF DR THOMAS FELL DATED 3/7/2011 AND INCLUDES ADDENDA "A to B".

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

D'VEAL FAMILY AND YOUTH SERVICES

FACSIMILE TRANSMITTAL SHEET

TO: Yolanda

FROM: ☐ F. Rooks

COMPANY: 707 646-2609

DATE: ~~3/5/12~~ 3/9/12

FAX NUMBER:

TOTAL NO. OF PAGES, INCLUDING COVER: ~~6~~ 2

PHONE NUMBER:

Pg 3 of 3

RE:

> C + R

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

For further questions please contact:

☐

Hello ☺ is Pg 7 of 9 DWC-CA form 10214 attached ~~due~~ ~~5 pgs~~ ~~that I thought would suffice. If not call me please~~

(626) 744-1906 x22

~~Thanks~~

855 N. ORANGE GROVE BLVD., PASADENA, CA 91103, (626) 796-3453

8083

STATE COMPENSATION INSURANCE FUND

IN REPLY REFER TO:
05170360

November 6, 2009

Ms. Floreen Rooks
1315 South Gladys Avenue
San Gabriel, CA 91776-3623

Re: Floreen Rooks v. D'Veal Family & Youth Services
WCAB Case No. Unassigned

Dear Ms. Rooks:

The Glendale - A Legal Department and the undersigned have been assigned the legal defense of the above-captioned case.

Please send all notices, pleadings and correspondence addressed to State Compensation Insurance Fund, Legal Department, at the address shown below. Be further advised that notices of hearings or depositions served on any other address may not be legally effective under the doctrine stated in *Hartford Accident and Indemnity Co. v. WCAB (Phillips),* 86 Cal. App. 3d 1, 43 CCC 1193 (1978). Also, please serve a separate copy of any application(s), medical report(s) and any other pleading(s) or document(s) on this office. Pursuant to Labor Code § 4906, please forward the attorney disclosure form to my office.

State Compensation Insurance Fund requests that you comply with Title 8, Section 10418, which requires notice of medical-legal examinations. We will object to any billings and entry into evidence of reports that do not comply with this section.

Please serve any medical reports in your possession or control as prescribed by the Rules of Practice and Procedure.

Defendant State Compensation Insurance Fund will not accept service by facsimile.

Very truly yours,

Lena W. Tsui
Attorney
(818)662-6736
adr

cc: D'Veal Family & Youth Services, Post Office Box 40255, Pasadena, CA 91114
Yolanda L. Nielsen, Glendale Unit 5 (SA) Claims Department

LEGAL DEPARTMENT
655 North Central Avenue • Glendale, CA 91203-1400
(818) 291-7100
Mailing Address: P.O. Box 92622 • Los Angeles, CA 90009-2622

8083

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

MINUTES OF HEARING

ADJ 7024643
Case No.
ADJ 7024645

03/12/2012
Date of Hearing (MM/DD/YYYY)

Hearing Information

☐ Before ☒ AT ☐ Trial ☐ Conf ☒ MSC ☐ EXP. HEARING ☐ Lien

Request Date (MM/DD/YYYY) _____

Applicant

FLOREEN
First Name

MI

ROOKS
Last Name

VS

Defendants

DUVAL FAMILY AND YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

Appearances

		Attorney	Hearing Rep
Applicant	☐ Present ☒ Not Present		
Applicant Represented By		☐	☐
Defendant Represented By	LENA TSUI FOR STATE FUND	☒	☐
Others Appearing		☐	☐

Interpreter _____ Cert. No. _____

Party Making Request

☐ Joint ☐ Applicant ☐ Defendant ☐ Other _____

Request For: ☐ Continuance ☐ OTOC Request By: ☐ Letter ☐ Telephone

Position of Opposing Party

☐ Agree ☐ Oppose ☐ Unreachable ☐ Unknown

Reason For Request

☐ Applicant: Illness ☐ Applicant Now Represented ☐ Applicant Requests Representation

☐ Applicant: Vacation ☐ Calendar Conflict: Applicant ☐ Calendar Conflict: Defense

☐ Calender Conflict: Lien Claimant ☐ Change of Circumstances ☐ Consolidation ☐ Defense: Illness

☐ Defense: Vacation ☐ Dispute Resolved by Agreement ☐ Further Discovery: App Med

☐ Further Discovery: Def Med ☐ Further Discovery: AME ☐ Further Discovery: Depo

☐ Improper/Insufficient Notice by Party ☐ Joinder ☐ New Application ☐ No Issues Pending

☐ Non Appearance: Applicant ☐ Non Appearance: Defense ☐ Non Appearance: Lien Claimant

☐ Non Appearance: Witness ☐ Settlement Pending ☐ Unavailability of Witnesses: Applicant

☐ Unavailability of Witnesses: Defense ☐ Venue

Board Reason

☐ Arbitration ☐ Bankruptcy Pending ☐ Defective Notice ☐ Insufficient Time to Start

☐ Insufficient Time to Finish ☐ Interpreter Not Available ☐ Recusal ☐ Reporter Not Available

☐ Service Defective ☐ UEF Issues ☐ WCJ Not Available

☑ Other/ Comments

I+A consulted w/ applicant.

Good Cause Appearing, It Is Ordered That the Request For

☐ Continuance Granted ☐ Continuance Denied ☑ DTOC Granted ☐ OTOC Denied

_____ Days For ☐ C&R ☐ STIPS ☐ OTOC

Decision

☑ OTOC ☐ C&R / STIPS Submitted for Approval ☑ C&R / STIPS Approved

☐ LIEN STIPS and ORDER Approved ☐ N.O.I. to Allow/Disallow Issued

☐ MSC ☐ CONF ☐ TRIAL ☐ LIEN TRIAL ☐ CONTD TESTIMONY

Set On _____ (MM/DD/YYYY) At _____

Location _____

Before Judge _____

☐ Supplemental Pages Attached _____ Pages

MAR 1 2 2012
Date - MM/DD/YYYY

Lynn A Devine
WORKERS' COMPENSATION ADMINSTRATIVE LAW JUDGE
JUDGE LYNN A. DEVINE

Notice To SCIF

Pursuant to Rule 10500 you are designated to serve this/these document(s) on all parties.

☑ Served on parties and lien claimants present

TO: SCIF RECD DTE 04/11/2012 VLSCAN 42 04/12/2012 10:12 AM 038861 10 4

REQUEST FOR ASSISTANCE

NAME OF CALLER:

REPRESENTING

DATE: 3/12/2012 TIME: PHONE

( ) TELEPHONED ( ) PLEASE CALL ( ) WAS IN
( ) RETURNED CALL ( ) WILL CALL AGAIN ( ) WANTS TO SEE YOU

NATURE OF CALLER:

A. EMPLOYEE	( )
B. EMPLOYER	( )
C. INS. CARRIER	( )
D. PHYSICIAN	( )
E. APP. ATTORNEY	( )
F. DEF. ATTORNEY	( )
G. UNION REP.	( )
H. LIEN CLAIMANT	( )
J. DIA/WCAB	( )
K. LEGISLATOR	( )
L. OTHER	( )

I&A #:

DEB #:

WCAB #(S): MJ 0124625

EMPLOYEE: Maureen Rocks D/I:

ADDRESS: ( ) TELEPHONE

EMPLOYER: DVera Family Youth Services

ADDRESS: ( ) TELEPHONE

INSURANCE CARRIER: SCIF

ADDRESS: ( ) TELEPHONE

CARRIER CLAIM #:

OTHER CLAIM #:

ATTORNEY:

DOCTOR:

MEMO: I Spoke to the Applicant on Several occassions, She ASKED questions & DID her own Research We Also discussed the "Medical Set Aside" which Came in Lower this the SCIF estimate

Lena W. Tsoi
Attorney

MAR 12 2012 claim # 05124168

DIA FORM IAB-4

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF INDUSTRIAL ACCIDENTS
INFORMATION AND ASSISTANCE BUREAU

RESOLUTION

RESOLVED	( )
NOT RESOLVED	( )
DEFERRED	( )

INFORMATION & ASSISTANCE OFFICER

I&A BUREAU (LOCATION)

8083

SCIF INSURED GLENDALE UNIT A
SALLY JACQUELINE G. SMITH
818-291-7270
SJGSMITH@SCIF.COM

PROOF OF SERVICE BY MAIL - CCP 1013a, 2015.5

I declare that I am employed in the County of Los Angeles, State of California. I am over the age of eighteen years and not a party to the within entitled cause. My business address is: 655 North Central Avenue, Suite 400, Glendale, California 91203-1400. On April 11, 2012, I served the attached **ORDER APPROVING COMPROMISE & RELEASE WITH C&R PAPERS; MINUTES OF HEARING** on the interested parties in said cause, by placing a true copy thereof, enclosed in an envelope addressed as follows:

Floreen Rooks
2374 Olive Avenue
Altadena, CA 91001

I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice such envelope would be sealed and deposited with U.S. postal service on that same day with postage thereon fully prepaid at Glendale, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing in this affidavit.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on April 11, 2012, at Glendale, California.

Pauline Cisneros

Pauline Cisneros

Floreen Rooks
05170360
ADJ7024643

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

MINUTES OF HEARING

ADJ7024643
ADJ7024645
Case No.

02/09/2012
Date of Hearing (MM/DD/YYYY)

Hearing Information

☐ Before ☒ AT ☐ Trial ☒ Conf ☐ MSC ☐ EXP. HEARING ☐ Lien

Request Date (MM/DD/YYYY)

Applicant

FLOREEN
First Name

M.I.

BROOKS
Last Name

VS

Defendants

DVEAL FAMILY AND YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

Appearances

			Attorney	Hearing Rep
Applicant	☐ Present	☑ Not Present		
Applicant Represented By	w pro per		☐	☐
Defendant Represented By	LENA TSUI FOR STATE FUND		☒	☐
Others Appearing			☐	☐

Interpreter _____ Cert. No. _____

Party Making Request

☐ Joint ☐ Applicant ☐ Defendant ☐ Other _____

Request For: ☐ Continuance ☐ OTOC Request By: ☐ Letter ☐ Telephone

Position of Opposing Party

☐ Agree ☐ Oppose ☐ Unreachable ☐ Unknown

Reason For Request

- [ ] Applicant: Illness
- [ ] Applicant Now Represented
- [ ] Applicant Requests Representation
- [ ] Applicant: Vacation
- [ ] Calendar Conflict: Applicant
- [ ] Calendar Conflict: Defense
- [ ] Calendar Conflict: Lien Claimant
- [ ] Change of Circumstances
- [ ] Consolidation
- [ ] Defense: Illness
- [ ] Defense: Vacation
- [ ] Dispute Resolved by Agreement
- [ ] Further Discovery: App Med
- [ ] Further Discovery: Def Med
- [ ] Further Discovery: AME
- [ ] Further Discovery: Depo
- [ ] Improper/Insufficient Notice by Party
- [ ] Joinder
- [ ] New Application
- [ ] No Issues Pending
- [x] Non-Appearance-Applicant
- [ ] Non-Appearance-Defense
- [ ] Non-Appearance-Lien Claimant
- [ ] Non Appearance: Witness
- [ ] Settlement Pending
- [ ] Unavailability of Witnesses: Applicant
- [ ] Unavailability of Witnesses: Defense
- [ ] Venue

Board Reason

- [ ] Arbitration
- [ ] Bankruptcy Pending
- [ ] Defective Notice
- [ ] Insufficient Time to Start
- [ ] Insufficient Time to Finish
- [ ] Interpreter Not Available
- [ ] Recusal
- [ ] Reporter Not Available
- [ ] Service Defective
- [ ] UEF Issues
- [ ] WCJ Not Available
- [x] Other/Comments

Referred to Cynthia Goodwin @ I+A. No one is able to reach applicant despite many calls. Applicant is not present. PQME Dr. Fell is on file. Δ has increased offer. Applicant was under impression case was OTOC. Applicant has 1 more chance to appear at MSC or matter will be set for trial.

Good Cause Appearing, It is Ordered That the Request For

- [ ] Continuance Granted
- [ ] Continuance Denied
- [ ] OTOC Granted
- [ ] OTOC Denied

_____ Days For [ ] C&R [ ] STIPS [ ] OTOC

Decision

☐ OTOC ☐ C&R / STIPS Submitted for Approval ☐ C&R / STIPS Approved

☐ LIEN STIPS and ORDER Approved ☐ N.O.I. to Allow/Disallow Issued

☑ MSC ☐ CONF ☐ TRIAL ☐ LIEN TRIAL ☐ CONTD TESTIMONY

OK to set MSC
EHO

Set On 3/12/12 (MM/DD/YYYY) At 8:30

Location LBO

Before Judge Devine

☐ Supplemental Pages Attached _____ Pages

FEB 09 2012
Date - MM/DD/YYYY

Lynn Devine
WORKERS' COMPENSATION ADMINSTRATIVE LAW JUDGE
JUDGE LYNN A. DEVINE

Notice To dlf WT

Pursuant to Rule 10500 you are designated to serve this/these document(s) on all parties.

☑ Served on parties and lien claimants present A

DWC-CA form 10246 (11/2008) (Page 3)

8083

Lena W. Tsui (SBN)
State Compensation Insurance Fund
655 North Central Avenue, Suite 400
Glendale, CA 91203-1400

Mailing Address: P.O. Box 65005
Pinedale, CA 93650-5005

Telephone: 818-550-6736
Fax: 818-291-7881

Attorney for Defendant
State Compensation Insurance Fund

05170360

DIVISION OF WORKERS' COMPENSATION

STATE OF CALIFORNIA

FLOREEN ROOKS, Applicant, v. D'VEAL FAMILY & YOUTH SERVICES; STATE COMPENSATION INSURANCE FUND, Defendants.	Case No. ADJ7024643 **NOTICE OF HEARING**

NOTICE IS HEREBY GIVEN that this action has been set for hearing before the Division of Workers' Compensation as follows:

DATE:	**Monday, March 12, 2012**
TIME:	**08:30 AM**
TYPE OF HEARING:	**MSC**
LOCATION OF HEARING:	**Division of Workers' Compensation** **320 W. 4th Street, 9th Floor** **Los Angeles, CA 90013**
JUDGE:	**Lynn Devine**

8083

Please take notice that the claimant/applicant has the right to have a qualified interpreter present at this proceeding if he/she does not proficiently speak or understand the English language.

DATED: February 22, 2012

STATE COMPENSATION INSURANCE FUND

By: _____
Lena W. Tsui, Attorney

SCIF INSURED GLENDALE UNIT A
SALLY JACQUELINE G. SMITH
818-291-7270
SJGSMITH@SCIF.COM

PROOF OF SERVICE BY MAIL - CCP 1013a, 2015.5

I declare that I am employed in the County of Los Angeles, State of California. I am over the age of eighteen years and not a party to the within entitled cause. My business address is: 655 North Central Avenue, Suite 400, Glendale, California 91203-1400. On February 22, 2012, I served the attached **NOTICE OF HEARING; MINUTES OF HEARING** on the interested parties in said cause, by placing a true copy thereof, enclosed in an envelope addressed as follows:

Floreen Rooks
2374 Olive Avenue
Altadena, CA 91001

D'Veal Family & Youth Services
P.O. Box 40255
Pasadena, CA 91114

I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice such envelope would be sealed and deposited with U.S. postal service on that same day with postage thereon fully prepaid at Glendale, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing in this affidavit.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on February 22, 2012, at Glendale, California.

Pauline Cisneros

Floreen Rooks
05170360
ADJ7024643

DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF HEARING

DATE OF SERVICE: 02/10/2012

EAMS CASE NBR(s): ADJ7024643

EMPLOYEE: FLOREEN ROOKS

EMPLOYER: D'VEAL FAMILY & YOUTH SERVICES

INSURER: SCIF INSURED GLENDALE

TYPE OF HEARING: MSC

DATE OF HEARING: 03/12/2012 MONDAY

TIME OF HEARING: 08:30 A.M.

HEARING LENGTH (HOURS):

LOCATION: 320 W. 4TH ST.
#900
LOS ANGELES CA 90013

Map available at: *http://www.dir.ca.gov/dwc/dir2.htm*

JUDGE: Lynn Devine
213 576-7335

SPECIAL COMMENTS/INSTRUCTIONS:

You are hereby notified that the above entitled case is set for hearing before the Division of Workers' Compensation of the State of California. Continuances are not favored and will be granted only upon clear showing of good cause. Please arrive before scheduled appearance time.

NOTICE TO PARTIES: **Disability Accommodation is available upon request.** Individuals with a disability requiring a reasonable accommodation (such as an auxiliary aid or service or a modification of policies or procedures) to ensure effective communication and access to the programs of the Division of Workers' Compensation, should contact the **Disability Accommodation Coordinator** at the local District Office of the DWC, or the **Statewide Disability Accommodation Coordinator at 1-866-681-1459 (toll free) or through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TTY-Spanish).**

Accommodations can include reasonable modifications of procedures or the provision of auxiliary aids or services including, but not limited to, assistive listening devices (ALD), Computer-Aided Realtime Translation (CART), sign language interpreters, documents in alternative formats, magnifiers, and audio cassette recordings. **Accommodation requests should be made as soon as possible and at least five (5) days before the hearing, especially for requests for an ALD, a sign language interpreter, or CART.**

NOTICE TO INSURER : The employer will not receive Notice of Hearing.

WC01

LAO-ADJ
320 W. 4TH ST.
#900
LOS ANGELES CA 90013

SCIF INSURED GLENDALE
PO BOX 65005
PINEDALE CA 93650

DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF HEARING

DATE OF SERVICE: 02/10/2012

EAMS CASE NBR(s): ADJ7024645

EMPLOYEE: FLOREEN ROOKS

EMPLOYER: D'VEAL FAMILY & YOUTH SERVICES

INSURER: SCIF INSURED GLENDALE

TYPE OF HEARING: MSC

DATE OF HEARING: 03/12/2012 MONDAY

TIME OF HEARING: 08:30 A.M.

HEARING LENGTH (HOURS):

LOCATION: 320 W. 4TH ST.
#900
LOS ANGELES CA 90013

Map available at: *http://www.dir.ca.gov/dwc/dir2.htm*

JUDGE: Lynn Devine
213 576-7335

SPECIAL COMMENTS/INSTRUCTIONS:

You are hereby notified that the above entitled case is set for hearing before the Division of Workers' Compensation of the State of California. Continuances are not favored and will be granted only upon clear showing of good cause. Please arrive before scheduled appearance time.

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NOTICE TO INSURER : The employer will not receive Notice of Hearing.

WC01

LAO-ADJ
320 W. 4TH ST.
#900
LOS ANGELES CA 90013

SCIF INSURED GLENDALE
PO BOX 65005
PINEDALE CA 93650

DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

NOTICE OF HEARING

DATE OF SERVICE: 01/09/2012

EAMS CASE NBR(s): ADJ7024643

EMPLOYEE: FLOREEN ROOKS

EMPLOYER: D'VEAL FAMILY & YOUTH SERVICES

INSURER: SCIF INSURED GLENDALE

TYPE OF HEARING: Status Conference

DATE OF HEARING: 02/09/2012 THURSDAY

TIME OF HEARING: 08:30 A.M.

HEARING LENGTH (HOURS):

LOCATION: 320 W. 4TH ST.
#900
LOS ANGELES CA 90013

Map available at: *http://www.dir.ca.gov/dwc/dir2.htm*

JUDGE: Lynn Devine
213 576-7335

SPECIAL COMMENTS/INSTRUCTIONS:

RE: OSA

You are hereby notified that the above entitled case is set for hearing before the Division of Workers' Compensation of the State of California. Continuances are not favored and will be granted only upon clear showing of good cause. Please arrive before scheduled appearance time.

NOTICE TO PARTIES: **Disability Accommodation is available upon request.** Individuals with a disability requiring a reasonable accommodation (such as an auxiliary aid or service or a modification of policies or procedures) to ensure effective communication and access to the programs of the Division of Workers' Compensation, should contact the **Disability Accommodation Coordinator** at the local District Office of the DWC, or the **Statewide Disability Accommodation Coordinator at 1-866-661-1459 (toll free) or through the California Relay Service, by dialing 711 or 1-800-735-2929 (TTY) or 1-800-855-3000 (TTY-Spanish).**

Accommodations can include reasonable modifications of procedures or the provision of auxiliary aids or services including, but not limited to, assistive listening devices (ALD), Computer-Aided Realtime Translation (CART), sign language interpreters, documents in alternative formats, magnifiers, and audio cassette recordings. **Accommodation requests should be made as soon as possible and at least five (5) days before the hearing, especially for requests for an ALD, a sign language interpreter, or CART.**

NOTICE TO INSURER : The employer will not receive Notice of Hearing.

WC01

8083

3. Applicant releases Defendants and State Compensation Insurance Fund from further liability for any claim that applicant may have against Defendants and State Compensation Insurance Fund for, or as a result of, any and all claims against Applicant made by CMS against these settlement proceeds, and for sums which may be paid by Medicare to the applicant in the future for this industrial injury. Applicant releases Defendants and State Compensation Insurance Fund from any liability for any claim made by or against applicant due to loss, either at present or in the future, of Federal Program benefits, including but not limited to: Social Security, the aforementioned Medicare benefits including prescriptions, and possibly other relief and entitlement benefits governed by Federal Statute, to the extent the Applicant would have been entitled to same in the absence of this settlement. Applicant acknowledges and verifies he/she has read (or has had read to him/her) the entire Compromise and Release, including this Addendum. He/She understands and accepts the provisions of these documents. Applicant acknowledges he/she has the right to discuss these documents with legal counsel, and if represented, he/she has had the opportunity to confidentially discuss same with legal counsel so as to fully understand the significance of these documents.

Signed this 5 day of March 2012 at L.A. County, California.

APPLICANT Florence Cooks

APPLICANT'S ATTORNEY _____

INTERPRETER _____

CERTIFICATION NUMBER _____

D'VEAL FAMILY AND YOUTH SERVICES

FACSIMILE TRANSMITTAL SHEET

TO: Yolanda
FROM: ☐ F. Rooks
COMPANY: 707 646-2609
DATE: 3/5/12
FAX NUMBER:
TOTAL NO. OF PAGES, INCLUDING COVER: ~~6~~ 2
PHONE NUMBER:
Pg 3 of 3
RE: > C + R

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

For further questions please contact: ☐

Hello ☺

attached are 5 pgs that I thought would suffice. If not call me please (626) 744-1906 x22

Thanks

855 N. ORANGE GROVE BLVD., PASADENA, CA 91103, (626) 796-3453

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 5 day of March 2012 at Pasadena, CA

Florence Lobo 3/5/2012

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

3. Applicant releases Defendants and State Compensation Insurance Fund from further liability for any claim that applicant may have against Defendants and State Compensation Insurance Fund for, or as a result of, any and all claims against Applicant made by CMS against these settlement proceeds, and for sums which may be paid by Medicare to the applicant in the future for this industrial injury. Applicant releases Defendants and State Compensation Insurance Fund from any liability for any claim made by or against applicant due to loss, either at present or in the future, of Federal Program benefits, including but not limited to: Social Security, the aforementioned Medicare benefits including prescriptions, and possibly other relief and entitlement benefits governed by Federal Statute, to the extent the Applicant would have been entitled to same in the absence of this settlement. Applicant acknowledges and verifies he/she has read (or has had read to him/her) the entire Compromise and Release, including this Addendum. He/She understands and accepts the provisions of these documents. Applicant acknowledges he/she has the right to discuss these documents with legal counsel, and if represented, he/she has had the opportunity to confidentially discuss same with legal counsel so as to fully understand the significance of these documents.

Signed this 5 day of March 2012 at L.A. County, California.

APPLICANT _____

APPLICANT'S ATTORNEY _____

INTERPRETER _____

CERTIFICATION NUMBER _____

3. RODGERS/CARTER RELEASE – Supplemental Job Displacement Benefits

In the event applicant has participated, is participating, or later participates in an education related re-training or skill enhancement program or plan, pursuant to Labor Code section 4658.5, the following release applies: Applicant has been advised, fully understands, and specifically agrees this settlement agreement releases all liability of the defendants for any workers' compensation benefits including, but not limited to, potential disability benefits and medical benefits, to which applicant may be entitled for any injury or injuries to applicant that may occur or might have occurred during education related re-training or skill enhancement program which are a direct and natural consequence of the original injury or injuries recited in this Compromise and Release. The applicant hereby agrees to waive such potential claim or claims for workers' compensation benefits pursuant to *Rodgers v. Workers' Comp. Appeals Bd. et al.* (1985) 168 Cal.App.3d 567, 50 Cal.Comp.Cases 299, and *Carter et al., v. County of Los Angeles et al.* (1986) 51 Cal.Comp.Cases 255 (*en banc*).

APPLICANT Florence Locke DATE March 5, 2012

APPLICANT'S ATTORNEY _____ DATE _____

DEFENDANT'S ATTORNEY _____ DATE _____

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 62,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount.

$ ~~14986.14~~ ~~15515.14~~ 16435.14 for permanent disability advances through ~~01/31/2012~~ 01/17/2012 2-28-12 AND CONTINUING

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 45,564.86, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

THIS COMPROMISE & RELEASE (C&R) INCLUDES RESOLUTION OF ALL ISSUES, ALL DATES OF INJURIES, ALL BODY PARTS INDICATED IN THE CLAIM FORM INCLUDING RIGHT FOOT, LEFT ANKLE, RIGHT ANKLE LEFT KNEE; AND OTHER BODY PARTS MENTIONED IN ANY MEDICAL REPORT(S).

THIS C&R INCLUDES ALL TEMPORARY DISABILITY (TD), RETRO TD, PERMANENT DISABILITY (PD), RETRO PD, VOCATIONAL REHABILITATION MAINTENANCE ALLOWANCE (VRMA), RETRO VRMA, SUPPLEMENTAL JOB DISPLACEMENT BENEFIT (SJDB), RETRO MEDICAL BENEFITS, FUTURE MEDICAL BENEFITS, MILEAGE, OUT OF POCKET MEDICAL EXPENSES, PENALTIES, AND INTERESTS (P&I).

PENALITES AND INTEREST WILL BE WAIVED WHEN C&R AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT OF STATE FUND.

ALL MED LEGAL FEES WILL BE PAID BY STATE FUND.

STATE FUND WILL ADDRESS ALL LIENS.

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California
County of **Los Angeles**

On MARCH 5, 2012 (Date) before me, **Gustavo R. Salgado, Notary Public** (Here Insert Name and Title of the Officer)

personally appeared FLOREEN ROOKS (Name(s) of Signer(s))

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Signature of Notary Public)

GUSTAVO R. SALGADO
COMM. #1811961
NOTARY PUBLIC - CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires Sep. 26, 2012

Place Notary Seal Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: COMPROMISE + RELEASE

Document Date: 3-5-12 Number of Pages: 9

Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name:	Signer's Name:
☐ Individual	☐ Individual
☐ Corporate Officer — Title(s):	☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☐ General
☐ Attorney in Fact	☐ Attorney in Fact
☐ Trustee	☐ Trustee
☐ Guardian or Conservator	☐ Guardian or Conservator
☐ Other:	☐ Other:
Signer Is Representing:	Signer Is Representing:
RIGHT THUMBPRINT OF SIGNER — Top of thumb here	RIGHT THUMBPRINT OF SIGNER — Top of thumb here

D'VEAL FAMILY AND YOUTH SERVICES

FACSIMILE TRANSMITTAL SHEET

TO: Yolanda

FROM: ☐ F. Rooks

COMPANY: 707 646-2609

DATE: 3/5/12

FAX NUMBER:

TOTAL NO. OF PAGES, INCLUDING COVER: (6)

PHONE NUMBER:

RE: > C + R

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

For further questions please contact: ☐

Hello ☺

attached are 5 pgs that I thought would suffice. If not call me please (626) 744-1906 x22

Thanks

855 N. ORANGE GROVE BLVD., PASADENA, CA 91103, (626) 796-3453

8083

05170360

STATE OF CALIFORNIA
WORKERS' COMPENSATION APPEALS BOARD

FLOREEN ROOKS, Applicant,

vs.

D'VEAL FAMILY & YOUTH SERVICES; STATE COMPENSATION INSURANCE FUND, Defendants.

Case No(s): ADJ7024643 ADJ7024645

ORDER APPROVING COMPROMISE AND RELEASE And AWARD

☒ JOINT ORDER APPROVING C&R

The parties have filed a Compromise and Release in the above-entitled action together with the entire medical record, which is admitted into evidence and have waived the provisions of Labor Code § 5313. For the reasons set forth in the Compromise and Release and based upon an evaluation of the entire record, the settlement appears adequate and should be approved.

☒ The court has considered the release of applicant's dependents' rights to death benefits in determining the adequacy of the Compromise and Release. Sumner v. WCAB, 48 CCC 369.

☒ The court has considered the applicant's release of Supplemental Job Displacement Benefits in the Compromise and Release.

☐ In view of the contested issues as set forth in the offer of proof, there are good faith issues, which, if resolved against the employee, would defeat the employee's right to compensation.

☐ The parties have filed a Medicare Set Aside as part of the Compromise and Release.

Now therefore, IT IS ORDERED that said Compromise and Release is approved. ☑ Addendums attached are side agreements that do not require judicial approval or exceed jurisdiction.

AWARD is made in favor of FLOREEN ROOKS and against STATE COMPENSATION INSURANCE FUND in the sum of $ 62,000

less the sum of $ 0

payable to N/A as reasonable attorney's fees,

☒ and less permanent disability advances, according to proof, of $ 16435.14

☐ and less _____ of $ _____

☒ leaving a balance payable to applicant of $ 45,564.86

The Board retains jurisdiction over liens filed to date and penalties and interest thereon.

Dated: MAR 1 2 2012

LYNN A. DEVINE
Workers' Compensation Judge

☑ Defendant/ ~~applicant~~ Ordered to serve _____ Service on Official Address Record: By: _____ Date: _____

YOLANDA NIELSEN
MAR 1 4 2012
GLENDALE LOC.

JOSE HERRERA - ACM
JAN 17 2012
LA/TRI COUNTY CLAIMS

8083

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

ADJ7024643
Case Number 1

Case Number 4

ADJ 7024645
Case Number 2

Case Number 5

Case Number 3

130-38-8570
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

[X] County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

[ ] County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

[ ] County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

LAO
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(Completion of this section is required)

FLOREEN
First Name

MI

ROOKS
Last Name

2374 OLIVE AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

ALTADENA
City

CA
State

91001
Zip Code

Employer Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

D'VEAL FAMILY & YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

PO BOX 40255
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PASADENA
City

CA
State

91114
Zip Code

ADJUSTER: YOLANDA NIELSEN GLENDALE (SA)

Tracking Id: 12369162

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

LENA
First Name

TSUI
Last Name

5225007
Law Firm Number

SCIF INSURED GLENDALE UNIT A
Law Firm Name

PO BOX 65005
Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE CA 93650
City State Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE CA 93650
City State Zip Code

Tracking Id: 12369162

Claims Administrator Information (if known and if applicable)

SCIF INSURED GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE — City
CA — State
93650 — Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 06/20/1949 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

THERAPIST (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

[X] Specific injury

ADJ7024643
Case Number 1

[ ] Cumulative injury

11/10/2007 (Start Date: MM/DD/YYYY)
(End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 530 FOOT RT
Body Part 2: 513 KNEE LEFT
Body Part 3: 520 RIGHT
Body Part 4:
Other Body Parts:

The injury occurred at JOBSITE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

ALTADENA — City
CA — State
91001 — Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[X] Specific Injury

ADJ 7024645
Case Number 2

[ ] Cumulative Injury

08/09/2007
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific injury, use the start date as the specific date of injury)

Body Part 1: 513 KNEE LEFT Body Part 2: 520 ANKLE LEFT Body Part 3: 440 HIP LEFT

Body Part 4: _____ Other Body Parts: _____

The injury occurred at COMPANY OUTING
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

LOS ANGELES , CA 91001
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[ ] Specific Injury

Case Number 3

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[ ] Specific Injury

Case Number 4

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Tracking Id: 12369162

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City _____ State _____ Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 389 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 971.15

TEMPORARY DISABILITY INDEMNITY PAID 30885.53 Weekly Rate $ 647.44

Period(s) Paid 08/22/2007 (Start Date: MM/DD/YYYY) 09/14/2008 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 14986.14 ~~15,515.14~~ 16,435.14 Weekly Rate $ 230.00 + 264.50

Period(s) Paid 09/19/2008 (Start Date: MM/DD/YYYY) End date ~~01/17/2012~~ ~~4/8/2012~~ 2-28-12 (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 20836.63 Total Unpaid Medical Expense to be Paid By: DEFENDANTS

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 62,000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount.

$ ~~14996.14~~ 16,435.14 for permanent disability advances through ~~01/17/2012~~ 2-28-12 AND CONTINUING

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ 45,564.86, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

THIS COMPROMISE & RELEASE (C&R) INCLUDES RESOLUTION OF ALL ISSUES, ALL DATES OF INJURIES, ALL BODY PARTS INDICATED IN THE CLAIM FORM INCLUDING RIGHT FOOT, LEFT ANKLE, RIGHT ANKLE LEFT KNEE, AND OTHER BODY PARTS MENTIONED IN ANY MEDICAL REPORT(S).

THIS C&R INCLUDES ALL TEMPORARY DISABILITY (TD), RETRO TD, PERMANENT DISABILITY (PD), RETRO PD, VOCATIONAL REHABILITATION MAINTENANCE ALLOWANCE (VRMA), RETRO VRMA, SUPPLEMENTAL JOB DISPLACHMENT BENEFIT (SJDB), RETRO MEDICAL BENEFITS, FUTURE MEDICAL BENEFITS, MILEAGE, OUT OF POCKET MEDICAL EXPENSES, PENALTIES, AND INTERESTS (P&I).

PENALITIES AND INTEREST WILL BE WAIVED WHEN C&R AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT OF STATE FUND.

ALL MED LEGAL FEES WILL BE PAID BY STATE FUND.

STATE FUND WILL ADDRESS ALL LIENS.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
DV	DV	damage
DV	DV	temporary disability
DV	DV	jurisdiction
DV	DV	apportionment
DV	DV	employment
DV	DV	injury AOE/COE
DV	DV	serious and willful misconduct
DV	DV	discrimination (Labor Code §132a)
DV	DV	statute of limitations
DV	DV	future medical treatment
DV	DV	other ALL ISSUES
DV	DV	permanent disability 24% LT ANKLE/LT KNEE
DV	DV	self-procured medical treatment, except as provided in Paragraph 7
DV	DV	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS

INJURED WORKER IS NOT RECEIVING MEDICARE BENEFITS AT THIS TIME AND IS CURRENTLY CONTINUALLY WORKING FULL TIME WITH DVEAL FAMILY & YOUTH SERVICES SO THERE IS NO NEED FOR A MEDICARE SET ASIDE ALLOCATION REPORT AT THIS TIME. SETTLEMENT BASED ON PANEL QME REPORT OF DR. THOMAS FELL DATED 3/7/2011 AND INCLUDES ADDENDA "A to B".

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 5 day of March 2012 at Pasadena, CA

Witness 1	(Date)	Applicant (Employee) Steven Lotter	(Date) 3/5/2012
Witness 2	(Date)	Attorney for Applicant	(Date) 3-5-12
Interpreter	(Date)	Attorney for Defendant YOLANDA NELSON, CLAIMS ADJUSTER	(Date)
		Attorney for Defendant	(Date) 3/5/2012
		Attorney for Defendant JOE HERRERA, ASSISTANT CLAIMS MANAGER	(Date)
		Attorney for Defendant	(Date)

ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Tracking Id: 12369162

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California
County of Los Angeles

On MARCH 5, 2012 (Date) before me, Gustavo R. Salgado, Notary Public (Here Insert Name and Title of the Officer)

personally appeared FLOREEN ROOKS (Name(s) of Signer(s))

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

GUSTAVO R. SALGADO
COMM. #1811961
NOTARY PUBLIC - CALIFORNIA
LOS ANGELES COUNTY
My Comm. Expires Sep. 26, 2013

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Signature of Notary Public)

Place Notary Seal Above

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: COMPROMISE + RELEASE

Document Date: 3-5-12 Number of Pages: 9

Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name:	Signer's Name:
☐ Individual	☐ Individual
☐ Corporate Officer — Title(s):	☐ Corporate Officer — Title(s):
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☐ General
☐ Attorney in Fact	☐ Attorney in Fact
☐ Trustee	☐ Trustee
☐ Guardian or Conservator	☐ Guardian or Conservator
☐ Other:	☐ Other:
Signer Is Representing:	Signer Is Representing:
RIGHT THUMBPRINT OF SIGNER — Top of thumb here	RIGHT THUMBPRINT OF SIGNER — Top of thumb here

8083

APPLICANT: FLOREEN ROOKS
WCAB CASE NUMBER(S): ADJ7024643, ADJ 7024645
SCIF CLAIM NUMBER(S): 05170360 AMD 05/29/68

LIEN ADDENDUM

LIENS OF RECORD AND AFFIDAVIT
RE: GOOD FAITH EFFORTS TO RESOLVE LIENS

The following are the liens of record as of the date of this Compromise and Release. Defendants will pay, adjust, or litigate, the following liens, less credit for payments previously made.

Jurisdiction is reserved with the Workers' Compensation Appeals Board as to all issues that may arise regarding disposition of these liens.

Lien Claimant Name & Address	Amount	Description, Date & Result of Lien Resolution Efforts
There are no liens on record for this claim.		

FREEFORM PARAGRAPH

I declare under penalty of perjury as follows:

I am the representative for defendant State Compensation Insurance Fund. I have made the above-referenced good faith efforts to resolve each of the listed liens.

Y Nieves 1-31-12

State Fund Representative Date

YOLANDA NIEVES
CLAIMS ADJUSTOR

APPLICANT: Floreen Rooks

WCAB NO: ADJ7024643 & ADJ7024645

STATE FUND CLAIM NO: 05170360 & 05124168

SJDB/Rodgers & Carter/Accrued Benefits Addendum A

1. SETTLEMENT OF ACCRUED BENEFITS

The settlement includes any claims for retroactive benefits and reimbursement, including, but not limited to, temporary disability indemnity, mileage reimbursement, out-of-pocket medical expense, and any interest or penalties, including, but not limited to, sanctions and self-imposed penalties, claimed up to the date of the Order Approving Compromise and Release.

2. SUPPLEMENTAL JOB DISPLACEMENT BENEFITS [SELECT ONE]

☑ Applicant is not prevented from returning or has returned to work for the employer; therefore, applicant is not entitled to the supplemental job displacement benefit.

☐ The employer has offered modified or alternative work; therefore, applicant is not entitled to the supplemental job displacement benefit.

☐ As a result of the injury settled herein, applicant is entitled to a SJDB voucher in an amount (select one of the following amounts if entitled to SJDB voucher)

☐ up to $4,000 (PD less than 15%) ☐ up to $6,000 (PD: 15% to 25%)

☐ up to $8,000 (PD: 26% to 49% ☐ up to $10,000 (PD: 50% to 99%)

☐ The settlement amount indicated in paragraph 7 includes consideration to settle the potential eligibility for the SJDB voucher. Therefore, no supplemental job displacement benefit is owed to applicant. [8 CCR 10133.52]

3. RODGERS/CARTER RELEASE – Supplemental Job Displacement Benefits

In the event applicant has participated, is participating, or later participates in an education related re-training or skill enhancement program or plan, pursuant to Labor Code section 4658.5, the following release applies: Applicant has been advised, fully understands, and specifically agrees this settlement agreement releases all liability of the defendants for any workers' compensation benefits including, but not limited to, potential disability benefits and medical benefits, to which applicant may be entitled for any injury or injuries to applicant that may occur or might have occurred during education related re-training or skill enhancement program which are a direct and natural consequence of the original injury or injuries recited in this Compromise and Release. The applicant hereby agrees to waive such potential claim or claims for workers' compensation benefits pursuant to *Rodgers v. Workers' Comp. Appeals Bd. et al.* (1985) 168 Cal.App.3d 567, 50 Cal.Comp.Cases 299, and *Carter et al., v. County of Los Angeles et al.* (1986) 51 Cal.Comp.Cases 255 (*en banc*).

APPLICANT Eileen Rooker DATE March 5, 2012

APPLICANT'S ATTORNEY _____ DATE _____

DEFENDANT'S ATTORNEY Y Nelson DATE 3-5-12

YOLANDA NELSON.
CLAIMS ADJUSTA

APPLICANT Floreen Rooks

SOCIAL SECURITY NUMBER 130-38-8570

WCAB NUMBER ADJ7024643 & ADJ7024645

CLAIM NUMBER 05170360 & 05124168

ADDENDUM B

MEDICARE ELIGIBILITY VERIFICATION

I, Floreen Rooks, attest that I am not currently receiving, nor have I ever received Medicare benefits at the time of the approval of the Compromise and Release in this matter.

1. I do understand that this Medicare Eligibility Verification is an essential part of the settlement on my workers compensation case by way of a Compromise and Release. I do understand that I have a right to seek the advice of an attorney if I have any questions. I do understand that, under Federal Law: I, as beneficiary am "...responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers compensation"; and that Medicare will not pay benefits until my remedies under workers compensation are exhausted. (Title 42CFR 411.43)

2. I do understand that, in the event that I have ever received, are currently receiving, or have ever applied for Medicare benefits, my failure to advise Medicare of my receipt of benefits under the Workers Compensation System in the State of California may result in Medicare's refusal to pay for any medical services until such time as my medical expenditures have exhausted the amount of this Compromise and Release or the portion of the Compromise and release which clearly relates to medical care.

☑ A. For Medicare purposes, this Compromise & Release includes an allocation of $21,965.00 in consideration for the applicant's Permanent Disability, estimated to be rated at 24 %, with regard to the industrial injury. The settlement amount also takes into consideration other disputed benefits, such as temporary disability benefits, past and future, non-Medicare covered expenses such as nursing home fees, all or a portion of sums which are claimed as regular non-medical benefits. The balance of settlement proceeds is paid in consideration of potential medical benefits, including pharmacy costs, which is valued at the sum of $ 27,621.00 PER MSA 2-17-12

☐ B. The Applicant and Defendant agree that the settlement sum indicated in Paragraph #7 of this Compromise & Release includes $_____ (*total MSA recommended amount*) in consideration for the Applicant's estimated Medicare-covered future medical expenses due to the industrial injury. A third-party vendor specializing in Medicare allocation and set-aside issues has reviewed the Applicant's history of medical expenses and treatment resulting from the subject industrial injury and made a recommendation for the Medicare Set-Aside. See attached report from _____

(*name of third-party vendor*), which is incorporated herein by reference. The Medicare Set-Aside allocation has been completed but not submitted to the Centers for Medicare and Medicaid Services for approval. A copy of the Medicare Set-Aside allocation has been provided to the Applicant.

3. Applicant releases Defendants and State Compensation Insurance Fund from further liability for any claim that applicant may have against Defendants and State Compensation Insurance Fund for, or as a result of, any and all claims against Applicant made by CMS against these settlement proceeds, and for sums which may be paid by Medicare to the applicant in the future for this industrial injury. Applicant releases Defendants and State Compensation Insurance Fund from any liability for any claim made by or against applicant due to loss, either at present or in the future, of Federal Program benefits, including but not limited to: Social Security, the aforementioned Medicare benefits including prescriptions, and possibly other relief and entitlement benefits governed by Federal Statute, to the extent the Applicant would have been entitled to same in the absence of this settlement. Applicant acknowledges and verifies he/she has read (or has had read to him/her) the entire Compromise and Release, including this Addendum. He/She understands and accepts the provisions of these documents. Applicant acknowledges he/she has the right to discuss these documents with legal counsel, and if represented, he/she has had the opportunity to confidentially discuss same with legal counsel so as to fully understand the significance of these documents.

Signed this 5 day of March 2012 at L.A. County, California.

APPLICANT Steven Rooks

APPLICANT'S ATTORNEY _____

INTERPRETER _____

CERTIFICATION NUMBER _____

8.Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

9.Other stipulations:

PER PQME, DR. THOMAS FELL 3/17/11, RIGHT FOOT IS COMPLETELY HEALED WITH NO RESIDUALS AND NO FUTURE MEDICAL.

PER PQME, DR. THOMAS FELL 3/17/11, NO FUTURE MEDICAL TO THE LEFT ANKLE AS THIS IS DUE TO PRE-EXISTING ARTHRITIS.

FUTURE MEDICAL REGARDING THE LEFT KNEE WILL BE BASED ON PQME REPORT OF DR. THOMAS FELL 3/17/11 AND SUBJECT TO STATE FUND'S UTILIZATION REVIEW.

PENALTIES AND INTERESTS WILL BE WAIVED IF AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT OF STATE FUND.

STATE FUND WILL ADDRESS ALL LIENS EITHER BY PAYING, NEGOTIATING, SETTLING, OR LITIGATING.

Dated 06/06/2011 (MM/DD/YYYY) Floreen Cook (Applicant)

Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Dated (MM/DD/YYYY) Applicant Attorney Signature

DWC-CA form 10214 (a) Page 7 (Rev 11/2008)

8083

70360

STATE COMPENSATION INSURANCE FUND

ATTN: Yolanda Nielsen 6/06/2011

FAX 707-646-2609

June 3, 2011

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks

Enclosed are Stipulations with Request for Award in the above-entitled matter. We ask that you sign the form. Please also sign and date the enclosed Addendum(s) to the form. If you have any questions, you may contact me or a State Information and Assistance Office at 1-800-736-7401 or call your local Information and Assistance Officer at (213)576-7389.

Please complete the form(s) using all CAPITAL letters and in BLACK ink only. Do not fold, staple or bend any of the pages of the forms and return the form(s) in the enclosed envelope.

Please return the executed Stipulations with Request for Award to this office. I will then complete and submit it to the assigned Workers' Compensation Appeals Board for approval and I will return an executed copy to you.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7826

Enc: Business Reply Envelope (SCIF 19619)
Stipulation with Request for Awards (DWC-CA Form 10214(a)

Attached is signed pg.

P.O. Box 65005 • Pinedale, CA 93650-5305

19211

8083

STATE OF CALIFORNIA
Division of Workers' Compensation
Workers' Compensation Appeals Board

FLOREEN ROOKS,

Applicant,
vs.
D'VEAL FAMILY & YOUTH SERVICES;
SCIF INSURED GLENDALE;

Defendant.

Case No. ADJ7024643; ADJ7024645

ORDER SUSPENDING ACTION

The above document is on file herein. Approval thereof will be stayed and the matters set for hearing.

Action has been suspended for the following reason(s):

☒ 1. The stipulation does not address adequately address the two injuries, in particular the apportionment claimed between the two events, in particular the left ankle or right foot.

☒ 2. Dr. Saucedo MD does not perform an examination or report for all the parts of body at issue adequate to support the proposed stipulated awards or be rated by the DEU; the apportionment is unsupported by the medical record.

DATE: 01/06/2011

Lynn A. Devine

Lynn Devine
WORKERS' COMPENSATION
ADMINISTRATIVE LAW JUDGE

Served on relevant parties as shown on the OAR/ POS attached
By: lh **ON: 01/19/2012**
Lydia Hunter

Document ID: -4487780232027176960

8083

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

01-19-2012

OFFICIAL ADDRESS RECORD—PROOF OF SERVICE BY MAIL – CCP 1013a, 2015.5

ORDER SUSPENDING ACTION ON STIPULATIONS W/REQUEST FOR AWARD

Case Number: ADJ7024643; ADJ7024645

D'VEAL FAMILY & YOUTH SERVICES — Employer, 855 N ORANGE GROVE BLVD PASADENA CA 91103

FLOREEN ROOKS — **Injured Worker, 1315 S GLADYS AVE SAN GABRIEL CA 91776**

SCIF INSURED GLENDALE — **Insurance Company, PO BOX 65005 PINEDALE CA 93650**

PARTY(IES) IN BOLD PRINT HAS/HAVE BEEN SERVED VIA U.S. MAIL

I am over age 18, not a party to this proceeding, and am employed by the State of California, DWC, Los Angeles District Office of the WCAB, located at 320 W. 4th Street, Los Angeles, CA 90013.

On **01/19/2012** I deposited in the United States mail at 320 W. 4th Street, Los Angeles CA 90013, a sealed envelope containing a copy of **ORDER SUSPENDING ACTION ON STIPULATIONS W/REQUEST FOR AWARD,** with postage fully paid, addressed to the party or parties listed on the above.

"I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct."

Signed by: Lydia Hunter _____ **ON: 01/19/2012**

8083

November 15, 2007

Floreen Rooks
1317 1/2 S Gladys Ave
San Gabriel CA 91776

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of November 10, 2007.

Payments are beginning for temporary disability for the period from November 15, 2007 through November 15, 2007.

The payment in the amount of $92.49 was sent separately. Your temporary total disability payment is based on two-thirds of your average weekly wage at the time of injury and is subject to maximum and minimum rates which are set by state law depending on the date of injury. No payments will be paid to you for the first three days of disability unless you were hospitalized or are disabled for more than 14 days. For injuries occurring on or after April 19, 2004, it is also subject to a maximum of 104 compensable weeks within two years from the date of initial payment; or if the injury involves pulmonary fibrosis, chronic lung disease, chemical burns to the eyes, human immunodeficiency virus (HIV), severe burns, amputations, or high velocity eye injuries – a maximum of 240 compensable weeks within five years from the date of injury. Your weekly compensation rate is $647.44 based on your earnings of $971.15 per week.

Payments will be sent every two weeks on Thursday until you are able to return to work, your medical condition becomes permanent and stationary, or you have been paid the maximum number of benefit weeks allowed by law, whichever occurs first.

If you believe your average weekly wages noted above are inaccurate, please provide us with additional earnings documentation from any employment so that we may make the appropriate adjustment to your temporary disability rate. The rate noted above may change pending additional earnings information.

We will also pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of 48.5 cents a mile. If you receive any medical bills, please send them to me.

02 324022 000000001 300 378 05170360

You may also receive recorded information by calling the state Information and Assistance Officer at 1-800-736-7401 or you may call your local Information and Assistance Officer at 1-213-576-7389.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number 1-888-222-3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

If you have any questions, please feel free to call me at the number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626
Fax: (707)646-2609

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

**You may lose important rights if you do not take certain actions within 10 days.
Read this letter and any enclosed fact sheets very carefully.**

September 18, 2008

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING TEMPORARY DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of temporary disability payments for your workers' compensation injury of November 10, 2007.

Your final payment of temporary disability was sent separately. Payments are ending because you have returned to modified work on September 15, 2008.

Temporary disability benefits paid to you total $28,487.36. This amount covers the following period(s) at the following rate(s) per week: from 11/12/07 through 09/14/08 at $647.44 per week.

Our records indicate that you have not participated in a comprehensive medical evaluation. Please be advised that both you and State Compensation Insurance Fund have the right to disagree with the treating doctor's findings regarding your temporary disability status. The Workers' Compensation Laws of California under Labor Codes § § 4062 and 4062.1 provide a process to follow when such a disagreement arises. Either you or State Fund may request and obtain (at no cost to you) a comprehensive medical evaluation prepared by a physician selected from a panel of Qualified Medical Evaluators to help resolve the dispute. These medical evaluators are physicians certified by the Administrative Director of the Division of Workers' Compensation specifically for these purposes.

We accept the findings of your treating physician.

If you disagree with our decision or the findings of the treating physician, enclosed is the form prescribed by the DWC Medical Unit for your use to request assignment of a panel of Qualified Medical Evaluators. If you choose to request a panel, you have 10 days to submit your request to the DWC Medical Unit. If you do not submit your request within 10 days, Labor Code § 4062.1 allows the State Fund to submit the panel request.

When the Administrative Director sends you the panel, you are responsible for selecting one of the physicians on the panel, making the appointment and providing us this information. You have up to 10 days from receipt of the panel to do this. Please complete the attached form (Panel QME Appointment Notice SCIF Form 3051) to notify us of the name of the doctor you have chosen and the date of the appointment. We are required to send you money for mileage and any other allowed expenses. When scheduling an appointment, please allow at least 20 days for State Fund to send your medical file to the physician before the examination date. If you do not select the physician from the panel within 10 days, Labor Code § 4062.1 allows State Fund to select the physician.

Since you have not filed a Workers' Compensation Claim Form (DWC−1), you are not entitled to participate in the panel Qualified Medical Evaluation process. If you wish to be evaluated by a Qualified Medical Evaluator, you must first submit a properly completed claim form. For your convenience, we have enclosed a Workers' Compensation Claim Form (DWC−1) for you to complete. Please complete the employee's section of the form and then forward the form to your employer so they can complete their section of the form. Once we receive the completed DWC−1 form, you may proceed with requesting a panel from the DWC Medical Unit.

While temporary disability benefits are ending, you may be entitled to other workers' compensation benefits. We will advise you if additional benefits are due.

We will continue to pay for appropriate medical care and will reimburse you for necessary transportation expenses at the rate of up to 58.5 cents a mile. If you receive any medical bills, please send them to me.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

> You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291−7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576−7389.
>
> For recorded information and a list of offices, call (800)736−7401. You may also visit the DWC website at:
>
> http://www.dir.ca.gov/DWC/dwc_home_page.htm
>
> You also have a right to consult with an attorney of your choice. Should you decide to

be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

The law limits the time period within which you may collect benefits. Should you disagree with any action taken by State Fund, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board by filing an Application for Adjudication of Claim within one year of the date of your injury, or one year from the last furnishing of indemnity or medical treatment benefits by your employer or State Fund. If you do not do so, your right to benefits may be lost.

Sincerely

Margarit Sislyan

Margarit Sislyan
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

Enc: How to Request a Qualified Medical Evaluation (SCIF e3475) (Rev. 01/08) [I&A 2 (Rev. 3/07)]
Request for QME (SCIF e3131) (Rev. 12/00) [IMC Form 106 (Rev. 4/14/00)]
QME Panel Appointment Notice (SCIF 3051)
Workers' Compensation Claim Form (SCIF e3301) (Rev. 7/04) [DWC-1 (Rev. 7/04)]
Business Reply Envelope
DWC Fact Sheet C (Rev. 2/08)
DWC Fact Sheet E (Rev. 12/05)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

Department of Industrial Relations

INDUSTRIAL MEDICAL COUNCIL

Request for Qualified Medical Evaluator

(Please Complete Form/type or Print)

EMPLOYEE INFORMATION	
TODAY'S DATE	DATE OF INJURY (LIST ONLY ONE) (Requests without month/day/year of injury will be returned).
September 18, 2008	November 10, 2007
NAME: Floreen Rooks	
ADDRESS: 1315 S Gladys Ave	
CITY, STATE, ZIP CODE: San Gabriel CA 91776-3623	
(AREA CODE) PHONE #: (626)573-1906	
If currently residing out of state, list residence at the time of injury:	
CITY, ZIP CODE:	

EMPLOYER INFORMATION
NAME D'Veal Family & Youth Services
ADDRESS Po Box 40255
CITY, STATE, ZIP CODE Pasadena CA 91114
(AREA CODE) PHONE # (826)798-3453

INSURER or CLAIMS ADMINISTRATOR INFORMATION
NAME: Yolanda Nielsen
ADDRESS: PO Box 92622
CITY, STATE, ZIP CODE: Los Angeles CA 90009-2622
(AREA CODE) PHONE #: (818)291-7626: CLAIM_NUMBER: 05170360

This Section to be Filled out by the Injured Worker ONLY

Please list ONLY ONE specialty (INSERT three letter code from the back of this form)

Yolanda L. Nielsen

Specialty Physician Requested: _____ _____ (signature of Adjuster) _____ (signature of Injured Worker)

PLEASE NOTE: Panels will be issued in the area of the injured worker's residence. If the injured worker resides out of state the panel will be issued in the area of residence at the time of injury. If due to special circumstances another city is required please attach letter of agreement from the carrier and the city and the zip code being requested.

If the IMC does not issue a panel within 15 working days after this request is received by the IMC, you are entitled to select a QME of your choice. Send this completed form to

DIVISION OF WORKERS' COMPENSATION MEDICAL UNIT
P.O. Box 71010
Oakland, CA 94612-7110
(510)288-3700 or (800)794-8900

For Use with the QME Panel Request Form

MD/DO SPECIALTY CODES

MAI Allergy and Immunology
MAA Anesthesiology
MRS Colon & Rectal Surgery
MDE Dermatology
MEM Emergency Medicine
MFP Family Practice – MD
OFP Family Practice –DO
OFM Family Practice – DO – Including Osteo-pathic Manipulation
MPM General Preventive Medicine
MOH Hand – Orthopaedic Surged
MPH Hand – Plastic Surgery
MSH Hand – Surgery
MMM Internal Medicine
MMV Internal Medicine – Cardiovascular Disease
MME Internal Medicine – Endocrinology Diabetes and Metabolism
MMG Internal Medicine –Gastroenterology
MMH Internal Medicine – Hematology
MMI Internal Medicine – Infectious Disease
MMO Internal Medicine – Medical Oncology
MMN Internal Medicine – Nephrology
MMP Internal Medicine – Pulmonary Disease
MMR Internal Medicine – Rheumatology
MOQ Medicine – Otherwise Qualified
MPN Neurology
MNS Neurological Surgery
MNM Nuclear Medicine
MOG Obstetrics and Gynecology
MPO Occupational Medicine
MOP Ophthalmology
MOS Orthopaedic Surgery
MOB Orthopaedic Surgery – Including Back
MTO Otolaryngology
MAP Pain Management–Anesthesiology
MPP Pain Management – Pain Medicine
MHA Pathology
MEP Pediatrics
MPR Physical Medicine & Rehabilitation
MPS Plastic Surgery
MPD Psychiatry
MRY Radiology
MSY Surgery
MSG Surgery – General Vascular
MTS Thoracic Surgery
MPT Toxicology – Occupational Medicine
MET Toxicology Emergency – Medicine
MUU Urology

NON–MD/DO SPECIALTY CODES

*denotes a doctor of chiropractic who has completed a chiropractic post–graduate specialty program
ACA Acupuncture
DCH Chiropractic
DCN Chiropractic – Neurology
DCO Chiropractic – Orthopaedic *
DCR Chiropractic – Radiology*
DCS Chiropractic – Sports Medicine*
DCT Chiropractic –Rehabilitation*
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology
PSN Psychology––Clinical Neuropsychology

Attachment to Form 106
Rev. 4/14/00

PLEASE RETURN IN THE ENCLOSED ENVELOPE

Claim #: 05170360

Claimant: Floreen Rooks

Adjuster: _____

I have made an appointment with the following Qualified Medical Evaluator:

DOCTOR: _____

ADDRESS: _____

CITY/ZIP: _____ PHONE: (_____)_____

DATE OF APPT:_____TIME OF APPT:_____

_____
Signature

QME Panel Appointment Notice (SCIF 3051)

September 18, 2008

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation claim for your injury of November 10, 2007.

It is too soon to tell if you will have any permanent disability from your injury. We will monitor your medical condition until it is permanent and stationary. At that time, a medical evaluation will be performed to determine the existence and extent of permanent disability and the need for continuing medical care. We expect to have this information by December 14, 2008 and we will notify you of the status of permanent disability at that time.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291-7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576-7389.

For recorded information and a list of offices, call (800)736-7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be

necessary for you to receive your benefits.

To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

Sincerely

Margarit Sislyan

Margarit Sislyan
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

Enc: DWC Fact Sheet D (Rev. 12/05)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

June 3, 2011

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of November 10, 2007.

Dr. Thomas Fell has determined in the comprehensive medical evaluation that your injury is permanent and stationary. The findings of this report indicate that your injury has resulted in permanent disability that we estimated to be 24%. The evaluation also indicates that you are in need of continuing medical care. Both you and State Compensation Insurance Fund have the right to disagree with the doctor's findings in this report.

Payments for permanent disability are continuing for the period from May 25, 2011 through June 7, 2011.

The payment in the amount of $460.00 will be sent on June 7, 2011. Your weekly compensation rate is $230.00 based on your earnings of $971.15 per week.

Payments will be sent to you every two weeks on Tuesday and will continue until $21,965.00 has been paid based on Dr. Thomas Fell permanent and stationary report. These payments will be deducted from any award you may receive.

State Fund accepts the results of the evaluation. The law provides that if either you or State Fund disputes the results of the evaluation, you may be requested to return to the medical evaluator for a new evaluation to resolve the dispute.

We will not request a rating of the physician's report from the State of California Disability Evaluation Unit. However, you may contact an Information and Assistance Officer to have the report reviewed and rated by the Disability Evaluation Unit.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291−7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576−7389.

For recorded information and a list of offices, call (800)736−7401. You may also visit the DWC website at:

http://www.dir.ca.gov/DWC/dwc_home_page.htm

You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number 1−888−222−3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291−7626

Enc: DWC Fact Sheet D (Rev. 11/2010)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

April 29, 2011

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of November 10, 2007.

Dr. Thomas Fell has determined in the comprehensive medical evaluation that your injury is permanent and stationary. The findings of this report indicate that your injury has resulted in permanent disability that we estimated to be 25%. The evaluation also indicates that you are in need of continuing medical care. Both you and State Compensation Insurance Fund have the right to disagree with the doctor's findings in this report.

Payments for permanent disability are resuming for the period from March 17, 2011 through April 26, 2011.

The payment in the amount of $1,347.14 was sent separately. Your weekly compensation rate is $230.00 based on your earnings of $971.15 per week.

Payments will be sent to you every two weeks on Tuesday and will continue until $23.172.50 has been paid based on Dr. Thomas Fell permanent and stationary report dated 3/17/11. These payments will be deducted from any award you may receive.

State Fund accepts the results of the evaluation. The law provides that if either you or State Fund disputes the results of the evaluation, you may be requested to return to the medical evaluator for a new evaluation to resolve the dispute.

We will not request a rating of the physician's report from the State of California Disability Evaluation Unit. However, you may contact an Information and Assistance Officer to have the report reviewed and rated by the Disability Evaluation Unit.

We have paid you permanent disability from 9/15/08 through 10/05/08 at the rate of $230.00/week. We have also paid you permanent disability from 9/17/07 through 1/20/08 at

the rate of $230.0/week under claim number 05124168.
These payments will be deducted from any award you may receive.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

> You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291−7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576−7389.
>
> For recorded information and a list of offices, call (800)736−7401. You may also visit the DWC website at:
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> http://www.dir.ca.gov/DWC/dwc_home_page.htm
>
> You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number 1−888−222−3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291−7626

Enc: DWC Fact Sheet D (Rev. 11/2010)
Dr. Thomas Fell of 03/17/2011

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

**You may lose important rights if you do not take certain actions within 10 days.
Read this letter and any enclosed fact sheets very carefully.**

January 8, 2009

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE REGARDING PERMANENT DISABILITY BENEFITS

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim. This notice is to advise you of the status of permanent disability payments for your workers' compensation injury of November 10, 2007.

The final permanent disability payment in the amount of $690.00 was sent separately.

These benefits are ending because your permanent disability benefit has been paid in full.

We have paid you a total amount of $690.00 in permanent disability benefits. If your case has not been previously finalized, this amount will be deducted from any award (or additional award) you may receive.

Benefits were paid to you from September 15, 2008 through October 5, 2008.

Our records indicate you have had a prior comprehensive medical evaluation. Both you and State Compensation Insurance Fund have the right to dispute the comprehensive medical evaluation doctor's findings. You may be requested to return to that physician for a new evaluation to resolve the dispute. We accept the findings of your treating physician.

Since you have not filed a Workers' Compensation Claim Form (DWC-1), you are not entitled to participate in the panel Qualified Medical Evaluation process. If you wish to be evaluated by a Qualified Medical Evaluator, you must first submit a properly completed claim form. For your convenience, we have enclosed a Workers' Compensation Claim Form (DWC-1) for you to complete. Please complete the employee's section of the form and then forward the form to your employer so they can complete their section of the form. Once we receive the completed DWC-1 form,

you may proceed with requesting a panel from the DWC Medical Unit.

The State of California, Division of Workers' Compensation requires that you be provided with the following:

> You have a right to disagree with decisions affecting your claim. If you have any questions regarding the information provided to you in this notice, please call Yolanda Nielsen at (818)291−7626. However, if you are represented by an attorney, you should call your attorney, not the claims adjuster. If you want further information on your rights to benefits or disagree with our decision, you may contact your local state Information & Assistance Office of the Division of Workers' Compensation by calling (213)576−7389.
>
> For recorded information and a list of offices, call (800)736−7401. You may also visit the DWC website at:
>
> http://www.dir.ca.gov/DWC/dwc_home_page.htm
>
> You also have a right to consult with an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

To resolve a dispute, you may apply to the Workers' Compensation Appeals Board or the Administrative Director.

The law limits the time period within which you may collect benefits. Should you disagree with any action taken by State Fund, in order to protect your rights, you must commence proceedings before the Workers' Compensation Appeals Board by filing an Application for Adjudication of Claim within one year of the date of your injury, or one year from the last furnishing of indemnity or medical treatment benefits by your employer or State Fund. If you do not do so, your right to benefits may be lost.

If you have moved, or are moving soon, or want to know the status of your benefit check, please call our toll free number 1−888−222−3211, Monday through Friday, between 7:00 a.m. and 5:00 p.m. PST.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen

Adjuster
(818)291-7626

Enc: Workers' Compensation Claim Form (SCIF e3301) (Rev. 7/04) [DWC-1 (Rev. 7/04)]
Business Reply Envelope
DWC Fact Sheet D (Rev. 12/05)
DWC Fact Sheet E (Rev. 12/05)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

CERTIFIED MAIL

September 18, 2008

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE OF POTENTIAL RIGHT TO SUPPLEMENTAL JOB DISPLACEMENT BENEFIT

If your injury causes permanent partial disability, which prevented you from returning to work within 60 days of the last payment of temporary disability, and the claims administrator has not provided you with a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work," you may be eligible for a supplemental job displacement benefit in the form of a nontransferable voucher for education-related retraining or skill enhancement, or both, at state approved or accredited schools.

The amount of the voucher for the supplemental job displacement benefit will be as follows:

Up to four thousand dollars ($4,000) for a permanent partial disability award of less than 15%.

Up to six thousand dollars ($6,000) for a permanent partial disability award between 15 and 25 %.

Up to eight thousand dollars ($8,000) for a permanent partial disability award between 26 and 49 %.

Up to ten thousand dollars ($10,000) for a permanent partial disability award between 50 and 99 %.

A permanent partial disability award is issued by a Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board. You may also settle your potential eligibility for a voucher as part of a compromise and release settlement for a lump sum payment. Any settlement must be reviewed and approved by a Workers' Compensation Administrative Law Judge.

The voucher may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement. Not more than 10 percent of the voucher moneys may be used for vocational or return to work counseling. A list of vocational return to work counselors is available on the Division of Workers' Compensation's website www.dir.ca.gov or upon request.

If you are eligible, and you have not already settled the benefit, you will receive the voucher from the claims administrator within 25 calendar days from the date the permanent partial disability award is issued by the Workers' Compensation Administrative Law Judge or the Workers' Compensation Appeals Board.

If modified or alternative work is available, you will receive a Form DWC-AD 10133.53 "Notice of Offer of Modified or Alternative Work" from the claims administrator within 30 days of the termination of temporary disability indemnity payments. The claims administrator will not be required to pay for supplemental job displacement benefits if the offer for modified or alternative work meets the following conditions:

(1) You have the ability to perform the essential functions of the job provided;
(2) The job provided is in a regular position lasting at least 12 months;
(3) The job provided offers wages and compensation that are at least 85 percent of those paid to you at the time of the injury; and
(4) The job is located within reasonable commuting distance of your residence at the time of injury.

If there is a dispute regarding the Supplemental Job Displacement Benefit, the employee or claims administrator may file Form DWC-AD 10133.55 "Request for Dispute Resolution before the Administrative Director."

If you have a question or need more information, you can contact your employer or the claims administrator listed below. You can also contact a State Division of Workers' Compensation Information and Assistance Officer.

Sincerely

Margarit Sislyan

Margarit Sislyan
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

September 18, 2008

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim for your injury of November 10, 2007. We are advising you that your employer continues to provide the modified or an alternative job that you have returned to. The Notice of Offer of Modified or Alternative Work and the Position Requirements are enclosed. Please complete and return this form by October 17, 2008. If you fail to respond to this offer by this date, it will be considered rejected.

Since this offer meets the requirements of LC § 4658.6, your employer has no liability for the supplemental job displacement benefit.

Since this offer meets the requirements of LC § 4658(d)(3)(A), any potential permanent disability benefits may be decreased by 15%.

If you have any questions, please feel free to call me at the number listed below. However, if an attorney represents you, this phone call should be made through your attorney.

Sincerely

Margarit Sislyan

Margarit Sislyan
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

Enc: Business Reply Envelope
Notice of Offer of Modified or Alternative Work [DWC-AD 10133.53](Rev. 8/06)

cc: D'Veal Family & Youth Services, PO Box 40255, Pasadena, CA 91114

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

Employer D'Veal Family & Youth Services is offering you the position of a Therapist.

You may contact concerning this offer. Phone No.: .

Date of offer: September 15, 2008 Date job starts: September 15, 2008

Claims Administrator: Yolanda Nielsen Claim Number: 05170360

NOTICE TO EMPLOYEE Name of employee: Floreen Rooks

Date of Injury: November 10, 2007 Date offer received: September 15, 2008

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work [X] Alternative Work [ ]

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages offered were less than 85% of the wages paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

_____ I accept this offer of Modified or Alternative work.

_____ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

_____ _____

Signature Date

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is <u>not</u> accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 daysof acceptance or rejection. (A.D., "SJDB," Division of Workers' Compensation, P.O. Box 420603, S.F., CA 94142-0603)If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the disputeby filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

POSITION REQUIREMENTS

Actual job title: Therapist

Wages: $971.15 per Week

Is salary of modified/alternative work the same as pre-injury job? Yes

Is salary of modified/alternative work at least 85% of pre-injury job? Yes

Will job last at least 12 months? Yes

Is the job a regular position required by the employer's business? Yes

Work location:

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): Date of report:

Date of last payment of Temporary Total Disability:

Preparer's Name: Margarit Sislyan

Preparer's Signature: Margarit Sislyan Date: September 18, 2008

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

Proof of Service By Mail

I am a citizen of the United States and a resident of the County of _____.
I am over the age of eighteen years and not a party to the within matter.

My business address is:

_____.

On _____, I served the **Notice of Offer of Modified or Alternative Work** on the parties listed below by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid, and thereafter deposited in the U. S. Mail at the place so addressed.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at _____on _____.

Signature:_____

Copies Served On:

October 25, 2011

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Floreen Rooks

We have received the March 17, 2011 permanent and stationary report of Dr. Thomas Fell, Jr., M.D., the Primary Treating Physician. Your doctor indicates that your injury has resulted in permanent disability, which we estimate is 24%. This rating is equivalent to $21,956.00.

To settle your claim, we are willing to offer you a Stipulated Award for 24%, which is equivalent to 95.5 weeks at $230.00 per week for the total amount of $21,956.00 less previously paid permanent disability advances in the amount of $11,697.14, and less any additional permanent disability advances through date the Award is paid.

A Stipulation with Request for Award settles all issues except the right to reopen for new and further disability and the right to future medical care. The parties generally agree as to the level of permanent disability. Permanent Disability is paid every two weeks until the benefits are paid in full. Future medical care may be awarded.

If you would rather receive a one time lump sum payment to settle your claim, we are willing to offer a Compromise and Release in the amount of $62,000.00 less previously paid permanent disability advances in the amount of $11,697.14, and less any additional permanent disability advances through date the Award is paid.

A Compromise and Release is a complete and full settlement and would settle any and all aspects of a claim. This would include temporary disability, permanent disability, future medical treatment, right to reopen, etc. In short, the employee has no further claims against the employer and State Compensation Insurance Fund. All monies would be paid in a lump sum amount.

Enclosed is a copy of your complete medical file for your review.

Before any settlement can be approved, the Workers' Compensation Appeals Board must review it. You can be assured that this settlement must be found to be fair and adequate before the Board will issue approval. To finalize your industrial injury claim(s), please check your preferred settlement option on the next page and return in the enclosed envelope.

If you have any questions, you may telephone me at the number listed below or you may

contact the Information and Assistance Officer provided to you at no charge by the State Division of Workers' Compensation at (213)576−7389.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291−7626

Enc: Business Reply Envelope
Medical File

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

_____ **I choose the Stipulations with Request for Award.**

_____ _____
Signature Date

_____ **I choose the Compromise and Release Agreement**

_____ _____
Signature Date

Please provide the following information and return in the enclosed envelope:

Are you currently receiving Medicare benefits? _____ Yes _____No

_____ _____
Signature Date

Have you applied for Social Security Disability Insurance (SSDI) benefits?
_____ Yes _____No

_____ _____
Signature Date

List of Medical Reports

ATTENTION: MEDICAL PROVIDERS
COPIES – Please dispose the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date
Synergy	03/23/2011
Dr. Thomas Fell	03/17/2011
Dr. Fell	01/26/2011
*State Fund	10/22/2010
*State Fund	10/13/2010
Dr. Thomas Saucedo	10/11/2010
Tomas Saucedo, Md	10/11/2010
*State Fund	10/05/2010
*State Fund	10/05/2010
Dr. Saucedo	09/04/2009
Thomas Saucedo, Md	01/23/2009
Tomas Saucedo, Md	01/23/2009
Thomas Saucedo	12/05/2008
Tomas Saucedo Md	12/05/2008
Tomas Saucedo, Md	12/05/2008
Thomas Saucedo, Md	11/11/2008
Tomas Saucedo, Md	11/11/2008
Ortho Supplemental Report	11/07/2008
Ortho Supplemental Report	11/07/2008
Ortho Supplemental Report	10/10/2008
Ortho Supplemental Report	10/10/2008
Ortho Supplemental Report	09/05/2008
Tomas Saucedo, Md	09/05/2008
Tomas Saucedo, Md	09/05/2008
Tomas Saucedo, Md	08/28/2008
Associated Sports Therapy	08/08/2008
Tomas Saucedo, Md	08/08/2008

Comppartners	07/22/2008
Comppartners	07/22/2008
Judith Moosmann, Rn	07/18/2008
Associated Sport Therapy	07/16/2008
*State Fund	07/15/2008
Assoc Sports Therapy	07/11/2008
Tomas Saucedo, Md	07/11/2008
Tomas Saucedo, Md	07/02/2008
Comppartners	06/28/2008
Assoc Sports Therapy	06/19/2008
Associated Sport Therapy	06/18/2008
Associated Sport Therapy	06/18/2008
Assoc Sport Therapy	06/06/2008
Assoc Sports Therapy	06/06/2008
Pt	06/06/2008
Thomas Saucedo, M.D.	06/06/2008
Tomas Saucedo, Md	06/06/2008
Eoma	05/26/2008
Assoc Sports Therapy	05/22/2008
Comppartners	05/19/2008
Assoc Sports Therapy	05/13/2008
Assoc Sport Therapy	05/09/2008
Thomas Saucedo, M.D.	04/24/2008
Tomas Saucedo, Md	04/24/2008
Thomas Saucedo, M.D.	04/23/2008
Healthcare Partners	04/18/2008
Thomas Saucedo, M.D.	04/17/2008
Healthcare Med Group	04/15/2008
Healthcare Partners	04/15/2008
Healthcare Partners	04/15/2008
Healthcare Partners	04/08/2008
Eoma	03/26/2008
Health Care Partners	03/20/2008
Michael Vo, M.D.	03/20/2008
Thomas Saucedo, M.D.	03/20/2008
Anthony Bledin, M.D.	03/19/2008
Mri Of Left Knee	03/19/2008

Comppartners	02/28/2008
Michael Vo, M.D.	02/21/2008
Thomas Saucedo	02/21/2008
Thomas Saucedo, M.D.	02/21/2008
Thomas Saucedo, M.D.	02/21/2008
Comppartners	02/12/2008
Comppartners	02/08/2008
Healthcare Partners	01/17/2008
Michael Vo, M.D.	01/17/2008
Thomas Saucedo, M.D.	01/17/2008
Michael Vo, M.D.	12/20/2007
Thomas Saucedo, M.D.	12/20/2007
Thomas Saucedo, M.D.	12/20/2007
Tomas Saucedo, Md	12/20/2007
Healthcare Partners	12/17/2007
Healthcare Partners	12/17/2007
Healthcare Partners	11/20/2007
Healthcare Partners	11/20/2007
Michael Hadley, M.D.	11/20/2007
Michael Vo, M.D.	11/20/2007
Kaiser Permanente	11/13/2007
Kaiser Permanente	11/12/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Tomas Saucedo, Md	11/10/2007

02 324022 000000001 329 378 05170360

November 15, 2007

Floreen Rooks
1317 1/2 S Gladys Ave
San Gabriel CA 91776

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Floreen Rooks

There is additional information that we need from you regarding your workers' compensation claim. The enclosed material will help us to provide accurate and timely benefits.

Enclosed is an *EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS (SCIF 3301-DWC 1)*. If you have not already completed one of these, please complete the top section and return this form to your employer. Do not send it to State Compensation Insurance Fund. Your employer must complete the bottom section and provide you with a copy. It is your employer's responsibility to return the form to our office. If you do not give your employer the completed claim form, it may result in your loss of some benefits or rights.

Enclosed is an *EMPLOYEE'S REPORT OF INJURY (SCIF 3048)*. The information on this form is important in the adjustment of your claim. Please complete and sign the form and return it in the enclosed business reply envelope.

Enclosed is a *MEDICAL MILEAGE FORM (SCIF 3065)* to be used for the reimbursement of travel expense. Please complete and return the form in the enclosed business reply envelope and keep a copy for your record. Contact me if you need more mileage forms.

Enclosed is an *EMPLOYEE'S STATEMENT OF EARNINGS (SCIF 3282)* to be completed with your total earnings for **one full year** prior to your date of injury. Attach copies of W-2(s) or check stubs showing year-to-date earnings. You may be entitled to more benefits, but without this information we are unable to revise your compensation rate.

Enclosed is an *EMPLOYEE'S WORK STATUS (SCIF 3069)* form. Please complete the top section and return it in the enclosed business reply envelope if you have returned to work. If you have not returned to work, please have your primary treating physician complete the bottom section and return it to us.

If you have any questions regarding the completion of these forms or questions regarding your benefits, please call me.

It is a felony for any person to knowingly misrepresent any fact in order to obtain workers' compensation benefits.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626
Fax: (707)646-2609

Enc: Employees Claim for Workers Compensation Benefits (SCIF Form 3301) [DWC Form 1]
Employees Report of Injury (SCIF Form 3048)
Medical Mileage Expense Form (SCIF e3065 Form)
Employees Statement of Earnings (SCIF Form 3282)
Employees Work Status (SCIF Form 3069)
Business Reply Envelope

STATE FUND

Floreen Rooks
Injured's Name / Nombre de la Persona Lesionada

05170360
Claim Number / Numero de Reclamo

Medical Mileage Expense Form
Forma de Gastos por Distancia Recorrida por Visitas Medica

You are entitled to reimbursement of medical travel expense incurred because of your industrial injury at the rate of 48.5 ¢ per mile. Mileage for reasonable travel to the pharmacy, parking, bridge tolls, public transportation costs are also included. Complete this form, attach receipts and send the original to State Compensation Insurance Fund. Keep a copy for your records.

Usted tiene derecho a recibir reembolso de 48.5 ¢ por milla por gastos de viaje por visitas medicas incurridos debido a la lesion sufrida en el trabajo. Millas por un viaje de distancia razonable a la farmacia, estacionamiento, pago de peaje, transporte publico tambien son incluidos. Complete esta forma y adjunte los recibos y envie la forma original a State Compensation Insurance Fund. Conserve la copia para su archivo.

Date/ Fecha	Traveled from (include address) Viaje desde (incluya direccion)	Traveled to (include name and address of doctor, hospital, therapist, etc.) Viaje a (incluya nombre y direccion del medico, hospital, terapeuta, etc.)	Round trip mileage/ Millaje viaje redondto	Parking/ Estacion? amiento	Toll/Public Trans/Other Peaje/Transporte Publico/Otros
Sample: 7/1/05	Sample: 1515 Maple, San Francisco	Sample: Dr. Sherman, 190 Oak, San Francisco	Sample: 14rmi	Sample: $2.50	Sample: $10.00
California law requires the following to appear on this from: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and my be subject to fines and confinement in state prison.		Total miles		x $ 0.485 / mile =	$
				Total parking	$
				Total tolls	$
		ADJUSTER'S STAMP			
			Total reimbursment requests $		
Las Leyes de California establecen que la siguiente redaracion aparezca en este formulario: Cualquier persona que a sabiendas presente reclames falsos o fraudulentos para el pago de una perdida, sera culpabli de un delito y se le podria multar y encarcelar en la "Penitenciaria estatal.		Signature / Firma			
		Printed name & Date Imprima su nombre & Fecha			

SCIF e3065 (REV 1-07)

So that we can compute your compensation rate, we need your help.
Please answer the questions as completely as possible.

05170360
CLAIM NUMBER

PLEASE COMPLETE AND RETURN THIS FORM TODAY

Please list your past earnings from November 10 2006 to November 10, 2007

INSTRUCTIONS:

1. List all periods of unemployment and state why you were not working. If due to illness or disability, please state the nature of the illness.
2. List gross wages before deductions under "total amount earned".
3. List all benefits received in addition to wages. State what they were (such as room, board, tips) and show their weekly value.

EMPLOYERS	DATES STARTED WORK	DATES LEFT WORK	TOTAL AMOUNT EARNED	Additional Benefits	COMMENTS (Reason unemployed ... why left work)
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					
NAME ADDRESS CITY					

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and maybe subjected to fines and confinement in state prison.

Signature_____**Date**_____

SCIF 3282 (REV. 5–96)

November 15, 2007

Floreen Rooks
1317 1/2 S Gladys Ave
San Gabriel CA 91776

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Floreen Rooks

Pursuant to Labor Code section 4663(d), we hereby request disclosure of **ALL permanent disabilities or physical impairments that existed prior to the injury.**

As provided in Labor Code section 4664, the employer is only liable for the portion of permanent disability directly caused by the work related injury. If applicable, an apportionment determination will be made by determining what approximate percentage of the permanent disability was caused by the work related injury, and what portion was caused by other factors, including prior industrial injuries.

Please list all previous permanent disabilities or physical impairments. If there are none, please advise. You may use the attached form and return using the enclosed business reply envelope.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626
Fax: (707)646-2609

Enc: Business Reply Envelope

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

Disclosure of Previous Permanent Disabilities or Physical Impairments pursuant to Labor Code Section 4663(d)

Pursuant to the requirements of Labor Code section 4663(d), I represent and disclose that the following is a complete list of permanent disabilities, physical impairments and awards for permanent disability that existed before the presently pending industrial injury.

Nature of permanent disability, physical impairment or disability award.

Add additional pages if necessary.

If applicable, please check the following box:

☐ No prior permanent disabilities or physical impairments.

Dated: _____ Signed: _____

November 15, 2007

Floreen Rooks
1317 1/2 S Gladys Ave
San Gabriel CA 91776

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Floreen Rooks

State Compensation Insurance Fund, the claims administrator for D'Veal Family & Youth Services, is handling your workers' compensation claim.

Effective April 19, 2004, California law requires your employer to authorize medical treatment for workers' compensation injuries or illnesses within one working day after you have filed a claim form (DWC−1). Medical treatment will be provided for your injury or illness until your claim is accepted or rejected up to a limit of $10,000 in total as required by law (L.C. §5402). You will also be reimbursed for reasonable transportation expenses based on current law. If you receive any medical bills for your workers' compensation injury or illness, please send them to me. Any treatment provided while your claim is on delay does not mean that your employer is accepting your claim. Any request for medical treatment authorization is subject to the medical treatment utilization schedule established by California law (L.C. §5307.27), the American College of Occupational and Environmental Medicine's (ACOEM) Occupational Medicine Practice Guidelines, or other evidence−based medical treatment guidelines, as appropriate.

The State Fund Medical Provider Network (MPN) will provide authorized medical treatment. Enclosed is a brochure outlining your rights and responsibilities as a covered employee in the State Fund MPN. The brochure explains how to obtain medical treatment for your injury or illness, how to select a primary treating physician, how to obtain a referral to a specialist, steps to take if you disagree with your physician's diagnosis or treatment, transfer of care, and continuity of care. If you have predesignated a personal physician prior to your injury or illness, you may obtain medical treatment from your personal physician.

We have not received a workers' compensation claim form (DWC−1) for your injury on November 10, 2007. If you have not already completed a claim form, please complete the top section of the enclosed claim form and return it to your employer. Do not send it to State Compensation Insurance Fund. Your employer must complete the bottom section and provide you with a copy. It is your employer's responsibility to return the form to our office. Once we have received your claim form, medical treatment will be provided for your injury or illness until your claim is accepted or rejected up to a limit of $10,000. Failure to file the claim form with your employer may preclude your entitlement to some benefits or rights.

02 324022 000000001 336 378 05170360

If you have any questions regarding the information above or the enclosed brochures, please feel free to contact me at the phone number listed below. However, if you are represented by an attorney, this phone call should be made through your attorney.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE.

Sincerely

Sherie Chou

Sherie Chou
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626
Fax: (707)646-2609

Enc: Your Guide to Workers Compensation (SCIF Form e13699)
Employees Claim for Workers Compensation Benefits (SCIF Form 3301) [DWC Form 1]
Employee's Guide to the State Fund Medical Provider Network (SCIF Form 13176)

cc: D'Veal Family & Youth Services, PO Box 40255 Pasadena, CA 91114

November 23, 2010

Thomas Fell, Jr., M.D.
4940 Van Nuys Blvd Ste 302
Sherman Oaks CA 91403

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Thomas Fell, Jr., M.D.

Thank you for agreeing to examine Floreen Rooks on January 6, 2011 at 11:00 a.m. as the Agreed Panel Qualified Medical Evaluator.

You are being asked to examine Floreen Rooks because there exists a dispute with the findings of the medical determination, regarding the following:

a. Permanent and stationary status
b. The extent and scope of medical treatment
c. The employee's preclusion or likely preclusion from engaging in her usual occupation
d. The level of permanent disability
e. The existence of new and further disability

BACKGROUND:

Floreen Rooks sustained an injury to her foot (right), knee (left) on November 10, 2007 while employed by D'Veal Family & Youth Services as a therapist.

MEDICAL RECORDS:

Medical record(s) enclosed for your review.

Please list all medical and non-medical records that you review in preparing your report pursuant to Section 10606(d) of the California Code of Regulations (CCR). Please dispose of the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

PLEASE ADDRESS THE FOLLOWING QUESTIONS IN YOUR REPORT:

1. A detailed medical and employment history, including any outside activities.

2. What is the diagnosis? Please describe the medical basis for your opinion.

3. Are your medical findings consistent with the mechanism of injury alleged by Floreen Rooks?

4. Please comment on the disputed findings of the treating physician. Do you agree or disagree with the treating physician's findings? Please be specific regarding the basis of your findings.

5. Is this a new injury or a continuation of a previous injury or illness?

6. What medical treatment is reasonably necessary to cure or relieve the effects of the injury? In accordance with Labor Code §4604.5, the Medical Treatment Utilization Schedule is to be utilized and shall be presumptively correct on the issue of extent and scope of medical treatment. Please use the Medical Treatment Utilization Schedule or other evidence-based criteria to substantiate your medical opinion and to describe the scope, frequency, and duration of such treatment.

7. Are there any periods of temporary total (TTD) or temporary partial disability (TPD) as a result of the industrially caused or aggravated injury? Please indicate these periods and the basis of your opinion.

8. Is Floreen Rooks capable of returning to work with temporary modifications to her position during recovery from the injury? If so, please describe in detail the type and duration of the modifications. If not, when would you expect her to be able to return to modified work?

9. Pursuant to recent changes to Labor Code Section 4663, apportionment of permanent disability shall be based on causation. Any physician preparing reports on the issue of permanent disability must address the issue of causation. The physician must make an apportionment determination by finding what approximate percentage of the permanent disability was caused as a direct result of the work-related injury, and what portion was caused by other factors, including prior industrial injuries or other non-industrial factors.

   Pursuant to recent changes to Labor Code Section 4664, if an injured worker has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. Based on the foregoing, please indicate what the approximate percentage of the applicant's current disability is due to the industrial injuries alleged in this case and which percentage is due to a) any previous industrial injuries; b) any subsequent industrial injuries; c) and any non-industrial injuries including asymptomatic prior conditions, retroactive prophylactic work preclusions, illnesses or pathology.

   Please provide a basis for any apportionment you give in your report. To be substantial evidence on the issue of apportionment, "a medical report must be framed in terms of

reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and must set forth reasoning in support of its conclusions." [WCAB En Banc Decision Escobedo v. Marshalls]

10. Indicate whether the employee's disability as a result of the industrial injury permanently precludes or is likely to preclude Floreen Rooks from engaging in her usual occupation or the position that he/she was performing at the time of injury.

11. Has Floreen Rooks's disability reached maximum medical improvement and considered permanent and stationary? If yes, please note as of what date and list all factors of permanent residuals and or if requires future medical care. If not yet considered at maximum medical improvement, please provide an estimate of when her MMI status can be expected.

12. For permanent disability evaluations performed pursuant to the 2005 Permanent Disability Rating Schedule, your report concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition. Your narrative permanent impairment evaluation report must include the following:

    * Narrative history
    * Current clinical status
    * Diagnostic study results
    * Medical basis for determining Maximum Medical Improvement
    * Diagnoses, impairments
    * Impairment rating criteria, prognosis, residual function, and limitations

    When listing your medical findings, please use the applicable reporting forms found in the AMA Guides to the Evaluation of Permanent Impairment, Fifth edition:

    * Cervical range of motion – page 422
    * Thoracic range of motion– page 416
    * Lumbar range of motion – page 410
    * Upper extremity – page 436
    * Lower extremity – page 561

You have the authority to conduct diagnostic tests that are necessary to complete your evaluation.

In order for the employer to potentially make a timely job offer and for State Fund to pay appropriate benefits, it is imperative that all parties receive information regarding permanent and stationary status and capability of returning to their usual and customary occupation as soon as possible after this exam. Please complete the form enclosed and fax to (707)646-2609 within 48 hours of the exam date.

Please submit your bill and the original of your report to State Compensation Insurance Fund, PO Box 92622 Los Angeles CA 90009-2622.

Per Labor Code 139.2(j)(1), you are required to submit your report within 30 days of the exam date.

Your bill will be paid in accordance with the Medical/Legal Fee Schedule set forth in Section 9795 of the Division of Workers' Compensation Administrative Director Rules.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE AND BILLING.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Claim Form of 11/13/2007
Medical File

cc: Floreen Rooks, 1315 S Gladys Ave, San Gabriel, CA 91776-3623

List of Medical Reports

ATTENTION: MEDICAL PROVIDERS
COPIES – Please dispose the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date
*State Fund	10/22/2010
*State Fund	10/13/2010
Dr. Thomas Saucedo	10/11/2010
Tomas Saucedo, Md	10/11/2010
*State Fund	10/05/2010
*State Fund	10/05/2010
Dr. Saucedo	09/04/2009
Thomas Saucedo, Md	01/23/2009
Tomas Saucedo, Md	01/23/2009
Thomas Saucedo	12/05/2008
Tomas Saucedo Md	12/05/2008
Tomas Saucedo, Md	12/05/2008
Thomas Saucedo, Md	11/11/2008
Tomas Saucedo, Md	11/11/2008
Ortho Supplemental Report	11/07/2008
Ortho Supplemental Report	11/07/2008
Ortho Supplemental Report	10/10/2008
Ortho Supplemental Report	10/10/2008
Ortho Supplemental Report	09/05/2008
Tomas Saucedo, Md	09/05/2008
Tomas Saucedo, Md	09/05/2008
Tomas Saucedo, Md	08/28/2008
Associated Sports Therapy	08/08/2008
Tomas Saucedo, Md	08/08/2008
Comppartners	07/22/2008
Comppartners	07/22/2008
Judith Moosmann, Rn	07/18/2008

Associated Sport Therapy	07/16/2008
*State Fund	07/15/2008
Assoc Sports Therapy	07/11/2008
Tomas Saucedo, Md	07/11/2008
Tomas Saucedo, Md	07/02/2008
Comppartners	06/28/2008
Assoc Sports Therapy	06/19/2008
Associated Sport Therapy	06/18/2008
Associated Sport Therapy	06/18/2008
Assoc Sport Therapy	06/06/2008
Assoc Sports Therapy	06/06/2008
PT	06/06/2008
Thomas Saucedo, M.D.	06/06/2008
Tomas Saucedo, Md	06/06/2008
Eoma	05/26/2008
Assoc Sports Therapy	05/22/2008
Comppartners	05/19/2008
Assoc Sports Therapy	05/13/2008
Assoc Sport Therapy	05/09/2008
Thomas Saucedo, M.D.	04/24/2008
Tomas Saucedo, Md	04/24/2008
Thomas Saucedo, M.D.	04/23/2008
Healthcare Partners	04/18/2008
Thomas Saucedo, M.D.	04/17/2008
Healthcare Med Group	04/15/2008
Healthcare Partners	04/15/2008
Healthcare Partners	04/15/2008
Healthcare Partners	04/08/2008
Eoma	03/26/2008
Health Care Partners	03/20/2008
Michael Vo, M.D.	03/20/2008
Thomas Saucedo, M.D.	03/20/2008
Anthony Bledin, M.D.	03/19/2008
Mri Of Left Knee	03/19/2008
Comppartners	02/28/2008
Michael Vo, M.D.	02/21/2008
Thomas Saucedo	02/21/2008

Thomas Saucedo, M.D.	02/21/2008
Thomas Saucedo, M.D.	02/21/2008
Comppartners	02/12/2008
Comppartners	02/08/2008
Healthcare Partners	01/17/2008
Michael Vo, M.D.	01/17/2008
Thomas Saucedo, M.D.	01/17/2008
Michael Vo, M.D.	12/20/2007
Thomas Saucedo, M.D.	12/20/2007
Thomas Saucedo, M.D.	12/20/2007
Tomas Saucedo, Md	12/20/2007
Healthcare Partners	12/17/2007
Healthcare Partners	12/17/2007
Healthcare Partners	11/20/2007
Healthcare Partners	11/20/2007
Michael Hadley, M.D.	11/20/2007
Michael Vo, M.D.	11/20/2007
Kaiser Permanente	11/13/2007
Kaiser Permanente	11/12/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Tomas Saucedo, Md	11/10/2007

October 22, 2010

Tomas Saucedo
3144 Santa Anita Avenue Module A
El Monte CA 91733

Claim Number: 05170360
Employee: Floreen Rooks
Tracking #: E000004811507
Date of Injury: 11/10/2007
Date of Birth: 06/20/1949
Adjuster Name: Yolanda Nielsen

Dear Medical Provider

Your request for medical treatment dated October 11, 2010 for Floreen Rooks was received on October 12, 2010 and has been reviewed in accordance with State Fund's Utilization Review Program:

Medical Treatment	Treatment ID	Req. Qty	Auth. Qty	Interval (Freq.)	Per Period	Decision	Decision Date
Omeprazole 20mg #30	E000004387456	1	1			Approved	10/22/2010

Please note: If the treatment status decision is *"Referred"*, we are still evaluating the request and you will be notified when a decision has been made. "Interval" in the above column describes number of treatments authorized per period.

Certifications are valid for 60 days from the date of this notice.

Any payments made will be reimbursed per the prevailing California Official Medical Fee Schedule (OMFS), or Contractual Agreement whichever is less. Payment is subject to applicable statutes and regulations, including, but not limited to, Labor Code §139.3 and 139.31 and California Business and Professions codes. For claims on *delayed status*, payment may also be limited to the criteria as mentioned in Labor Code 5402(c), subject to the $10,000 cap.

Please be advised that non-physician **providers of goods or services** identified in the request for authorization, shall be notified in writing of the decision modifying, delaying, or denying a request for authorization, but shall **not** receive the rationale, criteria or guidelines used for the decision as per Title 8, CCR § 9792.9 (b)(4).

Any appeal of this particular UR decision must be made by the requesting physician within 10 days of the date of the UR decision. The appeal must be submitted in writing or via FAX to the following phone number:

FAX Number: 818-550-6707

This written request for appeal should be prominently identified as a "UR Appeal" at the top of the page and include a copy of the specific UR Decision which you are appealing. Your appeal will be re-reviewed in accordance with State Fund's internal utilization review appeals process. *Participation in this process is entirely on a voluntary basis.*

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE OR BILLING.

Sincerely

Alicia C. Olivares
Alicia C. Olivares
For Yolanda Nielsen, Adjuster of this claim
Adjuster
(818)291-7626

cc: Floreen Rooks, 1315 S Gladys Ave, San Gabriel, CA 91776-3623

NOTICE TO INJURED EMPLOYEE

All utilization review disputes will be resolved in accordance with Labor Code Section 4062.

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The 20-day time limit may be extended for good cause or by mutual agreement of the parties. You also have the right to file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with Title 8, CCR sections 10136(b)(1), 10400, and 10408.

If you want further information, you may contact the local state Information and Assistance office by calling (213)576-7389 or you may receive recorded information by calling 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

FLOREEN ROOKS
2374 OLIVE AVE
ALTADENA CA 91001-5542

02 324022 000000001 347 378 05170360

8083

January 31, 2012

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks

Enclosed is a Compromise and Release in the above-entitled matter. Please sign the Compromise & Release before a Notary Public or in the presence of two disinterested witnesses, who should also sign in your presence. A spouse is not deemed to be a disinterested witness and should not sign as such. On page 7, paragraph 9 of the Compromise & Release; please initial each line in the 1st column next to the issues included in this settlement. Please also sign and date the enclosed Addendum(s) to the Compromise and Release. If you have any questions, you may contact me or a State Information and Assistance Office at 1-800-736-7401 or call your local Information and Assistance Officer at (213)576-7389.

Please initial and sign the form(s) using **BLACK** ink only. Do not fold, staple or bend any of the pages of the forms and return the form(s) in the enclosed envelope. If a correction needs to be made or information added, please contact me.

Please return the executed Compromise & Release to this office. I will then complete and submit it to the assigned Workers' Compensation Appeals Board for approval and will return an executed copy to you.

Please initial all of #9.

Sincerely

Yolanda L. Nielsen

Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Business Reply Envelope (SCIF 19619)
Compromise & Release (DWC-CA Form 10214(c)(Rev. 11/2008))
Lien Addendum Sheet

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02 324022 000000001 348 378 05170360

Dear Floreen Rooks

THIS PAGE MUST BE PLACED ON TOP OF THE DOCUMENT/FORM YOU ARE RETURNING TO STATE COMPENSATION INSURANCE FUND.

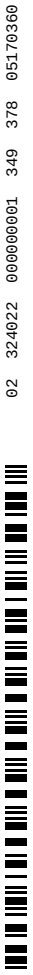
CLAIM NUMBER: 05170360

INJURED'S NAME: FLOREEN ROOKS

ADJUSTER'S NAME: YOLANDA NIELSEN

ADJUSTER'S RETURN ADDRESS:

PO BOX 65005
PINEDALE CA 93650



STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE

ADJ7024643
Case Number 1

Case Number 4

ADJ 7024645
Case Number 2

Case Number 5

Case Number 3

130-38-8570
SSN (Numbers Only)

Venue Choice is based upon: (Completion of this section is required)

[X] County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

[ ] County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

[ ] County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

LAO
Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee(Completion of this section is required)

FLOREEN
First Name

MI

ROOKS
Last Name

2374 OLIVE AVE
Address/PO Box (Please leave blank spaces between numbers, names or words)

ALTADENA
City

CA
State

91001
Zip Code

Employer Information (Completion of this section is required)

[X] Insured [ ] Self-Insured [ ] Legally Uninsured [ ] Uninsured

D'VEAL FAMILY & YOUTH SERVICES
Employer Name (Please leave blank spaces between numbers, names or words)

PO BOX 40255
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PASADENA
City

CA
State

91114
Zip Code

ADJUSTER: YOLANDA NIELSEN GLENDALE (SA)

Tracking Id: 12369162

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Applicant's Attorney or Authorized Representative:

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Law Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Defendant's Attorney or Authorized Representative:

☒ Law Firm/Attorney ☐ Non Attorney Representative

LENA
First Name

TSUI
Last Name

5225007
Law Firm Number

SCIF INSURED GLENDALE UNIT A
Law Firm Name

PO BOX 65005
Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE CA 93650
City State Zip Code

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)

STATE COMPENSATION INSURANCE FUND
Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE CA 93650
City State Zip Code

Tracking Id: 12369162

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Claims Administrator Information (if known and if applicable)

SCIF INSURED GLENDALE
Name (Please leave blank spaces between numbers, names or words)

PO BOX 65005
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

PINEDALE | CA | 93650
City | State | Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born 06/20/1949 (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)

THERAPIST (OCCUPATION AT THE TIME OF INJURY), sustained injury arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

[X] Specific Injury

ADJ7024643
Case Number 1

[ ] Cumulative Injury

11/10/2007 (Start Date: MM/DD/YYYY) — (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 530 FOOT Body Part 2: 513 KNEE Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at JOBSITE
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

ALTADENA (City), CA (State) 91001 (Zip Code).

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[X] Specific Injury

ADJ 7024645
Case Number 2

[ ] Cumulative Injury

08/09/2007
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 513 KNEE Body Part 2: 520 ANKLE Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at COMPANY OUTING
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

LOS ANGELES , CA 91001 .
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[ ] Specific Injury

Case Number 3

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

[ ] Specific Injury

Case Number 4

[ ] Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City , State Zip Code .

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Tracking Id: 12369162

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ , _____ _____ .
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY $ 971.15

TEMPORARY DISABILITY INDEMNITY PAID 30885.53 Weekly Rate $ 647.44

Period(s) Paid 08/22/2007 (Start Date: MM/DD/YYYY) 09/14/2008 (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 14986.14 Weekly Rate $ 230.00

Period(s) Paid 09/19/2008 (Start Date: MM/DD/YYYY) End date 01/17/2012 (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID $ 20836.63 Total Unpaid Medical Expense to be Paid By: DEFENDANTS

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

$ 80000.00
Settlement Amount

The following amounts are to be deducted from the settlement amount:

$ 14986.14 for permanent disability advances through 01/17/2012

$ _____ for temporary disability indemnity overpayment, if any.

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ payable to _____

$ _____ requested as applicant's attorney's fee.

LEAVING A BALANCE OF $ _____, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

THIS COMPROMISE & RELEASE (C&R) INCLUDES RESOLUTION OF ALL ISSUES, ALL DATES OF INJURIES, ALL BODY PARTS INDICATED IN THE CLAIM FORM INCLUDING RIGHT FOOT, LEFT ANKLE, LEFT KNEE; AND OTHER BODY PARTS MENTIONED IN ANY MEDICAL REPORT(S).

THIS C&R INCLUDES ALL TEMPORARY DISABILITY (TD), RETRO TD, PERMANENT DISABILITY (PD), RETRO PD, VOCATIONAL REHABILITATION MAINTENANCE ALLOWANCE (VRMA), RETRO VRMA, SUPPLEMENTAL JOB DISPLACEMENT BENEFIT (SJDB), RETRO MEDICAL BENEFITS, FUTURE MEDICAL BENEFITS, MILEAGE, OUT OF POCKET MEDICAL EXPENSES, PENALTIES, AND INTERESTS (P&I).

PENALITES AND INTEREST WILL BE WAIVED WHEN C&R AWARD IS PAID WITHIN 30 DAYS FROM DATE OF RECEIPT OF STATE FUND.

ALL MED LEGAL FEES WILL BE PAID BY STATE FUND.

STATE FUND WILL ADDRESS ALL LIENS.

Tracking Id: 12369162

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant	
_____	_____	earnings
_____	_____	temporary disability
_____	_____	jurisdiction
_____	_____	apportionment
_____	_____	employment
_____	_____	injury AOE/COE
_____	_____	serious and willful misconduct
_____	_____	discrimination (Labor Code §132a)
_____	_____	statute of limitations
_____	_____	future medical treatment
_____	_____	other ALL ISSUES
_____	_____	permanent disability 24% LT ANKLE/LT KNEE
_____	_____	self-procured medical treatment, except as provided in Paragraph 7
_____	_____	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

INJURED WORKER IS NOT RECEIVING MEDICARE BENEFITS AT THIS TIME AND IS CURRENTLY CONTINUALLY WORKING FULL TIME WITH D'VEAL FAMILY & YOUTH SERVICES SO THERE IS NO NEED FOR A MEDICARE SET ASIDE ALLOCATION REPORT AT THIS TIME.

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this _____ day of _____, _____ at _____

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

Tracking Id: 12369162

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ACKNOWLEDGMENT

State of Califomia
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

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Tracking Id: 12369162

APPLICANT: FLOREEN ROOKS
WCAB CASE NUMBER(S): ADJ7024643, ADJ 7024645
SCIF CLAIM NUMBER(S): 05170360

LIEN ADDENDUM

LIENS OF RECORD AND AFFIDAVIT
RE: GOOD FAITH EFFORTS TO RESOLVE LIENS

The following are the liens of record as of the date of this Compromise and Release. Defendants will pay, adjust, or litigate, the following liens, less credit for payments previously made.

Jurisdiction is reserved with the Workers' Compensation Appeals Board as to all issues that may arise regarding disposition of these liens.

Lien Claimant Name & Address	Amount	Description, Date & Result of Lien Resolution Efforts
There are no liens on record for this claim.		

FREEFORM PARAGRAPH

I declare under penalty of perjury as follows:

I am the representative for defendant State Compensation Insurance Fund. I have made the above-referenced good faith efforts to resolve each of the listed liens.

_____ _____

State Fund Representative Date

February 10, 2012

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

Thank you for your voicemail message.

We are not sure why you received a cancellation from the WCAB when the Hearing was in place.

The draft of the C&R is with the I&A Officer, Cynthia Goodwin. She left her direct phone in your cell phone number.

Please contact her regarding settlement amount. She would be able to discuss with you all your inquiries and concerns as well as advise you on what to do.

Thank you.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

02 324022 0000000001 362 378 05170360

February 2, 2012

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

Please accept our sincere apologies regarding your Permanent Disability Rate.

We inadvertently sent your benefit checks from 1/4/12 through 1/31/12 at the rate of $264.50 per week instead of $230.00 per week.

Again, we apologize for our mistake.

Your next check scheduled on 2/14/12 will be $230.00 per week, a total of $460.00.

Thank you for your understanding.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

December 29, 2011

Floreen Rooks
2374 Olive Ave
Altadena CA 91001-5542

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

Due to technical errors over the Holiday weekend, your Permanent Disability check due on Tuesday, 1/3/12, in the amount of $460.00 was sent on 12/27/11. This check covered the periods form 12/21/11 to 1/3/12.

We apologize for the confusion.

Your next benefit check will be sent on 1/17/12, Tuesday.

If you have any questions, please contact me.

Thank you for your kind consideration.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

November 15, 2010

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

At no cost to you, we have made arrangements for you to be evaluated by the Panel Qualified Medical Examiner in the field of Orthopedics, Dr. Thomas Fell.

Your appointment will be on 1/6/11, Thursday, 11:00 a.m.

Dr. Thomas Fell's office is located at 630 W. Duarte Road, #203, Arcadia, CA 91007.

Your round trip mileage check was separately. There are no parking fees in this location.

Failure to attend this evaluation may affect your entitlement to benefits.

If you are unable to keep this appointment, please notify Dr. Fell's office at (626) 447-8870, at least 48 hours prior to your scheduled appointment.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

cc: Thomas Fell, Jr., M.D., 4940 Van Nuys Blvd Ste 302, Sherman Oaks, CA 91403
Lena Tsui, Attorney

October 28, 2010

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

We received the Panel Qualified Medical Examiner (PQME) list on 10/25/10.

Please make your choice which PQME doctor you would like to be your PQME.

If we do not receive your response within 10 days from the date of this letter, we will proceed to make the PQME appointment with the Evaluator of our choice from the list.

Thank you for your immediate attention.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

cc: Lena Tsui, Attorney

February 3, 2011

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

We received information that you missed your appointment with the Panel Qualified Medical Examiner in the field of Orthopedics, Dr. Thomas Fell.

Please be reminded that this evaluation was recommended by the Workers' Compensation Judge.

We rescheduled your appointment to 3/17/11, Thursday, 3:30 p.m.

Please refer to the attached letter regarding the details of your appointment.

Please make every effort to keep this appointment.

Enclosed are the following reports and/or documents pertaining to the above-captioned case:

Reports/Documents	Date
1504 - Blank Letter	11/15/2010

Thank you for your attention and cooperation.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enclosure(s)

cc: Thomas Fell, Jr., M.D., 4940 Van Nuys Blvd Ste 302, Sherman Oaks, CA 91403
Lena Tsui, Attorney

January 3, 2011

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007

Dear Ms. Rooks:

This is a reminder regarding your Panel Qualified Medical Examiner appointment on **1/6/11**.

Please see attached letter dated **11/15/10** regarding details of your appointment.

Enclosed are the following reports and/or documents pertaining to the above-captioned case:

Reports/Documents	Date
1504 - Blank Letter	11/15/2010

Thank you for your cooperation.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enclosure(s)

cc: Thomas Fell, Jr., M.D., 4940 Van Nuys Blvd Ste 302, Sherman Oaks, CA 91403
Lena Tsui, Attorney

September 19, 2011

Nuquest / Bridge Pointe
PO Box 915619
Longwood FL 32791-5619

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

Dear Gentlepersons

In response to your written request, dated September 19, 2011, enclosed are copies of the medical records we have on file for Floreen Rooks.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Medical File

List of Medical Reports

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date
Synergy	03/23/2011
Dr. Thomas Fell	03/17/2011
Dr. Fell	01/26/2011
*State Fund	10/22/2010
*State Fund	10/13/2010
Dr. Thomas Saucedo	10/11/2010
Tomas Saucedo, Md	10/11/2010
*State Fund	10/05/2010
*State Fund	10/05/2010
Dr. Saucedo	09/04/2009
Thomas Saucedo, Md	01/23/2009
Tomas Saucedo, Md	01/23/2009
Thomas Saucedo	12/05/2008
Tomas Saucedo Md	12/05/2008
Tomas Saucedo, Md	12/05/2008
Thomas Saucedo, Md	11/11/2008
Tomas Saucedo, Md	11/11/2008
Ortho Supplemental Report	11/07/2008
Ortho Supplemental Report	11/07/2008
Ortho Supplemental Report	10/10/2008
Ortho Supplemental Report	10/10/2008
Ortho Supplemental Report	09/05/2008
Tomas Saucedo, Md	09/05/2008
Tomas Saucedo, Md	09/05/2008
Tomas Saucedo, Md	08/28/2008
Associated Sports Therapy	08/08/2008
Tomas Saucedo, Md	08/08/2008
Comppartners	07/22/2008
Comppartners	07/22/2008
Judith Moosmann, Rn	07/18/2008
Associated Sport Therapy	07/16/2008

*State Fund	07/15/2008
Assoc Sports Therapy	07/11/2008
Tomas Saucedo, Md	07/11/2008
Tomas Saucedo, Md	07/02/2008
Comppartners	06/28/2008
Assoc Sports Therapy	06/19/2008
Associated Sport Therapy	06/18/2008
Associated Sport Therapy	06/18/2008
Assoc Sport Therapy	06/06/2008
Assoc Sports Therapy	06/06/2008
Pt	06/06/2008
Thomas Saucedo, M.D.	06/06/2008
Tomas Saucedo, Md	06/06/2008
Eoma	05/26/2008
Assoc Sports Therapy	05/22/2008
Comppartners	05/19/2008
Assoc Sports Therapy	05/13/2008
Assoc Sport Therapy	05/09/2008
Thomas Saucedo, M.D.	04/24/2008
Tomas Saucedo, Md	04/24/2008
Thomas Saucedo, M.D.	04/23/2008
Healthcare Partners	04/18/2008
Thomas Saucedo, M.D.	04/17/2008
Healthcare Med Group	04/15/2008
Healthcare Partners	04/15/2008
Healthcare Partners	04/15/2008
Healthcare Partners	04/08/2008
Eoma	03/26/2008
Health Care Partners	03/20/2008
Michael Vo, M.D.	03/20/2008
Thomas Saucedo, M.D.	03/20/2008
Anthony Bledin, M.D.	03/19/2008
Mri Of Left Knee	03/19/2008
Comppartners	02/28/2008
Michael Vo, M.D.	02/21/2008
Thomas Saucedo	02/21/2008
Thomas Saucedo, M.D.	02/21/2008

Thomas Saucedo, M.D.	02/21/2008
Comppartners	02/12/2008
Comppartners	02/08/2008
Healthcare Partners	01/17/2008
Michael Vo, M.D.	01/17/2008
Thomas Saucedo, M.D.	01/17/2008
Michael Vo, M.D.	12/20/2007
Thomas Saucedo, M.D.	12/20/2007
Thomas Saucedo, M.D.	12/20/2007
Tomas Saucedo, Md	12/20/2007
Healthcare Partners	12/17/2007
Healthcare Partners	12/17/2007
Healthcare Partners	11/20/2007
Healthcare Partners	11/20/2007
Michael Hadley, M.D.	11/20/2007
Michael Vo, M.D.	11/20/2007
Kaiser Permanente	11/13/2007
Kaiser Permanente	11/12/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Healthcare Partners	11/10/2007
Tomas Saucedo, Md	11/10/2007

January 31, 2010

Floreen Rooks
1315 S Gladys Ave
San Gabriel CA 91776-3623

Claim Number: 05170360
Employee: Floreen Rooks
Date of Injury: 11/10/2007
Employer: D'Veal Family & Youth Services

MEDICARE QUESTIONNAIRE

We are writing to inform you of a new Federal law that requires insurers such as State Fund to obtain Medicare Beneficiary Status information from claimants.

As of January 1, 2009, a Federal law (Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007) mandates that insurers such as State Fund collect CMS Medicare Beneficiary Status information from their claimants for Medicare Quarterly Reporting (MQR). The Centers for Medicare and Medicaid Services (CMS) oversees the Medicare program and coordinates benefit payments to ensure that proper and timely payment is made.

Enclosed is a two-page Medicare Questionnaire along with a self-addressed stamped envelope. We ask that you complete and return the questionnaire within 10 days of receipt of this letter.

Please be advised that all information collected in this questionnaire will be used by CMS to accurately coordinate benefits with Medicare. State Fund recognizes the importance of respecting the privacy of our customers and is committed to providing the highest level of security and privacy regarding the collection and use of personal information.

This letter is being sent to you to meet federal reporting requirements and does not constitute acceptance of liability for your workers' compensation claim.

If you have any questions, please feel free to call me at the number listed below. However, if an attorney represents you, this phone call should be made through your attorney.

Sincerely

Yolanda L. Nielsen
Yolanda L. Nielsen
Adjuster
(818)291-7626

Enc: Medicare Questionnaire Form
Business Reply Envelope

For Internal Use: CPC Indexers–Please index this document to document type " Medicare Form"
Employee: Floreen Rooks Claim #: 05170360

MEDICARE QUESTIONNAIRE FORM

Please review this picture of the Medicare card to determine if you have, or have ever had a similar Medicare card and answer the following questions.

SECTION I		
Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	[ ] YES	[ ] NO
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name **exactly** as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth** *(Mo/Day/Year)*	– –
Social Security Number: *(If Medicare Claim Number is Unavailable)* – –	**Sex**	[ ]Female [ ] Male

SECTION II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____

Employee Name *(Please print)*

_____

Name of Person Completing This Form If Employee is Unable *(Please print)*

_____

Signature of Person Completing this Form **Date**

For Internal Use: CPC Indexers–Please index this document to document type " Medicare Form"
Employee: Floreen Rooks Claim #: 05170360

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

SECTION III

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____

_____

_____

Employee Name *(Please print)*

_____

Name of Person Completing This Form If Employee is Unable *(Please print)*

_____

Signature of Person Completing this Form

_____

Date

PD Rating Report

Date Requested: 09/14/2020

Claim 05170360 **Claimant** FLOREEN ROOKS

Trans Num	Date of Rating	Final PD %	Formula String
3	04/24/2012	24	APP FRAC FAC DIS NUM RTG OCC DIS MOD AGE SUBJECT FINAL C&R PD for $62K less JV to Meds $27,621.00.
2	04/29/2011	25	APP FRAC FAC DIS NUM RTG OCC DIS MOD AGE SUBJECT FINAL Left Ankle ¿ Arthritis 17.07.03.00 - 12 - [2] 14 - 110D - 11 - 14 Left Knee ¿ Other 17.05.06.00 - 11 - [2] 13 - 110D - 10 - 13 14 C 13 = 25%
1	04/24/2008	5	APP FRAC FAC DIS NUM RTG OCC DIS MOD AGE SUBJECT FINAL PD while treating before P&S.

-- End of Report --

Wage Calculation Report

Claim Num: 05170360 Claimant FLOREEN ROOKS

Date of Calculation	AWW	TD Rate	Selected Flag
11/13/07, 1:21 PM	$ 971.15	$ 647.44	YES

Wage Component

Wage Type		
Rate Wage		
Start Date	End Date	Period
		7
Gross Wages	Hours a Day	Days a Week
$ 971.15		
Seasonal Amount		
0.0		

Description

Date Requested: September 14, 2020

8083

Claim Num: 05170360 Claimant FLOREEN ROOKS

02 324022 000000001 377 378 05170360

Room and Board

Start Date	End Date
Weekly Rent Value	**Weekly Board**
0.0	0.0
Weekly Utility	**Weekly Other Value**
0.0	0.0

Description

Wage Summary

Claim Num: 05170360 Claimant FLOREEN ROOKS

Wage Summary

Wages Earned from (calculated date)	to (calculated date)		Weeks and	Days
null	null	=	null	null

Gross Wages from all Employment	divided by (weeks)		Result
0	0	=	null

Room and Board Weekly Amount if any	Bonus if any	Average Weekly Wage	Multiplied by	TD Rate
0.0	0.0	$ 0.0	.66667	$ 0.0

Reports

SCI000238

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P.O. Box420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24-hours

1. INSURER	2. EMPLOYER NAME	PLEASE DO NOT USE THIS COLUMN
State Comp 92622 P.O. Box 92622 Los Angeles, CA 90009-2622	D'Veal Family & Youth Services P.O. Box 40255 Pasadena, CA 91114	Case No Industry County

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. PATIENT NAME	6. Sex	7. Date of Birth	Age
ROOKS, FLOREEN	[ ] Male [X] Female	Mo. Day Year 06/20/1949	

8. Address	City	Zip	9. Telephone Number	Hazard
1315 S. GLADYS AVE.	SAN GABRIEL	91776	(626) 573-1906	

10. Occupation (Specific Job title)	11. Social Security Number	Disease
MARRIAGE FAMILY THERAPIST	130-38-8510	

12. Injured at:	City	County	Hospitalization
WORK PLACE			

13. Date and hour of injury or onset of illness	Mo. Day Year	Hour	14. Date Last Worked	Mo. Day Year	Occupation
	11/10/2007	10:30 am		11/10/2007	

15. Date and hour of first examination or treatment	Mo. Day Year	Hour	16. Have you (or your office) previously treated patient	Return Date/Code
	11/20/2007	11:04 am	[ ] Yes [X] No	

Patient please complete this portion, if able to do so, otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

"Fell on to ground gravel and fractured right foot to prevent from rolling into oncoming traffic Injured right foot "

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)

The patient states that she is employed as marriage and family therapist. On 11/10/2007 while trying to enter her vehicle that was moving even though it was parked she tripped on the ground and fell, she hit her left knee and she twisted (continued)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)

A. Physical examination

General appearance No acute distress. Vital sign BP 156/98, pulse 78, respirations 16. Examination of the right foot reveals that there is moderate edema with moderate to marked tenderne present on the do sum. There is no (continued)

B. X-ray and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (If occupational illness, specific etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No

924.11 CONTUSION, LEFT KNEE
825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or onset [X] Yes [ ] No
If "no" please explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No
If "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)

(1) Examination. (2) X-ray. (3) Dispensed walker boot/Cam walker. (4) Dispensed Motrin 800 mg x #30 tablets (5) Dispensed extra-strength Tylenol #30 tablets (6) Referral to orthopedic surgeon for evaluation and treatment

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duration 1 month.

24. If Hospitalized as inpatient, give hospital name and location (continued) Date admitted Mo. Day Year Estimated Stay

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No

If "no", patient can return to
Regular work _____
Modified work _____ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Doctor's signature _____ Date _____ CA License Number G36632

Doctor name and degree (Please print) Michael Hadley, M.D. IRS Number 95-4526112

Case# 80283 Telephone Number (626) 582-7989

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

#18.
her left ankle and also her right foot. Because of these injuries, the patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment.

While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN. She denies any history of diabetes, high blood pressure, ulcer disease or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

Review of systems: Denies any chest pain or shortness of breath. Patient denies any abdominal pain, nausea, vomiting, diarrhea or constipation.

#19A.
ecchymosis. The patient does have impaired weight bearing secondary to pain and altered gait secondary to pain. The patient is ambulating with the aid of a cane.

Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema.

Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain.

#19B.
preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending.

#20.
1. FRACTURE, RIGHT FOOT.
2. SPRAIN, LEFT ANKLE.
3. CONTUSION, LEFT KNEE.

#22.
hardware in her left ankle and this may impact upon her rate of recovery.

#23.
Further treatment: by the orthopedic surgeon.

#24.
To be determined by the orthopedic surgeon.

#25.
the following restrictions: No driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER State Comp 92622 P.O. Box 92622 Los Angeles, CA 90009-2622	2. EMPLOYER NAME D'Veal Family & Youth Services P.O. Box 40255 Pasadena, CA 91114	PLEASE DO NOT USE THIS COLUMN Case No Industry County
4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes)		

5. PATIENT NAME ROOKS, FLOREEN	6. Sex [ ] Male [X] Female	7. Date of Birth Mo. Day Year 06/20/1949		Age
8. Address 1315 S. GLADYS AVE.	City SAN GABRIEL	Zip 91776	9. Telephone Number (626) 573-1905	Hazard
10. Occupation (Specific job title) MARRIAGE FAMILY THERAPIST			11. Social Security Number 130-38-8510	Disease
12. Injured at: WORK PLACE	City	County		Hospitalization
13. Date and hour of injury or onset of illness Mo. Day Year: 11/10/2007	Hour 10:30 am		14. Date Last Worked Mo. Day Year 11/10/2007	Occupation
15. Date and hour of first examination or treatment Mo. Day Year: 11/20/2007	Hour 11:04 am		16. Have you (or your office) previously treated patient [ ] Yes [X] No	Return Date/Code

Patient please complete this portion, if able to do so, otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)
"Fell on to ground gravel and fractured right foot to prevent car from rolling into oncoming traffic. Injured right foot."

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)
The patient states that she is employed as a marriage and family therapist. On 11/10/2007 while trying to enter her vehicle that was moving even though it was parked she tripped on the ground and fell, she hit her left knee and she twisted (continued)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination
General appearance: No acute distress. Vital signs. BP 156/98, pulse 78, respirations 16. Examination of the right foot reveals that there is moderate edema with moderate to marked tenderne present on the dorsum. There '~ no (continued)

B. X-ray and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (If occupational illness, specific etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No
924.11 CONTUSION, LEFT KNEE
825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or [X] Yes [ ] No
If "no" please explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No
If "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)
(1) Examination. (2) X-ray. (3) Dispensed walker boot/Cam walker. (4) Dispensed Motrin 800 mg x #30 tablets. (5) Dispensed extra-strength Tylenol x #30 tablets (6) Referral to orthopedic surgeon for evaluation and treatment.

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duration: 1 month.

24. If Hospitalized as inpatient, give hospital name and location (continued) Date admitted Mo. Day Year Estimated Stay

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No
If "no", patient can return
Regular work _____
Modified work _____ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Doctor's signature _____ Date _____ CA License Number 036633
Doctor name and degree (Please print) Michael Hadley, M.D. IRS Number 95-4526112
Case# 80283 Telephone Number (626) 582-7989

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

FIRST.REPORT ADDITIONAL INFORMATION

#18.
her left ankle and also her right foot. Because of these injuries, the patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment.

While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN. She denies any history of diabetes, high blood pressure, ulcer disease or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

Review of systems: Denies any chest pain or shortness of breath. Patient denies any abdominal pain, nausea, vomiting, diarrhea or constipation.

#19A.
ecchymosis. The patient does have impaired weight bearing secondary to pain and altered gait secondary to pain. The patient is ambulating with the aid of a cane.

Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema.

Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain.

#19B.
preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending.

#20.
1. FRACTURE, RIGHT FOOT.
2. SPRAIN, LEFT ANKLE.
3. CONTUSION, LEFT KNEE.

#22.
hardware in her left ankle and this may impact upon her rate of recovery.

#23.
Further treatment: by the orthopedic surgeon.

#24.
To be determined by the orthopedic surgeon.

#25.
the following restrictions: No driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24-hours.

1. INSURER State Comp 92622 P.O. Box 92622 Los Angeles, CA 90009-2622	2. EMPLOYER NAME D'Veal Family & Youth Services P.O. Box 40255 Pasadena, CA 91114

PLEASE DO NOT USE THIS COLUMN
Case No
Industry
County

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. PATIENT NAME ROOKS, FLOREEN		6. Sex [ ] Male [X] Female	7. Date of Birth Mo. Day Year 06/20/1949	Age
8. Address 1315 S. GLADYS AVE.	City SAN GABRIEL	Zip 91776	9. Telephone Number (626) 573-1906	Hazard
10. Occupation (Specific Job title) MARRIAGE FAMILY THERAPIST			11. Social Security Number 130-38-8510	Disease
12. Injured at: WORK PLACE	City	County		Hospitalization
13. Date and hour of injury or onset of illness	Mo. Day Year 11/10/2007	Hour 10:30 am	14. Date Last Worked Mo. Day Year 11/10/2007	Occupation
15. Date and hour of first examination or treatment	Mo. Day Year 11/20/2007	Hour 11:04 am	16. Have you (or your office) previously treated patient [ ] Yes [X] No	Return Date/Code

Patient please complete this portion, if able to do so. otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her right s to workers' compensation under the California Labor Code

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

"Fell on to ground gravel and fractured ight foot preve ear rom ro ng ncoming raffi Inju ed ight foot "

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)

The patient states that she is employed as a marriage and family ..apist. On 11/10/200 while trying to ente her vehicl that was moving even though it was par ed she ipped on the gr nd and fell, she hit her left knee and she twisted (continued)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)

A. Physical examination

General appe.rance No acute distres . Vital signs BP 156/98, pulse 78, respi ion. 16. Examination of the ight foot reveals that there is moderate edema with moder e marked tenderness present on the dorsum. There no (continued)

B. X-ray and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (If occupational illness, specific etiologic agent and duratio of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No

924.11 CONTUSION, LEFT KNEE
825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or onset [X] Yes [ ] No
if "no" ple explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No
if "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)
(1) Examination. (2) X-ray. (3) Dispensed walker boot/Cam walker .. Dispen ed Mo in 800 mg x #30 tablet (5) Dispen ed extr strength Tylenol x #30 table (6) Re thopedi surgeon evalu ion and tment

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duratio.. 1 month.

24. If Hospitalized as Inpatient, give hospital name and location (continued) Date admitted Mo. Day Year Estimated Stay

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No
If "no", patient can return t
Regular work _____
Modified work _____ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Doctor's signature _____ Date _____ CA License Number G36632

Doctor name and degree (Please print) Michael Hadley, M.D. IRS Number 95-4526112

Case# 80283 Telephone Number (626) 582-7989

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

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While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN. She denies any history of diabetes, high blood pressure, ulcer disease or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

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E O M A

Eastside Orthopedic Medical Associates

Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

Associated Physicians

Luigi Gallioni, M.D., Inc.
Michael Esposito, M.D., Inc.
Barnard Barragan, M.D., Inc.

ORTHOPEDIC PERMANENT AND STATIONARY REPORT

December 5, 2008

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
AGE AND SEX:	**56-year-old female**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**12/05/08**

Gentleman:

As you are well aware, this patient has been under our care. She underwent arthroscopic surgery of her left knee on 04/24/07. At the time of surgery, she underwent a partial medial meniscectomy and an abrasive chondroplasty of the medial femoral condyle. Since then, she indicates that her pain has improved, however, not completely resolved. She indicates that she does have some mild discomfort of her left knee.

PHYSICAL EXAMINATION

LOWER EXTREMITIES

On examination of her left knee there is evidence of well healed surgical arthroscopic portals. There is no tenderness, swelling, effusion or laxity. She flexes the knee from 0 to 125 degrees. Motor and sensory function is intact distally.

IMPRESSION

1) STATUS POST LEFT KNEE ARTHROSCOPY WITH PARTIAL MENISCECTOMY

2) STATUS POST LEFT KNEE ABRASIVE CHONDROPLASTY

DISCUSSION

At this time it is apparent that Ms. Floreen Rooks has essentially plateaued and may be considered permanent and stationary. She has reached a maximum level of improvement having undergone arthroscopic surgery and placed on a postoperative physical therapy program.

SUBJECTIVE FACTORS OF DISABILITY

Her subjective complaints are rated in the range of intermittent minimal not exceeding that level.

OBJECTIVE FACTORS OF DISABILITY

Objectively, the patient did undergo a partial meniscectomy as well as an abrasive chondroplasty and has responded favorably.

WORK STATUS

Given this patient's clinical presentation and findings, I will recommend that this patient be released to her previous occupation with no restrictions.

FUTURE MEDICAL CARE

Future medical care in this patient's case certainly is indicated given the nature of this patient's injury and the clinical findings and I would recommend that we grant her physician care, pharmacotherapy, physical therapy and this would certainly provide her coverage should there be an aggravation or recurrence of the same similar symptoms as a result of the initial injury.

APPORTIONMENT

Apportionment in this patient's case is apparently not indicated since the patient denies any prior injuries of her involved knee.

VOCATIONAL REHABILITATION

Vocational rehabilitation is also not indicated since this patient will be released to her previous occupation with no restrictions.

IMPAIRMENT RATING

Based on the American Medical Association 5th Edition Guide to permanent impairment there is no loss of range of motion noted, however, she did undergo a partial meniscectomy which corresponds to a 1% whole person impairment rating.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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.

There may or may not be other medical information that is protected by special state and federal laws and cannot be released without the subject's specific written authorization, or pursuant to other procedures established by law.

This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 5th, of December, 2008.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

EOMA

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ORTHOPEDIC PERMANENT AND STATIONARY REPORT

December 5, 2008

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P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

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OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**12/05/08**

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PHYSICAL EXAMINATION

LOWER EXTREMITIES

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880 South Atlantic Boulevard, Suite 205, Monterey Park, California 91754 • (626) 289-0178 • FAX (626) 308-2083

IMPRESSION

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2) STATUS POST LEFT KNEE ABRASIVE CHONDROPLASTY

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Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

PLAZA SURGICAL CENTER
850 S Atlantic Blvd.
Monterey Park, California 91754
(626) 289-2894
(626) 289-2840

OPERATIVE REPORT

DATE: 04/24/2008 ROOM: Outpatient
PATIENT: ROOKS, FLOREEN DOB: Jun 20, 1949
MR #: Log#: 3
REF. PHYSICIAN: Tomas Saucedo, M.D.

OPERATIVE REPORT

DATE: 04/24/2008

SURGEON: Tomas Saucedo, M.D.

ASSISTANT: None.

PREOPERATIVE DIAGNOSIS: Left knee internal derangement.

POSTOPERATIVE DIAGNOSES:
1. Evidence of left knee complex tear of the medial and lateral meniscus.
2. Evidence of cartilage tears of the patellofemoral groove, tears of the medial femoral condyle cartilage, lateral femoral condyle cartilage, medial tibial plateau and lateral tibial plateau.

OPERATION PERFORMED:
1. Left knee diagnostic and surgical arthroscopy.
2. Left knee partial medial and partial lateral meniscectomy.
3. Left knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral and tibial plateau cartilage.

ANESTHESIA: Laryngeal mask anesthetic.

INDICATIONS: The patient was taken to the operating room, and under adequate laryngeal mask anesthetic, the patient's left lower extremity was prepped and draped in the usual sterile manner. The patient was given 600 mg of Clindamycin on a prophylaxis basis.

We then proceeded to make three arthroscopic portals after taking the tourniquet up to 300 mmHg. We were able to examine the patellofemoral groove with evidence of what appeared to be grade II and grade III cartilage tears of the patellofemoral groove. We were able to shave this very thoroughly with the use of a motorized shaver, leaving a very smooth surface with no friable cartilage left behind.

Upon entering the medial compartment of the knee, there was evidence of grade I and grade II cartilage at the medial femoral condyle and grade II and grade III cartilage of the medial tibial plateau. There was also evidence of a very complex tear of the posterior horn of the medial meniscus which as resected with multiple forceps maskets in combination with the use of motorized shaver. We were able to perform partial medial meniscectomy with absolutely no

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OPERATIVE REPORT

DATE: 04/24/2008 ROOM: Outpatient
PATIENT: ROOKS, FLOREEN DOB: Jun 20, 1949
MR #: Log#: 3
REF. PHYSICIAN: Tomas Saucedo, M.D.

complications.

We proceeded to the notch noting evidence of an intact anterior cruciate ligament with no attenuation. The lateral compartment also revealed evidence of small tears of the cartilage of the femoral condyle and more moderate tears of the cartilage of the lateral tibial plateau which required abrasive chondroplasty with the use of motorized shaver. When this was completed, we noted evidence of very complex tears of the posterior and middle aspect of the lateral meniscus. We were able to use multiple forceps baskets, and in combination we used an ablator to smooth out the tears after resecting out the tears leaving no subluxable meniscal tissue behind.

Once this was completed, we irrigated the knee thoroughly and copiously with normal saline solution. The incisions were approximated with Steri-Strips. We injected 10 cc of 0.25% Marcaine for postoperative pain. The incisions were dressed then with Xeroform gauze, 4 x 4's, ABD pads and bias wrapping. The patient was awakened and taken to the recovery room in satisfactory condition with absolutely no complications.

Tomas Saucedo, M.D.

TS/c4
DD: 04/24/08 1055
DT: 04/27/08 0831
Job # 9301

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER	2. EMPLOYER NAME	PLEASE DO NOT USE THIS COLUMN
State Comp 92622 P.O. Box 92622 Los Angeles, CA 90009-2622	D'Veal Family & Youth Services P.O. Box 40255 Pasadena, CA 91114	Case No Industry County

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothing)

5. PATIENT NAME	6. Sex	7. Date of Birth (Mo. Day Year)	Age
ROOKS, FLOREEN	[ ] Male [X] Female	06/20/1949	

8. Address	City	Zip	9. Telephone Number	Hazard
1315 S. GLADYS AVE.	SAN GABRIEL	91776	(626) 573-1906	

10. Occupation (Specific Job title)	11. Social Security Number	Disease
MARRIAGE FAMILY THERAPIST	130-38-8510	

12. Injured at:	City	County	Hospitalization
WORK PLACE			

13. Date and hour of injury or onset of illness	Mo. Day Year	Hour	14. Date Last Worked	Mo. Day Year	Occupation
	11/10/2007	10:30 am		11/10/2007	

15. Date and hour of first examination or treatment	Mo. Day Year	Hour	16. Have you (or your office) previously treated patient	Return Date/Code
	11/20/2007	11:04 am	[ ] Yes [X] No	

Patient please complete this portion, if able to do so. otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her right s to workers' compensation under the California Labor Code

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

"Fell on to ground gravel and fractured right foot to prevent car from rolling into oncoming traffic. Injured right foot."

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)

The patient states that she is employed as a marriage and family therapist. On 11/10/2007 while trying to enter her vehicle that was moving even though it was parked she tripped on the ground and fell, she hit her left knee and she twisted (continued)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)

A. Physical examination

General appearance No acute distress. Vital signs: BP 156/98, pulse 78, respirations 16. Examination of the right foot reveals that there is moderate edema with moderate to marked tenderness present on the dorsum. There is no (continued)

B. X-ray and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (If occupational illness, specific etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No

924.11 CONTUSION, LEFT KNEE
825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or onset [X] Yes [ ] No

If "no" please explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No

If "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)

(1) Examination. (2) X-ray. (3) Dispensed walker boot/Cam walker. (4) Dispensed Motrin 800 mg x #30 tablets (5) Dispensed extra strength Tylenol x #30 tablets (6) Referral to orthopedic surgeon for evaluation and treatment

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duration: 1 month.

24. If Hospitalized as inpatient, give hospital name and location (continued) Date admitted (Mo. Day Year) Estimated Stay

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No

If "no", patient can return to

Regular work _____

Modified work _____ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Doctor's signature _____ Date _____ CA License Number G36632

Doctor name and degree (Please print) Michael Hadley, M.D. IRS Number 95-4526112

Case# 80283 Telephone Number (626) 582-7989

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FIRST REPORT - ADDITIONAL INFORMATION

#18.
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While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN. She denies any history of diabetes, high blood pressure, ulcer diseaae or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

Review of systems: Denies any chest pain or shortness of breath. Patient denies any abdominal pain, nausea, vomiting, diarrhea or constipation.

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Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema.

Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain.

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preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending.

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MR #: Log#: 3
REF. PHYSICIAN: Tomas Saucedo, M.D.

OPERATIVE REPORT

DATE: 04/24/2008

SURGEON: Tomas Saucedo, M.D.

ASSISTANT: None.

PREOPERATIVE DIAGNOSIS: Left knee internal derangement.

POSTOPERATIVE DIAGNOSES:
1. Evidence of left knee complex tear of the medial and lateral meniscus.
2. Evidence of cartilage tears of the patellofemoral groove, tears of the medial femoral condyle cartilage, lateral femoral condyle cartilage, medial tibial plateau and lateral tibial plateau.

OPERATION PERFORMED:
1. Left knee diagnostic and surgical arthroscopy.
2. Left knee partial medial and partial lateral meniscectomy.
3. Left knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral and tibial plateau cartilage.

ANESTHESIA: Laryngeal mask anesthetic.

INDICATIONS: The patient was taken to the operating room, and under adequate laryngeal mask anesthetic, the patient's left lower extremity was prepped and draped in the usual sterile manner. The patient was given 600 mg of Clindamycin on a propbylaxis basis.

We then proceeded to make three arthroscopic portals after taking the tourniquet up to 300 mmHg. We were able to examine the patellofemoral groove with evidence of what appeared to be grade II and grade III cartilage tears of the patellofemoral groove. We were able to shave this very thoroughly with the use of a motorized shaver, leaving a very smooth surface with no friable cartilage left behind.

Upon entering the medial compartment of the knee, there was evidence of grade I and grade II cartilage at the medial femoral condyle and grade II and grade III cartilage of the medial tibial plateau. There was also evidence of a very complex tear of the posterior horn of the medial meniscus which as resected with multiple forceps maskets in combination with the use of motorized shaver. We were able to perform partial medial meniscectomy with absolutely no

PLAZA SURGICAL CENTER
850 S Atlantic Blvd
Monterey Park, California 91754
(626) 289-2894
(626) 289-2840

OPERATIVE REPORT

DATE: 04/24/2008 ROOM: Outpatient
PATIENT: ROOKS, FLOREEN DOB: Jun 20, 1949
MR #: Log#: 3
REF. PHYSICIAN: Tomas Saucedo, M.D.

complications.

We proceeded to the notch noting evidence of an intact anterior cruciate ligament with no attenuation. The lateral compartment also revealed evidence of small tears of the cartilage of the femoral condyle and more moderate tears of the cartilage of the lateral tibial plateau which required abrasive chondroplasty with the use of motorized shaver. When this was completed, we noted evidence of very complex tears of the posterior and middle aspect of the lateral meniscus. We were able to use multiple forceps baskets, and in combination we used an ablator to smooth out the tears after resecting out the tears leaving no subluxable meniscal tissue behind.

Once this was completed, we irrigated the knee thoroughly and copiously with normal saline solution. The incisions were approximated with Steri-Strips. We injected 10 cc of 0.25% Marcaine for postoperative pain. The incisions were dressed then with Xeroform gauze, 4 x 4's, ABD pads and bias wrapping. The patient was awakened and taken to the recovery room in satisfactory condition with absolutely no complications.

Tomas Saucedo, M.D.

TS/c4
DD: 04/24/08 1055
DT: 04/27/08 0831
Job # 9301

05170360

DEC-04-2007 15:14 HCP 6265827928 P.03/04

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In case of diagnosed or suspected pesticide poisoning send copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER	2. EMPLOYER NAME	PLEASE DO N USE THIS COLUMN
State Comp 92622 P.O. Box 92622 Los Angeles, CA 90009-2622	D'Veal Family & Youth Services P.O. Box 40255 Pasadena, CA 91114	Claim No Industry County

4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. PATIENT NAME	6. Sex	7. Date of Birth Mo. Day Year	Age
ROOKS, FLOREEN	[ ] Male [X] Female	06/20/1949	

8. Address	City	Zip	9. Telephone Number	Hazard
1315 S. GLADYS AVE.	SAN GABRIEL	91776	(626) 573-1906	

10. Occupation (Specific Job title)	11. Social Security Number	Disease
MARRIAGE FAMILY THERAPIST	130-38-8510	

12. Injured at:	City	County	Hospitalizatic
WORK PLACE			

13. Date and hour of injury or onset of illness	Mo. Day Year	Hour	14. Date Last Worked	Mo. Day Year	Occupation
	11/10/2007	10:30 am		11/10/2007	
15. Date and hour of first examination or treatment	11/20/2007	11:04 am	16. Have you (or your office) previously treated patient	[ ] Yes [X] No	Return Date/Ca

Patient please complete this portion, if able to do so; otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)
"Fell on to ground gravel and fractured right foot to pr ent ... from rolling into oncoming traffi- Injured right foot."

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)
The patient states that she is employed as a marriage and family therapist. On 11/10/2007 while trying to enter her vehicle that was moving even though it was parked she tripped on the ground and fell, she hit her left knee and she twisted (continued)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination
General appearance. No acute distress. Vital signs. BP 156/98, pulse 78, respirations 16. Examination of the right foot reveals that there is moderate edema with moderate to marked tenderness present on the dorsum. The- is no (continued)

B. X-rays and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (If occupational illness, specific etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No
924.11 CONTUSION, LEFT KNEE
825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or [X] Yes [ ] No
If "no" please explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No
If "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)
(1) Examination. (2) X-ray. (3) Dispensed walker boot/Cam walker. (4) Dispensed Motri 800 mg #X #in tabl (5) Dispensed extra-strength Tylenol x #30 tablets (6) Referral to orthopedic surgeon fo- evaluation - treatment.

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duration: 1 month.

24. If Hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Year Estimated Stay
(continued)

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No
If "no", patient can return
Regular work _____
Modified work _____ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Doctor's signatur_____ Date_____ CA License Number G36632
Doctor name and degree (Please print) Michael Hadley, M.D. IRS Number 95-4526112
Case# 80283 Telephone Number (626) 582-7989

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

8083

FIRST REPORT ADDITIONAL INFORMATION

#18.
her left ankle and also her right foot. Because of these injuries, the patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment.

While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN She denies any history of diabetes, high blood pressure, ulcer disease or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

Review of systems: Denies any chest pain or shortness of breath. Patient denies any abdominal pain, nausea, vomiting, diarrhea or constipation.

#19A.
ecchymosis. The patient does have impaired weight bearing secondary to pain and altered gait secondary to pain. The patient is ambulating with the aid of a cane.

Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema.

Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain.

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preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes Final report is pending.

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2. SPRAIN, LEFT ANKLE.
3. CONTUSION, LEFT KNEE.

#22.
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5170360

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HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

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THOMAS W. FELL, JR., M.D.
Diplomate, American Board of Orthopedic Surgery

630 W. Duarte Road, Suite 203
Arcadia, California 91007
(626) 447-8870

March 17, 2011

STATE COMPENSATION INSURANCE FUND
P. O. Box 92622
Los Angeles, CA 90009

Attention : Yolanda Nielsen, Claims Representative

CLAIMANT : FLOREEN ROOKS
S.S. NO : 130-38-8570
CLAIM NO : 05124168 AND 05170360
EMPLOYER : D'VEAL FAMILY AND YOUTH SERVICES
ACCT. NO : 23185
D/INJURY : 08/09/07 AND 11/10/07
D/EXAMIN : 03/17/11

ORTHOPEDIC AGREED PANEL QME EVALUATION

Dear Ms. Nielsen:

Today, I had the opportunity to perform an orthopedic Agreed Panel QME evaluation on Floreen Rooks in my Arcadia office. She gives the following history.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances (ML104-94), of six and one-half hours in length. This evaluation required four complexity factors as follows: Over four hours was spent on the combination of review of medical records and in face-to-face time with the patient. I have addressed the issue of medical causation with written request. I have addressed the issue of apportionment with the claimant having two or more injuries to two or more body parts. I have addressed the issue of treatment. Two and one-half hours were spent on preparation of this report.

EMPLOYMENT AT TIME OF INCIDENT:

The patient is a 61-year-old, right-handed female employed as a marriage and family therapist by D'Veal Family and Youth Services. She worked for this employer for three years prior to her injury. She continues to work for this employer at this time.

FLOREEN ROOKS
03/17/11

HISTORY OF THE PRESENT INJURY:

Her first injury around August, 2007, when she slipped, fell and twisted her left ankle and her left knee. She was seen in an industrial clinic and treated with bracing for both of these as well as physical therapy.

While still healing from this injury, the patient had a second injury in November, 2007. She was picking up clients at work when she noticed that the car was rolling. She jumped in to pull up tension on the brake. In doing so, she fell striking her left knee on the ground and her right foot turned in. She had ongoing pain in the left knee and right ankle. She elevated and iced it.

Because of the pain, she went to Kaiser emergency room where she was evaluated and had x-rays. She was told that she had two fractures of the right foot. She was placed in a Cam walker which she wore for a number of weeks.

She then treated with Dr. Saucedo. As the right foot got better, she had persistent pain in the left knee. She had an MRI and eventually surgery of the left knee which helped the left knee. However, she has had residual ongoing symptoms of the left knee ever since the surgery. She was released in 2008 or so by Dr. Saucedo.

She returned to him a couple of months ago because of pain in the left knee. At that time, she could not use the clutch of her car. Dr. Saucedo had told her that she would need to get a different kind of car because of the clutch, but she continued to use the clutch. He took x-rays of her knee and gave her a cortisone injection.

She was off work for about a week. The injection helped a lot. However, she developed a skin burn from the topical used to freeze her knee prior to the injection. Dr. Saucedo told her she was bone on bone laterally and may need total knee replacement surgery in the future.

FLOREEN ROOKS
03/17/11

Prior injuries: The patient injured her left ankle a number of years ago, in the mid-90s. It was fractured medially and laterally. She had surgery. Ever since then she has had pain which became worse after the incident of August, 2007.

Regarding the left knee, she had no symptoms prior to the episode of August, 2007.

PRESENT COMPLAINTS:

The right foot: No symptoms.

The left ankle and left knee symptoms almost always occur together with any prolonged walking, climbing stairs, squatting, kneeling with cause swelling basically of the knee and then the ankle followed by pain. The ankle pain is medial and lateral. The left knee pain is diffuse peripatellar pain. The knee does not have any locking or buckling, but it has stiffness.

PAST MEDICAL HISTORY:

WORK INJURIES	:	These two work injuries, as mentioned above.
ILLNESSES	:	Denies diabetes, cancer, or lung disease. She had arthritis of the knee and a heart murmur.
OTHER ILLNESSES	:	Hypertension.
MEDICATIONS	:	The patient is taking Lisinopril and hydrochlorothiazide, ibuprofen, Vicodin.
ALLERGIES	:	Penicillin.
SURGERIES	:	Knee surgery for this injury. Prior left ankle surgery, as noted above.
AUTO ACCIDENTS	:	Denied.

FLOREEN ROOKS
03/17/11

SOCIAL HISTORY:

The patient admits to smoking cigarettes and drinking alcoholic beverages.

FAMILY HISTORY:

Her mother is deceased of cancer. Her father is deceased of trauma.

REVIEW OF MEDICAL RECORDS:

Dreamweaver Medical Group:

8/9/07, Dan La, D.O., Doctor's First Report of Occupational Injury. **Date of injury: 8/9/07.** Injury as described below. Diagnosis: Left hip, knee, ankle pain. Treatment: Naprosyn, ice packs.

8/9/07, signed by nurse, PR. Patient states that she slipped and fell on her left hip. Now with pain in left hip, left knee, left ankle which is the most painful. Also pain in right shoulder as well. She cannot describe how the pain in right shoulder originated. Naprosyn, x-rays. Off work.

8/14/07, signed by nurse, PR. States she is feeling moderately better. Left ankle still swollen. Naprosyn helped. Shoulder is better. Work status: Modified work with no continuous walking or prolonged standing. Must sit the majority of work shift. Must keep left foot elevated. Limited driving of jus to and from work. Must wear splint and use cane.

8/27/07, nurse, PR. Patient has only taken 2 Naprosyn since injury which give relief. Without it she was bedridden. Still has pain ans swelling of left knee. She is overweight. Diagnosis: Left knee sprain. Plan: MRI of left knee to R/O meniscal tear. PT for knee and ankle. Off work to 9/4/07.

FLOREEN ROOKS
03/17/11

Kenneth Jung, M.D.:

9/4/07, Initial Orthopedic Consultation. **Date of injury: 8/9/07.** Injury occurred to the left ankle and left knee. She was initially seen and given a cane and Naprosyn. She has been using an elastic ankle brace and taking anti-inflammatories. She describes sharp, achy, cramping, incapacitating pain. It hurts her most of the day. There is swelling, tenderness and giving way. It hurts when she drives and walks. She has a history of left ankle fracture about 14 years ago for which she underwent and ORIF. The fracture was not a work injury. It occurred with a fall down some stairs. Patient brought in x-ray films obtained on 8/10/07. Impression: 1. Left ankle post-traumatic arthritis, status post open reduction and internal fixation ankle fracture. 2. Industrial injury secondary to fall. 3. Ankle pain after industrial fall. Doctor recommends a lace-up ankle brace that provides further support; she is given one today. She can be weightbearing as tolerated. She says that she has an appointment with Dr. Ralph Gambardella for her left knee treatment. Work status: TTD until her visit with Dr. Gambardella on 9/10/07. After that she can return to sedentary work.

Kerlan Jobe Orthopaedic Clinic:

9/4/07, Treatment and disability Information. Transfer care to KJOC. Diagnosis: Left ankle. Brace. TTD. Sedentary work only.

9/10/07, Ralph A. Gambardella, M.D., Orthopaedic Evaluation. History of **injury of 8/9/07** is noted. Notes X-rays as noted below. Impression: 1. Synovitis of the left knee with underlying early degenerative osteoarthritis of left knee including patellofemoral early arthrosis with mild patellofemoral malalignment, left and right knees. 2. Pes bursitis, left knee. Recommendations: The work injury caused a flare up of the pre-existing degenerative arthritis. Would not recommend any diagnostic testing due to the patient's mild hypersensitivity and diffuse tenderness. Would recommend a comprehensive PT program 2x6 weeks. Switch from Naprosyn to Voltaren XR. Patient noted that prior to the injury, she was using 2-3 Advil in the morning for her ankle. Doctor would defer for ankle care to Dr. Jung but does recommend that she

maintain some ankle exercise program and intermittent elevation. Dr. Gambardella recommends she had work restrictions for the left knee of sedentary type of work activities, no climbing, no lifting over 10 pounds, no squatting or kneeling. Standing and walking limited to no more than 15 minutes per hour. If these restrictions not available she would be TTD pending follow up in 6 weeks.

11/26/07, Dr. Gambardella, Permanent and Stationary Report. Patient was seen regarding a work injury of 8/9/07. Patient returns today and states that she did to go PT which helped her knee condition. She states she is no longer having significant discomfort to the knee. No recurrent swelling other than occasionally. With regards to the knee, she feels she can return to work regular duty. She has had a new work injury which occurred to her right lower extremity resulting in a fracture of her right foot. She is aware she is being seen separately for her right foot injury. Final impression: Underlying degenerative osteoarthritis including patellofemoral arthrosis and mild patellofemoral mal-alignment, left knee status post posttraumatic synovitis and pes bursitis, left knee. She is permanent and stationary. Subjective factors: Occasional minimal pain with activities of daily living increasing to occasional to intermittent minimal-to-slight pain with heavier squatting, kneeling, or lifting activities. Objective: Radiographic evidence of the patellofemoral joint space narrowing and degenerative osteoarthritis joint space narrowing noted on x-rays. No permanent work restrictions. She may have flare up of her condition that may require anti-inflammatory medications, PT, and/or cortisone injection and/or arthroscopic surgical intervention. At this time, there is no residual disability and therefore there does not appear to be a need for apportionment. Impairment rating: Using Table 17-3, she has a 17% lower extremity impairment, 7% whole person impairment rating.

Diagnostic Studies:

8/10/07, Richard P. Chao, M.D., X-rays, left knee. Impression: 1. Generalized demineralization. 2. Suspect small loose body within the central joint. 3. No acute fracture or subluxation is demonstrated.

8/10/07, Dr. Chao, X-rays, left ankle. Impression: 1. Old post-traumatic changes of the malleoli, status post prior ORIF. 2. There is secondary deformity and secondary osteoarthritis changes at the distal tibia and talus.

8/10/07, Dr. Chao, X-rays, AP Pelvis, AP and lateral left hip. Impression: Negative study.

Misc. Records:

8/30/07, Workers' Compensation Claim Form. **Date of injury: 8/9/07**. Injury occurred when claimant flipped on a piece of cucumber and fell onto concrete pavement.

11/16/07, Workers' Compensation Claim Form. **Date of injury: 11/10/07**. Injury occurred while picking up a client. She fell onto ground/gravel and fractured right foot to prevent rolling car from entering into oncoming traffic.

There are duplicate copies of most reports.

HealthCare Partners:

11/20/07, Michael Hadley, M.D., Doctor's First Report of Occupational Injury. **Date of injury: 11/10/07**. The first page of report is poorly copied and difficult to read. Injury occurred with a fall to the ground with a fracture of the right foot. Diagnosis: 1. Fracture, right foot. 2. Sprain, left ankle. 3. Contusion, left knee. She developed pain mainly in her right foot. She went to Kaiser ER where she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise ot the left knee. She was given an ortho shoe and was told to report this to her employer as a work injury. She did so and was referred here by her insurance carrier. Today is her initial visit at this facility. She complains of mild discomfort in her left ankle and her left knee. However, she complains of significant discomfort in her right foot. Pertinent past medical history: She states that she has a heart valve problem for many years and uses prophylactic antibiotics for dental work. She had a fracture of her left ankle in 1992 that was treated operatively. She is allergic to penicillin. She has impaired weight bearing secondary to pain and

altered gait secondary to pain. She ambulates with the aid of a cane. X-rays were performed showing right foot fracture involving the 4th and 5th metatarsals with angulation present in the 4th metatarsal head. Work restrictions of no driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.

Thomas Saucedo, M.D.:

11/29/07, Orthopedic Consultation. **Injury date: 11/10/07.** Patient states that on 11/10/07, while working, she apparently parked on a gravel road. The car started rolling when she was out of the car. She ran towards the car, got into the car to put the emergency parking brake on and in that process twisted her right foot, fractured the 4th and 5th metatarsal and injury her left knee and left ankle. Past medical history: Left ankle surgery 14 years ago (plate and screws in place, left knee injury as well. Allergic to Penicillin. Left ankle fracture in 2007. Was off work for five weeks. Smokes one pack of cigarettes per week. Examination of right foot: Notable tenderness over the 4th and 5th metatarsal area. Notable swelling and ecchymosis. Left ankle: Diffuse tenderness over the anterior as well as the lateral and anterior aspect of the ankle. Left knee: Mild tenderness, mild swelling. No effusion. No gross laxity is noted. Impression: 1. Right foot 4th and 5th metatarsal fracture. 2. Left ankle posttraumatic degenerative osteoarthritis. 3. Left knee sprain. Recommendations: Continue use of the Cam walker for the right foot. Stay off work until further progress is made. Use of Motrin for pain and inflammation. Reexamine her in 3 weeks. X-rays will be obtained to assess the healing process of the fractures of the right foot.

12/20/07, PR2. X-rays of the right foot reveal evidence of a healing 4th and 5th metatarsal fracture, overall good position. Recommends that patient continue off work. Continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will be provided for her left knee.

1/17/08, PR2. Her right foot fractures appear to be healing quite well. Continue Cam walker to complete healing. X-rays will be

obtained in 4 weeks to assess healing. MRI of the left knee will be obtained due to notable swelling and effusion of the knee.

2/21/08, PR2. Right foot: mild tenderness, swelling. Motor and sensory intact distally. Impression: 1. Healing right 4th and 5th metatarsal fractures. 2. Left knee internal derangement. Patient has developed increased pain in her left knee as a result of favoring her right lower extremity. Recommends MRI of the left knee.

3/20/08, PR2. Right foot: No tenderness or swelling. Left ankle: No tenderness, swelling, spasms. Full ROM. Impression: 1. Left knee internal derangement with evidence of medial meniscus tear. 2. Right 4th and 5th metatarsal fracture, healed. 3. Left ankle sprain. Recommends arthroscopic surgery of left knee. Her left ankle and right foot are healed. On this basis, she will be released to her previous level of occupation with no restrictions.

4/17/08, PR2. She is scheduled for left knee surgery on 4/24/08. She wishes the surgery to be done. She will be off work.

4/24/08, Operative Report. Perioperative diagnosis: Left knee internal derangement. Postoperative diagnoses: 1. Evidence of left knee complex tear of the medial and lateral meniscus. 2. Evidence of cartilage tears of the patellofemoral groove, tears of th medial femoral condyle cartilage, lateral femoral condyle cartilage, medial tibial plateau and lateral tibial plateau. Operation performed: 1. Left knee diagnostic and surgical arthroscopy. 2. Left knee partial medial and partial lateral meniscectomy. 3. Left knee abrasive chondroplasty of the patellofemoral groove, medial femoral, medial tibial plateau, lateral femoral and tibial plateau cartilage.

6/6/08, PR2. The patient has undergone arthroscopic surgery of the left knee. She indicates that her pain has improved significantly. She has been in PT for the last four weeks and has responded favorable. Impression; Status post left knee arthroscopy. Recommendations: Continue on an aggressive PT program 3 x 4 weeks. Continue on Vicodin for pain.

9/5/08, PR2. Her knee pain has improved significantly. She does have some associated pain to her lower back and radiculopathy of her left lower extremity. Impression: 1. Status post left knee arthroscopy. 2. Lumbosacral spine strain. 3. Left lower extremity radiculopathy. Recommends return to work avoiding any prolonged periods of standing and walking, any squatting, climbing and pivoting type of activities. She is to continue exercises for strengthening her left lower extremity at home.

12/5/08, Orthopedic Permanent and Stationary Report. Since her surgery her knee pain has improved but not completely resolved. At this point, she has plateaued and may be considered P&S. Doctor recommends she be released to her previous occupation with no restrictions. She should be allowed future medical care. No apportionment. Impairment rating: There is no loss of ROM. She had a partial meniscectomy which corresponds to a 1% whole person impairment rating.

12/5/08, PR2. She indicates she was doing very well until two weeks ago. She developed significant tightness and difficulty with mobility to her neck and denies any new traumatic event. Impression: Cervical spine strain. Recommends the use of ibuprofen for pain. Also recommends a short course of PT 2 x 4 weeks.

1/23/09, PR2. Doctor apportions 50% of her injury to her pre-existing osteoarthritis of her knee as noted by Dr. Gambardella.

9/4/09, PR2. She indicates that this past week she was getting out of a friend's car when she apparently twisted her left knee causing her to develop pain of her left knee. She is concerned that she reinjured her knee. X-rays taken today reveal evidence of mild medial joint space narrowing. Impression: 1. Left knee re-injury. 2. Left knee evidence of mild degenerative osteoarthritis. Recommends she be provided with Motrin for the pain. He will see her back in the next four to six weeks time if her symptoms do not improve.

10/11/10, PR2. Ms. Rooks at this time has noted pain of the lower back which appears to be a new problem. This is not a continued medical problem from a previous injury. Therefore, it should be

treated as a new industrial injury. With respect to her left knee, she does have some tenderness over the medial collateral ligament area; however, there is no evidence of any acute injury. There is no evidence of loss of motor or sensory function; therefore, there is no need for any acute ongoing medical care. She will be provided an anti-inflammatory medication as well as an analgesic medication for her pain of her left knee.

Diagnostic Studies:

12/20/07, Michael Vo, M.D., X-rays right foot. Impression: Healing fractures of the 4th and 5th metatarsals.

1/17/08, Dr. Vo, X-rays right foot. Impression: 1. No significant interval change. 2. There is continued healing of fracture involving the 4th and 5th metatarsals.

2/21/08, Dr. Vo, X-rays right foot. Impression: Continued healing of fracture involving the 4th and 5th metatarsals.

3/19/08, Anthony Bledin, M.D., MRI of the left knee. Impression: 1. Tear, posterior horn, medial meniscus (Grade III). 2. Early osteoarthritic changes of the medial compartment of the knee joint. 3. Knee joint effusion.

3/20/08, Dr. Vo, X-rays right foot. Impression: Continued healing of fracture involving the 4th and 5th metatarsals.

There are PT progress reports.

This concludes the review of available medical records.

PHYSICAL EXAMINATION:

GENERAL : The patient appears to be her stated height and weight of 5'6" tall and 213 pounds.

GAIT : The patient walks without an appreciable limp.

LEFT KNEE : Examination of the left knee reveals mild swelling as compared to the right. There are

multiple well-healed arthroscopic portals. There is a 1.5 cm circular lesion on the superior medial aspect of the knee that is consistent with a first or second degree skin burn. There is tenderness over the anterior medial joint line and anterior lateral joint line with the anterior lateral joint line being more tender.

There is mild crepitus of the patellofemoral joint. There is moderate crepitus over the lateral joint.

The left knee is in valgus when compared to the right.

Range of motion of the left knee reveals extension to 0 degrees and flexion to 130 degrees.

The left knee is stable to anteroposterior and mediolateral stressors taking into consideration the valgus deformity.

McMurray's, jerk and patellar apprehension tests are all negative.

ANKLES/FEET : Examination of the left ankle reveals mild swelling about the left ankle medially and laterally. There are well-healed medial and lateral scars. Diffuse tenderness is noted medially and laterally of the ankle.

Pain with just the slightest motion of the ankle. Range of motion of the ankle reveals dorsiflexion is to 0 degrees and plantar flexion is to 5 degrees.

There is no instability of the left ankle.

The right ankle and foot are entirely nontender with no swelling.

Range of motion of the right ankle and foot shows dorsiflexion is to 15 degrees and plantar flexion is to 40 degrees. Range of motion is without pain.

The right ankle is stable to varus and valgus stressors in the neutral and plantar-flexed positions.

Eversion and inversion is without pain.

The right forefoot motion is without pain.

LOWER EXTREMITIES : Pinprick sensation in the lower extremities is intact.

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Ankles :	26.5 cm	29 cm
Calves :	41 cm	41 cm
Knees (mid-patella) :	41 cm	41.5 cm
Quadriceps (4" above the superior pole of the patella) :	57 cm	56.5 cm

REVIEW OF X-RAYS:

X-rays of the left ankle show lateral plate, screws, as well as medial motor screws. There is deformity of the talar tibial joint with virtual absence of any joint space at all. There appears to be an old fracture across the talus that may not have healed.

FLOREEN ROOKS
03/17/11

X-rays were also obtained of the left knee. There arthritis seen with approximately 2 mm of joint space interval to medial and lateral joint space. The narrowing is slightly more lateral than medial with marginal osteophytes laterally and prominence of the tibial spine. Very minimal spurring is noted in the patellofemoral joint.

DIAGNOSIS:

1. Sprain/strain of the left knee aggravating degenerative arthritis of the left knee. Status post arthroscopic partial lateral and medial meniscectomies.

2. Sprain of the left ankle temporarily aggravating significant pre-existing arthritis of the left ankle.

3. Fracture of the right foot, fourth and fifth metatarsals healed.

DISCUSSION:

This patient suffered two injuries, one on 8/9/07 and one on 11/10/07. The patient was doing well as far as her left knee was concerned even though she had pre-existing arthritis until she suffered the injury of August, 2007, and further injured it in November, 2007.

With regards to the left ankle, it has always given her pain, well prior to the two work incidents. She suffered an injury to the left ankle back in the mid-90s and had ORIF. She had residual symptoms. She then sprained it and had temporary increased pain with the work incidents. However, I expect that most of the symptoms now are residuals of her arthritis given the fact that she has significant limitation of motion of the ankle. A sprained ankle would not cause this type of limitation of motion. She would have excessive motion. There is no instability of the ankle. Even the slightest motion of the ankle causes pain so all of the pain is coming from the ankle joint. When I asked the patient about that and mentioned the fact that I thought that the knee pain aggravated the arthritis and the ankle pain would probably be present absent

the work injuries. She tended to agree that the arthritis of the knee was the one that was really aggravated by the work incidents and that the left knee really wasn't hurting her and the left ankle has always given her problems since the prior ankle surgery.

She did suffer a right foot fractures in the 11/10/07 incident. However, the right foot fractures have healed completely with no residuals.

The patient had a flareup of symptoms that precipitated a lot of this, needing an injection which settled down her knee, but it is still symptomatic.

Fortunately, individuals with valgus knees, that is, arthritis in the lateral aspect of the knee can tolerate a lot of arthritis without need for total knee replacement.

STATUS:

The patient is at maximum medical improvement from her injuries.

AMA IMPAIRMENT:

Using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

Right foot - The fracture is well healed without any impairment.

Left ankle - The ankle is rated according to arthritis Table 17-31. This patient has 0 mm of joint space which is a 30% lower extremity impairment.

Left knee - With regard to the left knee, she has approximately 2 mm of joint space on the left side. Using Table 17-31, this is a 20% lower extremity impairment. For the left knee, the patient is also rated according to Table 17-33. Because she has partial medial and partial lateral meniscectomies, she has a 10% lower extremity impairment. This gives her a 30% lower extremity impairment for the left knee.

Combining the 30% lower extremity impairment for the left knee with the 30% lower extremity impairment for the left ankle, using page 504 of the Guides, gives her a combined total of 51% lower extremity impairment which using Table 17-3, gives her a total of 20% whole person impairment.

FUTURE MEDICAL CARE:

Left knee - Allowance should be made for repeat orthopedic visits for her left knee including but not limited to evaluations, x-rays, corticosteroid injections. For more lasting relief than the corticosteroid injections, viscous supplementation such Synvisc would be beneficial. Should the left knee symptoms become such that they interfere significantly interfere with her quality of life, then she would be a total knee replacement candidate. She is not a knee replacement candidate at this time, however, this could change in the next few years. X-rays findings are not indicative of the need for total knee replacement. Only the pain and it's effect on the quality of living is an indication for a knee replacement.

Left ankle - With regards to the left ankle, any further care of the left ankle would be treatment of her pre-existing arthritis of the left ankle, not the injury of August, 2007 or November, 2007.

Right foot - None.

WORK STATUS:

She may do her present job without any formal restrictions. However in the open labor market, the patient would be precluded from more than occasional squatting, kneeling, and precluded from any type of climbing and more than occasional use of stairs.

CAUSATION & APPORTIONMENT:

With regards to her right foot, this was injured in the November 2007 work incident and 100% of any residual disability is due to the incident of November, 2007.

With regards to the left knee, prior to the work incidents, she was asymptomatic in the left knee even though she had arthritis. She injured the left knee in both the 8/9/07 and the 11/10/07 work incidents. The arthritis appears to have gotten worse since the injuries. Based upon these records and examination today, I would apportion 20% to the pre-existing pathology and the remaining 80% to the aggravation of the pre-existing pathology, further sprain/strain and tears of the menisci as a result of the two work incidents of August and November, 2007. I cannot separate these two as to which one caused the tear of the meniscus and which one caused more injury to the knee; I put them together as one injury.

With regard to the left ankle, while she have temporarily aggravated the left ankle in the 8/9/07 fall and 11/10/07 incident, she also had pre-existing arthritis from a prior injury that required surgery. At this point, any residual is 100% apportioned to the pre-existing arthritis. I think she had a temporary aggravation of the left ankle arthritis due to the sprains, but this settled back down. The patient's present complaints and need for treatment of the left ankle would be present absent the work injury. This is based upon the fact that she has significant limitation of motion of the ankle indicating severe arthritis. A sprain in the ankle would cause laxity and looseness of the ankle, not tightness of the ankle. this does not appear to be residual of the ankle sprain.

DISCLOSURE:

This patient was interviewed and examined by the undersigned; the medical records were reviewed; and this dictation was done in its entirety by the undersigned.

The attached statement for billing for the services of this evaluation and report are true and correct to the best of my knowledge.

There has not been a violation of Sec. 139.3 in conjunction with this evaluation to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to

FLOREEN ROOKS
03/17/11

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.

Sincerely,

THOMAS W. FELE, JR., M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on 4-15-11

TWF/sbe

cc: FLORREN ROOKS
1315 S. GLADYS AVE
SAN GABRIEL, CA 91776

DEC-18-2007 10:19 HCP 0517036O 6265827928 P.03

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

HealthCare Partners 95-4526112
3144 Santa Anita Avenue
El Monte, CA 91733-

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In case of diagnosed or suspected pesticide poisoning send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER State Comp 92622 P.O. Box 92622 Los Angeles, CA 90009-2622	2. EMPLOYER NAME Duveal Family & Youth Services P.O. Box 40255 Pasadena, CA 91114	PLEASE DO NOT USE THIS COLUMN Case No Indust'y County
4. Nature of Business (e.g., food manufacturing, building construction, retailer of women's clothes)		

5. PATIENT NAME ROOKS, FLOREEN	6. Sex [ ] Male [X] Female	7. Date of Birth Mo. Day Year 06/20/196_		Age
8. Address 1315 S. GLADYS AVE.	City SAN GABRIEL	Zip 91776	9. Telephone Number (626) 573-1906	Hazard
10. Occupation (Specific Job title) MARRIAGE FAMILY THERAPIST			11. Social Security Number 130-36-8510	Disease
12. Injured at WORK PLACE	City		County	Hospitalization
13. Date and hour of injury or onset of illness	Mo. Day Year 11/10/2007	Hour 10:30 am	14. Date Last Worked Mo. Day Year 11/19/2007	Occupation
15. Date and hour of first examination or treatment	Mo. Day Year 11/20/2007	Hour 11:00 am	16. Have you (or your office) previously treated patient [ ] Yes [X] No	Return Date/Code

Patient please complete this portion, if able to do so, otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her right a to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or, chemical. Use reverse side if more space is required.)
fell on to ground gravel and fractured right foot to prevent car from rolling into oncoming traffic. Injured right foot."

18. SUBJECTIVE COMPLAINTS (Describe fully. Use the reverse side if more space is required.)
The patient states that she is employed as a marriage and family therapist. On 11/10/2007 while trying to enter her vehicle that was moving even though it was parked she tripped on the ground and fell, she hit her left knee and she twisted (continued)

SCIF RECEIVED DEC 18 2007 GLENDALE LOC

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)
A. Physical examination
General appearance: No acute distress. Vital signs: BP 156/98, pulse 78, respirations 16. Examination of the right foot reveals that there is moderate edema with moderate to marked tenderness present on the dorsum. There is no (continued)

B. X-ray and laboratory results (State if none pending) X-rays were performed and (continued)

20. DIAGNOSIS (If occupational illness, specific etiologic agent and duration of exposure) Chemical or toxic compounds involved? [ ] Yes [X] No
924.11 CONTUSION, LEFT KNEE
825.20 FRACTURE, RIGHT FOOT

21. Are your findings and diagnosis consistent with patient's account of injury or [X] Yes [ ] No
If "no" please explain

22. Is there any other current condition that will impede or delay patient's recovery? [X] Yes [ ] No
If "yes" please explain Patient does have (continued)

23. TREATMENT RENDERED (Use reverse side if more space is required.)
(1) Examination. (2) X-ray. (3) Dispensed walker boot/Cam walker. (4) Dispensed Motrin 800 mg x #30 tablets (5) Dispensed extra-strength Tylenol x #30 tablets (6) Referral to orthopedic surgeon for evaluation and treatment.

If further treatment is required, specify treatment Yes, in the form of treatment (continued) Estimated duration 1 month.

24. If Hospitalized as inpatient, give hospital name and location (continued) Date admitted Mo. Day Year Estimated Stay

25. WORK STATUS Is patient able to perform usual work? [ ] Yes [X] No
If "no", patient can return
Regular work _____
Modified work _____ Specify Patient placed on modified duty

I have not violated Labor Code 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Doctor's signature _____ Date _____ CA License Number G36632

Doctor name and degree (Please print) Michael Radley, M.D. IRS Number 95-4526112

Case# 80283 Telephone Number (626) 582-7989

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

8083

FIRST.REPORT ADDITIONAL INFORMATION

#18.
her left ankle and also her right foot. Because of these injuries, the patient developed pain mostly in her right foot. As a result, she went to the Kaiser ER for evaluation and treatment.

While at Kaiser ER she was told that she had a fracture of the right foot, sprain to the left ankle and a bruise to the left knee. She was given an ortho shoe and was told to report this to her employer as a job-related injury. The patient did so and she was referred here by her Workers Compensation insurance carrier for evaluation and treatment. Today is her initial visit at this facility.

The patient does complain of mild discomfort in her left ankle and her left knee. However, she does complain of significant discomfort in her right foot.

Pertinent past medical history: The patient states that she has a heart valve problem for many years and does use prophylactic antibiotics for dental work. She has had a fracture of her left ankle in 1992 that was treated operatively. SHE IS ALLERGIC TO PENICILLIN. She denies any history of diabetes, high blood pressure, ulcer disease or asthma.

Social history: The patient occasionally smokes. She does play chess and write poetry.

Review of systems: Denies any chest pain or shortness of breath. Patient denies any abdominal pain, nausea, vomiting, diarrhea or constipation.

#19A.
ecchymosis. The patient does have impaired weight bearing secondary to pain and altered gait secondary to pain. The patient is ambulating with the aid of a cane.

Examination of the left ankle reveals that there is a healed surgical scar. There is trace tenderness and edema.

Examination of the left knee reveals vague tenderness present anteriorly, trace edema. There is full flexion with pain.

#19B.
preliminary reading of the right foot reveals that there is a fracture involving the fourth and fifth metatarsals with angulation present in the fourth metatarsal head. Final report is pending. X-ray exam of the left ankle reveals the presence of hardware, no acute finding seen. X-ray of the left knee is unremarkable except for degenerative changes. Final report is pending.

#20.
1. FRACTURE, RIGHT FOOT.
2. SPRAIN, LEFT ANKLE.
3. CONTUSION, LEFT KNEE.

#22.
hardware in her left ankle and this may impact upon her rate of recovery.

#23.
Further treatment: by the orthopedic surgeon.

#24.
To be determined by the orthopedic surgeon.

#25.
the following restrictions: No driving vehicle during working hours, no walking or standing for more than one hour, sitting work only.

Doctor's Notes

SCI000283

[redacted] ORTHOPEDIC SUPPLEMENTA[redacted]

NAME Rocks, Floreen EMPLOYER ____________ CASE# OCT 10 2008

CURRENT COMLAINTS [illegible]

PHYSICAL EXAMINATION: [illegible]

DX STUDY [illegible]

CURRENT DIAGNOSIS	CURRENT MEDICATION
A [illegible]	A [illegible]
B [illegible]	B [illegible]
C	C [illegible]

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: [illegible]

IS SURGERY INDICATED? YES NO PROCEDURE ____________

DX PROCEDURE ____________ HOSPITAL ____________

PHYSICAL THERAPY ____________

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT [illegible]

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT [illegible]

PHYSICIAN NAME [illegible]

8083

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA

Eastside Orthopedic Medical Associates
Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Associated Physicians
Luigi Gallioni, M.D., Inc.

ORTHOPEDIC SUPPLEMENTAL REPORT

January 26, 2011

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**01/26/11**

Gentleman:

As you are well aware, this patient has been under our care having previously undergone arthroscopic surgery of her knee. Surgery was performed on 04/24/08. She indicates that she did well, however, she did have some residual soreness, this soreness has steadily become more pronounced. She denies any new injuries to her left knee. She denies any other problem to her left knee and indicates that she has continued to work with D'Veal Family Youth Services performing her work related activities. However, she does complain of increased pain of her left knee especially over the last few months.

PHYSICAL EXAMINATION

GENERAL
Vital signs – blood pressure 206/100, pulse is 88, respirations 16.

LOWER EXTREMITIES
On physical examination of the left knee there is evidence of notable medial joint line tenderness, there is notable swelling. There is an effusion. She has a positive

McMurray sign and positive grind sign. There is notable pain and discomfort especially of the medial compartment of the knee. No gross laxity is noted. Motor and sensory function is intact distally.

DIAGNOSTIC STUDIES

X-rays of the left knee reveals evidence of Grade III medial compartment narrowing of the left knee with osteophyte formation noted primarily in the medial compartment.

IMPRESSION

LEFT KNEE EVIDENCE OF MEDIAL COMPARTMENT DEGENERATIVE OSTEOARTHRITIS

DISCUSSION

Given Ms. Rooks clinical findings as well as the results of her x-rays it appears that she has extensive degenerative changes of the medial compartment of her left knee. This has progressively gotten worse since she had surgery three years ago and at this point in time it appears that the pain is quite unrelenting. I will recommend that she be treated conservatively at this point in time with the use of an anti-inflammatory medication as well as an intra-articular cortisone injection to minimize her pain and discomfort, this was provided. The patient noted immediate improvement of the pain and discomfort of the left knee. I will see her back for follow-up in four weeks time. Should this patient's symptoms not improve or resolve significantly, she may require further intervention. This would entail a knee arthroplasty of her left knee. At this point in time I have discussed this in detail with the patient and I will see her back for follow-up to assess her progress in four weeks time. She will continue to work with no restrictions. I will keep you informed as noted.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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.

There may or may not be other medical information that is protected by special state and federal laws and cannot be released without the subject's specific written authorization, or pursuant to other procedures established by law.

This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 26th, of January, 2011.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

E O M A

Eastside Orthopedic Medical Associates
Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Associated Physicians
Luigi Gallioni, M.D., Inc.

ORTHOPEDIC RE-EXAMINATION

October 11, 2010

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**10/11/10**

Gentleman:

As you are well aware, this patient has been under our care. She has been previously declared permanent and stationary with an injury to her involved left knee. However, she was also presented with pain and discomfort of her lower back with associated radiculopathy to her left lower extremity. She indicates that this is a new problem and is quite concerned.

PHYSICAL EXAMINATION

BACK

On physical examination of the lumbar spine there is mild tenderness, there is no swelling or spasms. She flexes forward to 90 degrees, extends to 35 degrees, laterally bends to 35 degrees bilaterally.

LOWER EXTREMITIES

Left knee exam reveals evidence of mild diffuse medial collateral ligament tenderness. There is no swelling, effusion or laxity. She flexes the knee from 0 to 125 degrees. No gross laxity is noted. Motor and sensory function is intact distally.

IMPRESSION

1) STATUS POST LEFT KNEE SURGICAL ARTHROSCOPY

2) LUMBOSACRAL SPINE STRAIN WITH LEFT LOWER EXTREMITY RADICULOPATHY (NEW PROBLEM)

DISCUSSION

It appears that Ms. Rooks at this time has noted some pain and discomfort of the lower back which appears to be a new problem. I have discussed with the patient the fact that this is not a continued medical problem from a previous injury and therefore this should be seen and treated according to either a new industrial injury or non-industrial injury depending on the patient's presentation of the problem to the newly treating doctor.

With respect to her left knee, she does have some tenderness over the medial collateral ligament area, however, there is no evidence of any acute injury, there is no evidence of loss of motor or sensory function, therefore there is no need for any acute ongoing medical care. The patient will be provided with the use of an anti-inflammatory medication as well as an analgesic medication to ameliorate her level of pain and discomfort of her left knee. I will keep you informed as to this patient's progress should she return on reexamination purposes.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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.

There may or may not be other medical information that is protected by special state and federal laws and cannot be released without the subject's specific written authorization, or pursuant to other procedures established by law.

This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 11th, of October, 2010.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

Richard Zapanta, M.D., Inc.
Tomas Sancedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA

Eastside Orthopedic Medical Associates
Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Associated Physicians
Luigi Gallioni, M.D., Inc.

ORTHOPEDIC RE-EXAMINATION

October 11, 2010

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**10/11/10**

Gentleman:

As you are well aware, this patient has been under our care. She has been previously declared permanent and stationary with an injury to her involved left knee. However, she was also presented with pain and discomfort of her lower back with associated radiculopathy to her left lower extremity. She indicates that this is a new problem and is quite concerned.

PHYSICAL EXAMINATION

BACK

On physical examination of the lumbar spine there is mild tenderness, there is no swelling or spasms. She flexes forward to 90 degrees, extends to 35 degrees, laterally bends to 35 degrees bilaterally.

LOWER EXTREMITIES

Left knee exam reveals evidence of mild diffuse medial collateral ligament tenderness. There is no swelling, effusion or laxity. She flexes the knee from 0 to 125 degrees. No gross laxity is noted. Motor and sensory function is intact distally.

880 South Atlantic Boulevard, Suite 205, Monterey Park, California 91754 • (626) 289-0178 • FAX (626) 308-2083

IMPRESSION

1) STATUS POST LEFT KNEE SURGICAL ARTHROSCOPY

2) LUMBOSACRAL SPINE STRAIN WITH LEFT LOWER EXTREMITY RADICULOPATHY (NEW PROBLEM)

DISCUSSION

It appears that Ms. Rooks at this time has noted some pain and discomfort of the lower back which appears to be a new problem. I have discussed with the patient the fact that this is not a continued medical problem from a previous injury and therefore this should be seen and treated according to either a new industrial injury or non-industrial injury depending on the patient's presentation of the problem to the newly treating doctor.

With respect to her left knee, she does have some tenderness over the medial collateral ligament area, however, there is no evidence of any acute injury, there is no evidence of loss of motor or sensory function, therefore there is no need for any acute ongoing medical care. The patient will be provided with the use of an anti-inflammatory medication as well as an analgesic medication to ameliorate her level of pain and discomfort of her left knee. I will keep you informed as to this patient's progress should she return on reexamination purposes.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 11th, of October, 2010.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C

E O M A

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Qualified Medical Examiners

Associated Physicians
Luigi Gallioni, M.D., Inc.
Michael Esposito, M.D., Inc.
Barnard Barragan, M.D., Inc.

ORTHOPEDIC RE-EXAMINATION

September 4, 2009

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**09/04/09**

Gentleman:

As you are well aware, this patient has previously been under our care. She was last seen in this office on 12/05/08 and was considered permanent and stationary. Since then, the patient has been declared permanent and stationary. She indicates that this past week she apparently was getting out of a friend's car when she attempted to do so she apparently twisted her left knee causing her to develop pain and discomfort of her left knee. She was concerned that she may have re-injured the knee and therefore sought medical attention under our care and supervision. She denies any other injuries. She also indicates that she has not lost time from work.

PHYSICAL EXAMINATION

GENERAL

This is a well-developed, well-nourished young lady complaining of left knee soreness. She stands 5'6" tall and weighs 213 pounds. She is right hand dominant.

LOWER EXTREMITIES

On physical examination of her left knee reveals evidence of mild medial joint line tenderness. There is no gross swelling or gross effusion. There is a negative McMurray's sign and negative Apley's sign. She flexes the knee from 0 to 125 degrees. No gross laxity is noted. Motor and sensory function is intact distally.

DIAGNOSTIC STUDIES

X-rays taken today reveals evidence of mild medial joint space narrowing noted.

IMPRESSION

1) LEFT KNEE RE-INJURY

2) LEFT KNEE EVIDENCE OF MILD DEGENERATIVE OSTEOARTHRITIS

DISCUSSION

I will recommend that Ms. Rooks at this time be provided with Motrin for pain and inflammation. I am hopeful this will relieve her acute onset of this re-injury and it appears that she does not have anything more severe than a strain of her involved left knee. I will recommend that she continue working with no restrictions and I will see her back for follow-up should her symptoms not improve in the next four to six weeks time.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 4th, of September, 2009.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

EOMA

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Associated Physicians

Luigi Gallioni, M.D., Inc.
Michael Esposito, M.D., Inc.
Barnard Barragan, M.D., Inc.

ORTHOPEDIC SUPPLEMENTAL REPORT
(PR2)

January 23, 2009

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
AGE AND SEX:	**56-year-old female**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**

Gentleman:

As you are well aware, this patient underwent arthroscopic surgery of her knee on 04/24/08 at the Plaza Surgical Center. She underwent a partial medial and partial lateral meniscectomy with an abrasive chondroplasty of the patellofemoral groove, medial femoral condyle, medial tibial plateau, lateral femoral and lateral tibial plateau. Since then, she was considered permanent and stationary on her visit of 12/05/08. In reviewing this patient's history, she denied any prior injuries noted of her left knee. However, she does give us a history of having injured her left ankle in August of 2007. She was off of work for approximately four to five weeks, she informed us of this, however, in reviewing the report by Dr. Ralph Gamberdella, it appears that in fact that she did sustain an ankle sprain which was treated by Dr. Gamberdella's associate Dr. Jung. As a result of having developed pain to her left knee was referred to Dr. Gamberdella. However, he does not note an acute traumatic event to the left knee other than pain. As a result of the pain, Dr. Gamberdella awarded her a 7%

lower extremity impairment rating based on the joint space narrowing of the knee and a 10% lower extremity impairment rating as a result of the patellofemoral joint space narrowing, a total of 17% which corresponds to a 7% whole person impairment rating. On this basis, it appears that in fact this patient does in fact have a preexisting underlying degenerative osteoarthritis of her knee with previous pain which apparently improved and/or resolved and at this time has had a recurrence of the same problem. I would apportion this to at least 50% present industrial injury of 11/10/07 would be apportioned to her prior injury of her left knee as noted by Dr. Gamberdella.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 23rd, of January, 2009.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

EOMA

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Associated Physicians

Luigi Gallioni, M.D., Inc.
Michael Esposito, M.D., Inc.
Bernard Barragan, M.D., Inc.

ORTHOPEDIC SUPPLEMENTAL REPORT (PR2)

January 23, 2009

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
AGE AND SEX:	**56-year-old female**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**

Gentleman:

As you are well aware, this patient underwent arthroscopic surgery of her knee on 04/24/08 at the Plaza Surgical Center. She underwent a partial medial and partial lateral meniscectomy with an abrasive chondroplasty of the patellofemoral groove, medial femoral condyle, medial tibial plateau, lateral femoral and lateral tibial plateau. Since then, she was considered permanent and stationary on her visit of 12/05/08. In reviewing this patient's history, she denied any prior injuries noted of her left knee. However, she does give us a history of having injured her left ankle in August of 2007. She was off of work for approximately four to five weeks, she informed us of this, however, in reviewing the report by Dr. Ralph Gamberdella, it appears that in fact that she did sustain an ankle sprain which was treated by Dr. Gamberdella's associate Dr. Jung. As a result of having developed pain to her left knee was referred to Dr. Gamberdella. However, he does not note an acute traumatic event to the left knee other than pain. As a result of the pain, Dr. Gamberdella awarded her a 7%

lower extremity impairment rating based on the joint space narrowing of the knee and a 10% lower extremity impairment rating as a result of the patellofemoral joint space narrowing, a total of 17% which corresponds to a 7% whole person impairment rating. On this basis, it appears that in fact this patient does in fact have a preexisting underlying degenerative osteoarthritis of her knee with previous pain which apparently improved and/or resolved and at this time has had a recurrence of the same problem. I would apportion this to at least 50% present industrial injury of 11/10/07 would be apportioned to her prior injury of her left knee as noted by Dr. Gamberdella.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 23rd, of January, 2009.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

ORTHOPEDIC SUPPLEME" . REPORT

NAME Rooks, Floreen EMPLOYER _____ CASE# _____ NOV 07 2008

CURRENT COMLAINTS

(L) Knee pain is the same
re OA
meds Thought to get guy

PHYSICAL EXAMINATION:

(L) Knee ↓ ROM - 100
(L) joint knee pain
& laxity

DX STUDY _____

CURRENT DIAGNOSIS

A (L) Knee pain
B (L) Knee OA
C _____

CURRENT MEDICATION

A Motrin 800mg BID
B Vicodin (does not need refill)
C Patient
therapy needs to refer

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: _____

IS SURGERY INDICATED? YES NO PROCEDURE _____

DX PROCEDURE _____ HOSPITAL _____

PHYSICAL THERAPY _____ HEP - Bike
SLR
Swing

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT _____

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT 3 mos

PHYSICIAN NAME _____

8083

[redacted] ORTHOPEDIC SUPPLEME[redacted]

NAME Brooks, Floreen EMPLOYER _____ CASE# _____ NOV 07 2008

CURRENT COMLAINTS

(L) knee pain is the same
rel OA
meds Ibuprofen to get going

PHYSICAL EXAMINATION:

(L) knee ↓ ROM - 100,
(L) crit knee pain
& laxity

DX STUDY _____

CURRENT DIAGNOSIS

A (L) knee OA & Strain
B (L) knee OA
C _____

CURRENT MEDICATION

A Motrin 800mg BID
B Vicodin (does not need refill)
C Prilosec
Theramine (needs refill)

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: _____

IS SURGERY INDICATED? YES NO PROCEDURE _____

DX PROCEDURE _____ HOSPITAL _____

PHYSICAL THERAPY _____ HEP - Pike SLR sworn

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT _____

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT 3 weeks

PHYSICIAN NAME _____

8083

ORTHOPEDIC SUPPLEMENTA REPORT

NAME Rocks, Floreen EMPLOYER ____________ CASE# OCT 10 2008

CURRENT COMLAINTS
c/o - snapping / sounds / pain (R) knee
pain worse c climbing stairs

PHYSICAL EXAMINATION:
(R) knee - (+) McM
(+) [illegible]
(+) [illegible]
(+) [illegible]

DX STUDY X-ray (R) knee - (-) med / lat. [illegible]
[illegible]

CURRENT DIAGNOSIS
A (R) knee [illegible]
B
C [illegible]

CURRENT MEDICATION
A Motrin 800mg PRN
B [illegible]
C [illegible]

PATIENT WORK STATUS: A TTD B MODIFIED WORK (circled) C FULL DUTIES
RESTRICTIONS: no s/k/c
[illegible]

IS SURGERY INDICATED? YES NO (circled) PROCEDURE ____________

DX PROCEDURE ____________ HOSPITAL ____________

PHYSICAL THERAPY ____________

IS CONDITION PERMANENT AND STATIONARY? YES NO (circled)

OTHER TREATMENT HEP -

FURTHER TREATMENT NEEDED? YES (circled) NO

RETURN APPOINTMENT 4w

PHYSICIAN NAME [signature]

ASSOCIATED SPORTS THERAPY

880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rooks, Florence Date: 08-08-08

Diagnosis:

Precautions:

Frecuency: 3 x weekly for 4

☑ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
- ☑ Hot Packs
- ☐ Ultrasound
- ☑ Cold Packs

ELECTROTHERAPY
- ☑ Electrical Stimulation
- ☐ Iontophoresis
- ☐ TENS

HYDROTHERAPY
- ☐ Whirpool
- ☐ Contrast Bath

TRACTION
- ☐ Cervical
- ☐ Pelvic
- ☐ Inversion

PATIENT TEACHING
- ☐ Home Program

MASSAGE
- ☐ Therapeutic Massage
- ☐ Myofascial Release

EXERCISES
- ☑ Passive/Active ROM
- ☑ Stretches
- ☑ PRE's
- ☑ Therapeutic Ex
- ☑ Mobilization
- ☐ Isometrics

REHAB PROGRAM
- ☐ General Orthopedic
- ☐ Whiplash Syndrome
- ☐ Back Program
- ☐ Shoulder Problems

Other

SIGNATURE _____, M.D.

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA

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Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

ORTHOPEDIC SUPPLEMENTAL REPORT
(PR2)

September 5, 2008

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
AGE AND SEX:	**56-year-old female**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**09/05/08**
CLAIM NO:	

Gentleman:

As you are well aware, this patient has undergone arthroscopic surgery of the left knee on 04/24/08. Since then, she has been placed on an aggressive physical therapy program, a home exercise program and at this point in time indicates that her pain has improved significantly. She does complain of some associated pain to her lower back and some radiculopathy of her left lower extremity.

PHYSICAL EXAMINATION

BACK

On examination of her back there is evidence of mild tenderness, there is mild swelling. She flexes forward for 90 degrees, extends to 35 degrees, laterally bends to 35 degrees bilaterally.

LOWER EXTREMITIES
On examination of her left knee there is evidence of well healed surgical arthroscopic incisions. There is no swelling. There is no effusion. She flexes the knee from 0 to 125 degrees.

IMPRESSION

1) STATUS POST LEFT KNEE ARTHROSCOPY

2) LUMBOSACRAL SPINE STRAIN

3) LEFT LOWER EXTREMITY RADICULOPATHY

DISCUSSION

Given this patient's overall findings, I would recommend that this patient be released to a work related position avoiding any prolonged periods of standing and walking, any squatting, climbing and pivoting type of activities. I will recommend that the patient continue on a strengthening program on her own behalf for her left lower extremity. I will also recommend that she continue use of ibuprofen for pain and inflammation and I would like to re-examine her in four weeks time to assess her progress. I am hopeful that she will continue to improve and I will keep you informed as to her progress with supplemental reports.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

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This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 5th, of September, 2008.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA

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Qualified Medical Examiners

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

ORTHOPEDIC SUPPLEMENTAL REPORT (PR2)

September 5, 2008

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
AGE AND SEX:	**56-year-old female**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**09/05/08**
CLAIM NO:	

Gentleman:

As you are well aware, this patient has undergone arthroscopic surgery of the left knee on 04/24/08. Since then, she has been placed on an aggressive physical therapy program, a home exercise program and at this point in time indicates that her pain has improved significantly. She does complain of some associated pain to her lower back and some radiculopathy of her left lower extremity.

PHYSICAL EXAMINATION

BACK

On examination of her back there is evidence of mild tenderness, there is mild swelling. She flexes forward for 90 degrees, extends to 35 degrees, laterally bends to 35 degrees bilaterally.

LOWER EXTREMITIES

On examination of her left knee there is evidence of well healed surgical arthroscopic incisions. There is no swelling. There is no effusion. She flexes the knee from 0 to 125 degrees.

IMPRESSION

1) STATUS POST LEFT KNEE ARTHROSCOPY

2) LUMBOSACRAL SPINE STRAIN

3) LEFT LOWER EXTREMITY RADICULOPATHY

DISCUSSION

Given this patient's overall findings, I would recommend that this patient be released to a work related position avoiding any prolonged periods of standing and walking, any squatting, climbing and pivoting type of activities. I will recommend that the patient continue on a strengthening program on her own behalf for her left lower extremity. I will also recommend that she continue use of ibuprofen for pain and inflammation and I would like to re-examine her in four weeks time to assess her progress. I am hopeful that she will continue to improve and I will keep you informed as to her progress with supplemental reports.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

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This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 5th, of September, 2008.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

ORTHOPEDIC SUPPLEMENTARY REPORT

NAME Books, Florence EMPLOYER _____ CASE# SEP 05 2008

CURRENT COMLAINTS

PHYSICAL EXAMINATION:

DX STUDY

CURRENT DIAGNOSIS

A

B

C

CURRENT MEDICATION

A

B

C

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS:

IS SURGERY INDICATED? YES NO PROCEDURE

DX PROCEDURE HOSPITAL

PHYSICAL THERAPY

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT

8083

SCIF RECD DTE 08/30/2008 BKSCAN 3 09/02/2008 08:52 AM 024141 23 2

[redacted] ORTHOPEDIC SUPPLEM[illegible]Y REPORT [redacted]

NAME Rooks, Floreen EMPLOYER__________ CASE# AUG 28 2008

CURRENT COMLAINTS ______________________
[illegible] knee [illegible]
[illegible] of [illegible] electrical type pain
[illegible] lateral & LBP

PHYSICAL EXAMINATION:
(L) Knee Back Neuro
[illegible] [illegible] [illegible]
[illegible] [illegible]
(L) IT band (+) pain (+) pain on GT

DX STUDY______________________

CURRENT DIAGNOSIS
A [illegible] Bursitis
B [illegible] (L) Knee Sprain
C ______________

CURRENT MEDICATION
A [illegible], Motrin 3x/day [illegible]
B [illegible]
C [illegible] therapy

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS:______________________

IS SURGERY INDICATED? YES NO PROCEDURE______________

DX PROCEDURE______________ HOSPITAL______________

PHYSICAL THERAPY Stretches

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT______________________

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT______________

8083

[redacted]

ORTHOPEDIC SUPPLEMENTARY REPORT

[redacted]

NAME Rook, Floreen EMPLOYER _____ CASE# _____ AUG 08 2008

CURRENT COMLAINTS

PHYSICAL EXAMINATION:

DX STUDY

CURRENT DIAGNOSIS

A

B

C

CURRENT MEDICATION

A

B

C

PATIENT WORK STATUS: (A TTD) B MODIFIED WORK C FULL DUTIES

RESTRICTIONS:

IS SURGERY INDICATED? YES NO PROCEDURE

DX PROCEDURE HOSPITAL

PHYSICAL THERAPY

IS CONDITION PERMANENT AND STATIONARY? YES (NO)

OTHER TREATMENT

FURTHER TREATMENT NEEDED? (YES) NO

RETURN APPOINTMENT

PHYSICIAN NAME

8083

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

02/21/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAMILY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 02/21/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained a left ankle sprain and a left knee injury, and most recently her left knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her right lower extremity and putting all of the weight on her contralateral extremity, the pain has steadily gotten worse as a result of the initial injury as well as the underlying degenerative osteoarthritic changes from which the patient already suffers.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of medial joint line tenderness. There is notable swelling. There is notable effusion. Positive grind sign. Positive Apley sign. Positive McMurray's sign.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT.

DISCUSSION:

It appears quite evident that this patient has developed an increased level of pain and discomfort of her left knee as a result of favoring her right lower extremity. She initially incurred the injury of the left knee as well; however, it was certainly not as painful as it is now. I will recommend that an MRI of the left knee be ordered at the soonest possible time, although this apparently has already been denied due to lack of the ability to communicate with my office; however, that appears to be erroneous since I am always available either by cellphone or in our office. If you deem it necessary to

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

communicate with any review of service, I would be more than happy to do so. With respect to her right foot, it appears to be healing well and I am hopeful this will heal uneventfully. I would like to reexamine her in four weeks' time and I will continue her off of work until further progress is made.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 02/21/2008.

TS:pf/tj

ASSOCIATED SPORTS THERAPY

880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rooks, Floreen Date: 06-06-08

Diagnosis:

Precautions:

Frecuency: 2 x weekly for 4

☒ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
☒ Hot Packs
☐ Ultrasound
☒ Cold Packs

ELECTROTHERAPY
☒ Electrical Stimulation
☐ Iontophoresis
☐ TENS

HYDROTHERAPY
☐ Whirpool
☐ Contrast Bath

TRACTION
☐ Cervical
☐ Pelvic
☐ Inversion

PATIENT TEACHING
☐ Home Program

MASSAGE
☐ Therapeutic Massage
☐ Myofascial Release

EXERCISES
☒ Passive/Active ROM
☒ Stretches
☒ PRE's
☒ Therapeutic Ex
☒ Mobilization
☐ Isometrics

REHAB PROGRAM
☐ General Orthopedic
☐ Whiplash Syndrome
☐ Back Program
☐ Shoulder Problems

Other (T)

SIGNATURE ______________________, M.D.

ASSOCIATED SPORTS THERAPY

880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rooks, Floreen Date: 05-09-08

Diagnosis:

Precautions:

Frecuency: 3 x weekly for 4

☐ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
☒ Hot Packs
☐ Ultrasound
☒ Cold Packs

ELECTROTHERAPY
☒ Electrical Stimulation
☐ Iontophoresis
☐ TENS

HYDROTHERAPY
☐ Whirpool
☐ Contrast Bath

TRACTION
☐ Cervical
☐ Pelvic
☐ Inversion

PATIENT TEACHING
☐ Home Program

MASSAGE
☐ Therapeutic Massage
☐ Myofascial Release

EXERCISES
☒ Passive/Active ROM
☒ Stretches
☒ PRE's
☒ Therapeutic Ex
☒ Mobilization
☒ Isometrics

REHAB PROGRAM
☐ General Orthopedic
☐ Whiplash Syndrome
☐ Back Program
☐ Shoulder Problems

Other (T)

SIGNATURE ______________________, M.D.

02 324022 00000001 064 3/8 05170360

SCIF RECD DTE 07/21/2008 BKSCAN 9 07/22/2008 08:11 AM 032535 4 2

[redacted] ORTHOPEDIC SUPPLEM Y REPORT [redacted]

NAME Rooks, Floreen EMPLOYER ______ CASE# ______ 11 2008

CURRENT COMLAINTS [illegible]

PHYSICAL EXAMINATION: [illegible]

20 - 100'

DX STUDY [illegible]

CURRENT DIAGNOSIS

A [illegible]

B ______

C ______

CURRENT MEDICATION

A [illegible]

B [illegible]

C [illegible]

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: ______

IS SURGERY INDICATED? YES NO PROCEDURE ______

DX PROCEDURE ______ HOSPITAL ______

PHYSICAL THERAPY [illegible]

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT ______

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT 4 [illegible]

8083

[redacted] ORTHOPEDIC SUPPLEMENTARY REPORT [redacted]

NAME Rooks, Florence EMPLOYER _____ CASE# _____ JUL 11 2008

CURRENT COMLAINTS _____

PHYSICAL EXAMINATION: _____

DX STUDY _____

CURRENT DIAGNOSIS

A _____

B _____

C _____

CURRENT MEDICATION

A _____

B _____

C _____

PATIENT WORK STATUS: A TTD B MODIFIED WORK C. FULL DUTIES

RESTRICTIONS: _____

IS SURGERY INDICATED? YES NO PROCEDURE _____

DX PROCEDURE _____ HOSPITAL _____

PHYSICAL THERAPY _____

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT _____

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT _____

MYRA GUEVARA
JUL 14 2008
LOS ANGELES CLERKS

8083

EOMA
Eastside Orthopedic Medical Associates
880 South Atlantic Blvd., Suite 205
Monterey Park, California 91754
(626) 289-0178 • Fax (626) 308-2083

☐ R. ZAPANTA, M.D. ☒ T. SAUCEDO, M.D.

DATE: 07-11-08

IN: 11:30 NEXT APPOINTMENT: 08-08-08 PATIENT NAME: Books, Floree

OUT: 12:40 TIME: 11:00 DIAGNOSIS: _____

Patients is (able) unable to return to (regular) modified work as of: _____

Further treatment: (is) is not required: _____

Estimatad length of total disability: _____ Patient is permanent & stationary Yes _____ No _____

Physical Therapy (IS) (IS NOT) recommended: 2 times e week for 4 weeks.

Location: ☐ Ind. Clinic ☒ Ass. Sports Therapy ☐ Other _____

MODIFIED WORK AS INDICATED BELOW:

- ☐ No Prolonged Standing / Walking
- ☐ No Lifting Over _____ Pounds
- ☐ No Climbing, Bending or Stooping
- ☐ No Machine / Vehicle Operation
- ☐ Limited Use of Right / Left Hand
- ☐ Right / Left-Handed Work Only
- ☐ Right / Left no working over the shoulder

- ☐ Diagnostic Test _____
- ☐ Surgery has been scheduled _____

_____

_____, M.D.

MYRA GUEVARA
JUL 14 2008
LOS ANGELES CLAIMS

8083

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rooks, D. / Florence Date: 07-11-08

Diagnosis: _____

Precautions: _____

Frequency: 2 x weekly for 4

☐ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
- ☑ Hot Packs
- ☐ Ultrasound
- ☐ Cold Packs

ELECTROTHERAPY
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ TENS

HYDROTHERAPY
- ☐ Whirpool
- ☐ Contrast Bath

TRACTION
- ☐ Cervical
- ☐ Pelvic
- ☐ Inversion

PATIENT TEACHING
- ☐ Home Program

MASSAGE
- ☐ Therapeutic Massage
- ☐ Myofascial Release

EXERCISES
- ☐ Passive/Active ROM
- ☐ Stretches
- ☐ PRE's
- ☐ Therapeutic Ex
- ☐ Mobilization
- ☐ Isometrics

REHAB PROGRAM
- ☐ General Orthopedic
- ☐ Whiplash Syndrome
- ☐ Back Program
- ☐ Shoulder Problems

Other: _____

SIGNATURE _____, M.D.

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rocks, Floreen Date: 06-06-08

Diagnosis: L5-S1

Precautions:

Frequency: 2 x weekly for 4

☒ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
- ☑ Hot Packs
- ☐ Ultrasound
- ☑ Cold Packs

ELECTROTHERAPY
- ☑ Electrical Stimulation
- ☐ Iontophoresis
- ☐ TENS

HYDROTHERAPY
- ☐ Whirlpool
- ☐ Contrast Bath

TRACTION
- ☐ Cervical
- ☐ Pelvic
- ☐ Inversion

PATIENT TEACHING
- ☐ Home Program

MASSAGE
- ☐ Therapeutic Massage
- ☐ Myofascial Release

EXERCISES
- ☑ Passive/Active ROM
- ☑ Stretches
- ☑ PRE's
- ☑ Therapeutic Ex
- ☑ Mobilization
- ☐ Isometrics

REHAB PROGRAM
- ☐ General Orthopedic
- ☐ Whiplash Syndrome
- ☐ Back Program
- ☐ Shoulder Problems

Other T

SIGNATURE _____, M.D.

RECEIVED
JUN 19 2008
LA DIA GLENDALE LOC.

6/19/08

8083

EOMA
Eastside Orthopedic Medical Associates
☐880 South Atlantic Blvd., Suite 205
Monterey Park, California 91754
(626) 289-0178 - Fax (626) 308-2083

DATE: 6-06-08

IN: 10:25 NEXT APPOINTMENT: 7-11-08 PATIENT NAME: Rooks, Floreen

OUT: 12:03 TIME: 11:00 DIAGNOSIS:

Patient is able / unable to return to regular / modified work as of:

Further treatment is / is not required:

Estimated length of total disability: ____ Patient is permanent & stationary Yes ___ No ___

Physical Therapy (IS) / (IS NOT) recommended: 3 times a week for 4 wee

Location: ☐ Ind. Clinic ☒ Ass. Sports Therapy ☐ Other

MODIFIED WORK AS INDICATED BELOW:

☐ No Prolonged Standing / Walking
☐ No Lifting Over ____ Pounds
☐ No Climbing, Bending or Stooping
☐ No Machine / Vehicle Operation
☐ Limited Use of Right / Left Hand
☐ Right / Left-Handed Work Only
☐ Right / Left no working over the shoulder

☐ Diagnostic Test
☐ Surgery has been scheduled

☐ R. ZAPANTA, M.D. ☒ SAUCEDO, M.D.

#19175

RECEIVED
JUN 19 2008
GLENDALE LOC.

6/19/08

ORTHOPEDIC SUPPLEMENT REPORT

NAME Rocks, Floreen EMPLOYER _____ CASE# _____ JUN 06 2008

CURRENT COMLAINTS Ankle F Knee

PHYSICAL EXAMINATION:

DX STUDY _____

CURRENT DIAGNOSIS	CURRENT MEDICATION
A F Ankle	A Vicodin
B	B
C	C

PATIENT WORK STATUS: (A) TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: _____

IS SURGERY INDICATED? YES (NO) PROCEDURE _____

DX PROCEDURE _____ HOSPITAL _____

PHYSICAL THERAPY 3x wk x 4wks

RECEIVED
JUN 19 2008
GLENDALE LOC

IS CONDITION PERMANENT AND STATIONARY? YES (NO)

OTHER TREATMENT _____

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT 4wks

PHYSICIAN NAME _____

6/19/08 mb

8083

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (628) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

12/20/2007

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAMILY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 12/20/2007

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has been under our care with a diagnosis of a fracture of her right fourth and fifth metatarsal. She has been using a Cam walker and indicates that her pain has steadily improved.

Patient has also complained of pain and discomfort of her left knee and her left ankle, which she indicates has been improving subjectively since her last visit.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of mild tenderness. There is no swelling. There is no spasm. No gross effusion is noted. No laxity is noted.

LEFT ANKLE: Reveals evidence of mild tenderness in the anterolateral aspect of the ankle. No swelling or spasm is noted. Motor and sensory function is intact distally.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture, overall good position.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE SPRAIN.
3. LEFT ANKLE SPRAIN.

DISCUSSION:

I will recommend that Ms. Rooks at this time continue off of work. I will encourage her to continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will be provided for her left knee and I will recommend that she weightbear as tolerated with the assistive devices. I will maintain her off of work and I would like to see her back

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

for follow-up in four weeks' time, at which time x-rays will be taken to assess the healing fractures.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 12/20/2007.

TS:pf/tj

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA
Eastside Orthopedic Medical Associates
Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

ORTHOPEDIC SUPPLEMENTAL REPORT
(PR2)

June 6, 2008

State Compensation Insurance
P.O. Box 92622
Los Angeles, CA 90009-2622

Attention: Worker's Compensation Claims

RE:	**FLOREEN ROOKS**
AGE AND SEX:	**56-year-old female**
OCCUPATION:	**Marriage & Family Therapist**
EMP:	**D'Veal Family Youth Services**
DATE OF INJURY:	**11/10/07**
DATE OF EXAMINATION:	**06/06/08**
CLAIM NO:	

Gentleman:

As you are well aware, this patient has undergone arthroscopic surgery of the left knee. She indicates that her pain has improved significantly. She is now approximately six weeks since she underwent the surgery and has improved significantly with respect to the surgical procedure. She has also been in physical therapy for the last four weeks and has responded favorably.

PHYSICAL EXAMINATION

Lower Extremities

On examination of her left knee there is evidence of mild tenderness. There is mild swelling. There is no gross erythema. There is no drainage. There are well healed surgical arthroscopic portals. Motor and sensory function is intact distally. Range of motion is 0 to approximately 100 degrees.

880 South Atlantic Boulevard, Suite 205, Monterey Park, California 91754 • (626) 289-0178 • FAX (626) 308-2083

IMPRESSION

STATUS POST LEFT KNEE ARTHROSCOPY

DISCUSSION

I will recommend that Ms. Roks at this time continue on an aggressive physical therapy program three times a week for the next four weeks as well as an aggressive home exercise program to continue to strengthen the extremity. She will continue on Vicodin for pain and discomfort. I will see her back for follow-up in four weeks time and I am hopeful she will respond to conservative measures. In the meantime, I will recommend that she continue off of work until further progress is made.

Should you have any further questions or concerns, please do not hesitate to contact me.

DISCLOSURE

I declare under penalty of perjury that I, the signing physician, have actually performed this examination, and the time spent in performing this evaluation is in compliance with the IMC Guidelines (Section 5307.1 and 5307.6).

I declare under penalty of perjury that I have devoted at least one-third of my total practice time to providing medical treatment.

I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury.

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.

There may or may not be other medical information that is protected by special state and federal laws and cannot be released without the subject's specific written authorization, or pursuant to other procedures established by law.

This report was done in the State of California in the County of Los Angeles, in the City of Monterey Park, on the 6th, of June, 2008.

Sincerely,

Tomas Saucedo, M.D.
Diplomate, American Board of
Orthopedic Surgery

TS/mc

SCIF [redacted]008 BKSCAN 11 06/13/2008 08[redacted]65 5 2

NAME Rooks, Floreen EMPLOYER ______ CASE# ______ JUN 06 2008

CURRENT COMLAINTS [illegible]

PHYSICAL EXAMINATION: [illegible]

DX STUDY ______

CURRENT DIAGNOSIS	CURRENT MEDICATION
A [illegible]	A Vicodin [illegible]
B	B
C	C [illegible]

PATIENT WORK STATUS: (A TTD) B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: ______

IS SURGERY INDICATED? YES (NO) PROCEDURE ______

DX PROCEDURE ______ HOSPITAL ______

PHYSICAL THERAPY 3X WEEK x 4 wk

IS CONDITION PERMANENT AND STATIONARY? YES (NO)

OTHER TREATMENT ______

FURTHER TREATMENT NEEDED? (YES) NO

RETURN APPOINTMENT 4 wk

PHYSICIAN NAME [signature]

ORIGINAL REC'D
POOR QUALITY
CLAIMS PROCESSING CENTER
BURBANK LOCATION

8083

SCIF RECD DTE 05/23/2008 BKSCAN 3 05/23/2008 10:49 AM 021628 4 2

[redacted] ORTHOPEDIC SUPPLEM Y REPORT [redacted]

NAME Rooks, Floreen EMPLOYER ______ CASE# ______ MAY 9 2008

CURRENT COMLAINTS ______

c/o (R) knee

05170360

PHYSICAL EXAMINATION:

DX STUDY ______

CURRENT DIAGNOSIS

A ______

B ______

C ______

CURRENT MEDICATION

A ______

B ______

C ______

PATIENT WORK STATUS: A TTD B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: ______

IS SURGERY INDICATED? YES NO PROCEDURE ______

DX PROCEDURE ______ HOSPITAL ______

PHYSICAL THERAPY ______

IS CONDITION PERMANENT AND STATIONARY? YES NO

OTHER TREATMENT ______

FURTHER TREATMENT NEEDED? YES NO

RETURN APPOINTMENT 4wk

PHYSICIAN NAME ______

8083

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rooks, Eloween Date: 05-09-08

Diagnosis: [illegible] I.D. 7/8/08

Precautions: d/A

Frecuency: 3 x weekly for 4

☐ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
- ☑ Hot Packs
- ☐ Ultrasound
- ☑ Cold Packs

ELECTROTHERAPY
- ☑ Electrical Stimulation
- ☐ Iontophoresis
- ☐ TENS

HYDROTHERAPY
- ☐ Whirlpool
- ☐ Contrast Bath

TRACTION
- ☐ Cervical
- ☐ Pelvic
- ☐ Inversion

PATIENT TEACHING
- ☐ Home Program

MASSAGE
- ☐ Therapeutic Massage
- ☐ Myofascial Release

EXERCISES
- ☑ Passive/Active ROM
- ☑ Stretches
- ☑ PRE's
- ☑ Therapeutic Ex
- ☑ Mobilization
- ☑ Isometrics

REHAB PROGRAM
- ☐ General Orthopedic
- ☐ Whiplash Syndrome
- ☐ [illegible]
- ☐ Shoulder Problems

Other: (T)

SIGNATURE: [signature]

PAMELA SELEVICH
MAY 14 2008
LOS ANGELES CLAIMS

SCIF RECD DTE 05/19/2008 BKSCAN 6 05/19/2008 08:05 PM 029961 1 2

8083

ORTHOPEDIC SUPPLEM... ...Y REPORT

[redacted] [redacted]

NAME Kooks, Floreen EMPLOYER ____________ CASE# ____ MAY 09 2008

CURRENT COMLAINTS [illegible]

PHYSICAL EXAMINATION: [illegible]

DX STUDY ____________

CURRENT DIAGNOSIS
A [illegible]
B ____________
C ____________

CURRENT MEDICATION
A ____________
B ____________
C ____________

PATIENT WORK STATUS: (A TTD) B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: ____________

IS SURGERY INDICATED? YES NO PROCEDURE ____________

DX PROCEDURE ____________ HOSPITAL ____________

PHYSICAL THERAPY ____________

IS CONDITION PERMANENT AND STATIONARY? YES (NO)

OTHER TREATMENT ____________

PAMELA SELEVICH
MAY 14 2008
LOS ANGELES CLAIMS

FURTHER TREATMENT NEEDED? (YES) NO

RETURN APPOINTMENT [illegible]

PHYSICIAN NAME [illegible]

SCIF RECD DTE 05/19/2008 BKSCAN 6 05/19/2008 08:05 PM 02961 1 3

SCIF RECD DTE 05/05/2008 BKSCAN11 05/05/2008 01:28 PM 026886 1 2

[redacted] [redacted]

NAME Rooks, Floreen EMPLOYER __________ CASE# __________ APR 23 2008

CURRENT COMLAINTS [illegible]

PHYSICAL EXAMINATION: [illegible]

DX STUDY __________

CURRENT DIAGNOSIS	CURRENT MEDICATION
A [illegible]	A Vicodin
B	B
C	C

PATIENT WORK STATUS: A TTD (circled) B MODIFIED WORK C FULL DUTIES

RESTRICTIONS: __________

IS SURGERY INDICATED? YES NO PROCEDURE __________

DX PROCEDURE __________ HOSPITAL __________

PHYSICAL THERAPY __________

IS CONDITION PERMANENT AND STATIONARY? YES NO (NO circled)

ORIGINAL REC'D POOR QUALITY PROCESSING CENTER BL... K LOCATION

OTHER TREATMENT __________

FURTHER TREATMENT NEEDED? YES (circled) NO

RETURN APPOINTMENT 2 wks

PHYSICIAN NAME [signature]

8083

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

02/21/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

07/703

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAM1LY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 02/21/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained a left ankle sprain and a left knee injury, and most recently her left knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her right lower extremity and putting all of the weight on her contralateral extremity, the pain has steadily gotten worse as a result of the initial injury as well as the underlying degenerative osteoarthritic changes from which the patient already suffers.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of medial joint line tenderness. There is notable swelling. There is notable effusion. Positive grind sign. Positive Apley sign. Positive McMurray's sign.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT.

DISCUSSION:

It appears quite evident that this patient has developed an increased level of pain and discomfort of her left knee as a result of favoring her right lower extremity. She initially incurred the injury of the left knee as well; however, it was certainly not as painful as it is now. I will recommend that an MRI of the left knee be ordered at the soonest possible time, although this apparently has already been denied due to lack of the ability to communicate with my office; however, that appears to be erroneous since I am always available either by cellphone or in our office. If you deem it necessary to

Specialists
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El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

communicate with any review of service, I would be more than happy to do so. With respect to her right foot, it appears to be healing well and I am hopeful this will heal uneventfully. I would like to reexamine her in four weeks' time and I will continue her off of work until further progress is made.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 02/21/2008.

TS:pf/tj

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	04/17/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

04/17/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE:	ROOKS, FLOREEN
Age & Sex:	58 & F
Occupation:	MARRIAGE FAMILY THERAPIST
Employer:	D'VEAL FAMILY & YOUTH SERVICES
Date of Injury:	11/10/2007
Date of Exam:	04/17/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has been under our care. She has been treated for a fracture of her right foot. The fracture at this time has healed completely. She has no pain or discomfort. However, she does continue to complain of left knee pain primarily with activities of squatting, kneeling and climbing. She has minimal soreness and discomfort of her left ankle; otherwise, she notes pain increasing of the left ankle when she is required to stand for prolonged periods of time.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is no tenderness. There is no swelling. There is no spasm. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of medial joint line tenderness. There is notable swelling. There is positive effusion, positive McMurray's sign, positive Apley sign. No gross laxity is noted.

LEFT ANKLE: Reveals evidence of limited range of motion of the ankle. She dorsiflexes the ankle to 10 degrees. She plantar flexes the ankle to 25 degrees. Motor and sensory function is intact distally.

IMPRESSION:

1. HEALED RIGHT FOOT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT WITH EVIDENCE OF MEDIAL MENISCUS TEAR.
3. LEFT ANKLE POSTOP DEGENERATIVE OSTEOARTHRITIC CHANGES WITH LIMITED RANGE OF MOTION.

DISCUSSION:

At this time, it is quite apparent that Ms. Rooks at this time is focusing primarily on her left knee injury. An MRI has revealed evidence of a medial meniscus tear and she will be scheduled for surgery arthroscopically of her left knee on 4/24/2008. She understands the risks and benefits and wishes this to be done. We will treat her conservatively for her right foot as well as her left ankle. I will maintain her off of work. I will see her

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3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	04/17/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

preoperatively in my office on 4/23/2008, at which time she will undergo preop evaluation and treatment before surgery on 4/24/2008.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 04/17/2008.

TS:pf/tj

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	03/20/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

03/20/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAMILY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 03/20/2008

ORTHOPEDIC RE-EXAMINATION

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right foot involving the fourth and fifth metatarsal and at this time indicates that she has no pain or discomfort. She also has no significant pain of her left ankle; however, she continues to complain of left knee pain. As a result, an MRI of the left knee has been ordered. The MRI reveals evidence of a tear of the posterior aspect of the medial meniscus. There is also evidence of mild early osteoarthritic degenerative arthritic changes of the left knee probably in the medial compartment and a knee effusion.

PHYSICAL EXAMINATION:

RIGHT FOOT: Reveals no tenderness. There is no swelling over the fourth and fifth metatarsal area. Motor and sensory function is intact distally.

LEFT ANKLE: Reveals no tenderness, no swelling, no spasms. A full range of motion is noted.

LEFT KNEE: Reveals evidence of notable swelling. There is tenderness. There is an effusion. There is positive Apley sign, positive McMurray's sign, positive grind sign. She flexes the knee from 0 to 125 degrees with noticeable pain.

IMPRESSION:

1. LEFT KNEE INTERNAL DERANGEMENT WITH EVIDENCE OF MEDIAL MENISCUS TEAR.
2. RIGHT FOURTH AND FIFTH METATARSAL FRACTURE, HEALED.
3. LEFT ANKLE SPRAIN.

DISCUSSION:

I will recommend that Ms. Rooks at this time continue off of work given her pain and discomfort of her left knee. I will request authorization and approval for surgery arthroscopically of her left knee, which will be done as an outpatient. I will maintain her off of work until further progress is made. I will see her back for follow-up in 3-4 weeks' time to assess her progress. With respect to her right foot and her left ankle, she

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3144 Santa Anita Avenue. Module A
El Monte, CA 91733

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DATE	03/20/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

can and has responded favorably to conservative measures. On this basis, she will be released to her previous level of occupation with no restrictions.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 03/20/2008.

TS:pf/tj

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

02/21/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAMILY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 02/21/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained a left ankle sprain and a left knee injury, and most recently her left knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her right lower extremity and putting all of the weight on her contralateral extremity, the pain has steadily gotten worse as a result of the initial injury as well as the underlying degenerative osteoarthritic changes from which the patient already suffers.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of medial joint line tenderness. There is notable swelling. There is notable effusion. Positive grind sign. Positive Apley sign. Positive McMurray's sign.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT.

DISCUSSION:

It appears quite evident that this patient has developed an increased level of pain and discomfort of her left knee as a result of favoring her right lower extremity. She initially incurred the injury of the left knee as well; however, it was certainly not as painful as it is now. I will recommend that an MRI of the left knee be ordered at the soonest possible time, although this apparently has already been denied due to lack of the

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

ability to communicate with my office; however, that appears to be erroneous since I am always available either by cellphone or in our office. If you deem it necessary to communicate with any review of service, I would be more than happy to do so. With respect to her right foot, it appears to be healing well and I am hopeful this will heal uneventfully. I would like to reexamine her in four weeks' time and I will continue her off of work until further progress is made.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 02/21/2008.

TS:pf/tj

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

12/20/2007

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE:	ROOKS, FLOREEN
Age & Sex:	58 & F
Occupation:	MARRIAGE FAMILY THERAPIST
Employer:	D'VEAL FAMILY & YOUTH SERVICES
Date of Injury:	11/10/2007
Date of Exam:	12/20/2007

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has been under our care with a diagnosis of a fracture of her right fourth and fifth metatarsal. She has been using a Cam walker and indicates that her pain has steadily improved.

Patient has also complained of pain and discomfort of her left knee and her left ankle, which she indicates has been improving subjectively since her last visit.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of mild tenderness. There is no swelling. There is no spasm. No gross effusion is noted. No laxity is noted.

LEFT ANKLE: Reveals evidence of mild tenderness in the anterolateral aspect of the ankle. No swelling or spasm is noted. Motor and sensory function is intact distally.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture, overall good position.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE SPRAIN.
3. LEFT ANKLE SPRAIN.

DISCUSSION:

I will recommend that Ms. Rooks at this time continue off of work. I will encourage her to continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will be provided for her left knee and I will recommend that she weightbear as tolerated with the assistive devices. I will maintain her off of work and I would like to see her back

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

for follow-up in four weeks' time, at which time x-rays will be taken to assess the healing fractures.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 12/20/2007.

TS:pf/tj

HealthCare PARTNERS MEDICAL GROUP

Occupational Medical Care

Name: ROOKS,FLOREEN
DOB : 06/20/1949
SS# : 130-38-8510
MRN : 32-295496 Case 80283

REFERRAL SLIP

DOI: 11/10/07

Requested by: ☐ Dr. Hadley ☐ Dr. Wilson ☐ Dave Weitzel, PA-C ☑ Other: Saucedo

Date of Request: 1/17/08

Employer: D Real Family & Youth Telephone:

Guarantor: Telephone:

Contact/Adjuster: Claim #:

REFERRED TO:

☐ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☑ Knee - Left ☐ Right ☐ Shoulder - Left ☐ Right
☐ Head CT (no contrast) ☐ Bone Scan - Location:
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other

☐ Evaluation ONLY ☐ Evaluation and Treatment

DIAGNOSIS:

1)

2)

3)

REASON FOR REQUEST:

ACTIVITY:

	Date	Comments:
1ST call		
2ND call		
3RD call		
4TH call		
5TH call		
6TH call		

RECEIVED
FEB 05 2008
LA GLENDALE LOC.

Authorized by: Date Authorized:

Referred to: Appt Date & Time:

MGD-FO-014 (2/02) WHITE - Patient Chart CANARY - Referral Coordinator

8083

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	01/17/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

01/17/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE:	ROOKS, FLOREEN
Age & Sex:	58 & F
Occupation:	MARRIAGE FAMILY THERAPIST
Employer:	D'VEAL FAMILY & YOUTH SERVICES
Date of Injury:	11/10/2007
Date of Exam:	01/17/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right fourth and fifth metatarsals. She also has an injury to her left knee as well as her left ankle. She indicates that her right foot pain has steadily improved; however, she complains of pain especially of her left knee with swelling and effusion of the knee, difficulty with squatting, kneeling and climbing activities. She also complains of soreness of her left ankle.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of tenderness over the dorsal aspect of the fourth and fifth metatarsal. Minimal swelling is noted. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of notable swelling. There is a small effusion, medial joint line tenderness. She flexes the knee from 0 to 110 degrees with noticeable pain and discomfort. Positive McMurray's sign. Positive Apley's sign is noted.

LEFT ANKLE: Reveals evidence of mildly diffuse medial and lateral malleolar area swelling. Motor and sensory function is intact distally.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture with notable present callus formation.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT.
3. LEFT ANKLE SPRAIN.

DISCUSSION:

At this time, it is quite apparent that Ms. Rooks' right foot fractures appear to be healing quite well. I will recommend that we continue conservative measures utilizing the Cam walker to allow the fractures to heal. She will be given an appointment for four weeks, at which time x-rays will be repeated to assess the healing fracture consolidation.

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	01/17/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

With respect to her left knee, there is notable swelling and effusion of her left knee and findings consistent with a possible cartilage or meniscal tear; therefore, an MRI of the left knee will be requested and ordered at this point in time. I will continue her off of work as a result of these injuries.

With respect to her left ankle, I will recommend she continue on an aggressive exercise program, continue use of Tylenol for pain and discomfort, and I will see her back for follow-up in four weeks' time to assess her progress.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 01/17/2008.

TS:pf/tj

Name: ROOKS,FLOREEN
DOB : 05/20/1949
SS# : 130-38-8510
MRN : 32-295496

05170360

Case 80283

HealthCare PARTNERS MEDICAL GROUP

Occupational Medical Care

REFERRAL SLIP

DOI: 11/10/07

Requested by: ☒ Dr. Hadley ☐ Dr. Wilson ☐ Dave Weitzel, PA-C ☐ Other: _____

Date of Request: 07 NOV 20 PM 12:57

Employer: _____ **Telephone:** _____

Guarantor: _____ **Telephone:** _____

Contact/Adjuster: _____ **Claim #:** _____

REFERRED TO:
☐ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☐ Knee - Left___ Right___ ☐ Shoulder - Left___ Right___
☐ Head CT (no contrast) ☐ Bone Scan - Location: _____
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other _____

☐ Evaluation ONLY ☐ Evaluation and Treatment

SCIF - RECEIVED
GLENDALE

DIAGNOSIS:
1) Fracture (R) Foot
2) Sprain (L) Ankle
3) Contusion (L) Knee

REASON FOR REQUEST: Radiculopathy Bilateral L. Cervical

ACTIVITY:

	Date	Comments:
1ST call		
2ND call		
3RD call		
4TH call		
5TH call		
6TH call		

Yolanda Nelson x 762

Authorized by: _____ **Date Authorized:** _____

Referred to: _____ **Appt Date & Time:** _____

UR 818 550 67

MGO-FO-014 (2/02) WHITE - Patient Chart CANARY - Referral Coordinator

Name: ROOKS,FLOREEN
DOB : 06/20/1949
SS# : 130-38-8510
MRN : 32-295496

05170360

Case 80283

HealthCare PARTNERS MEDICAL GROUP

Occupational Medical Care

REFERRAL SLIP

DOI: 11/10/04

Requested by: ☒ Dr/Hadley ☐ Dr. Wilson
☐ Dave Weitzel, PA-C
☐ Other: _____

Date of Request: _____

07 NOV 20 PM 1:03

Employer: _____ Telephone: _____

Guarantor: _____ Telephone: _____

Contact/Adjuster: _____ Claim #: _____

ORIGINAL REC'D
POOR QUALITY
CLAIMS PROCESSING CENTER
BURBANK LOCATION

REFERRED TO:
☐ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☐ Knee - Left ___ Right ___ ☐ Shoulder - Left ___ Right ___
☐ Head CT (no contrast) ☐ Bone Scan - Location: _____
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other: _____

☐ Evaluation ONLY ☐ Evaluation and Treatment

DIAGNOSIS:
1) Fracture (R) Foot
2) Sprain (L) Ankle
3) Contusion (L) Knee

REASON FOR REQUEST: Reduction Surgical F.
Cyte referral

ACTIVITY:

	Date	Comments:
1ST call	_____	_____
2ND call	_____	_____
3RD call	_____	_____
4TH call	_____	_____
5TH call	_____	_____
6TH call	_____	707.646.2609 fx Yolanda Nelson

Authorized by: _____ _____ Date Authorized: _____ x 7626

Referred to: _____ Appt Date & Time: 818 291 7626

UR 818 3506707

MGO-FD-014 (2/02) WHITE - Patient Chart; CANARY - Referral Coordinator

8083

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

12/20/2007

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAMILY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 12/20/2007

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has been under our care with a diagnosis of a fracture of her right fourth and fifth metatarsal. She has been using a Cam walker and indicates that her pain has steadily improved.

Patient has also complained of pain and discomfort of her left knee and her left ankle, which she indicates has been improving subjectively since her last visit.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of mild tenderness. There is no swelling. There is no spasm. No gross effusion is noted. No laxity is noted.

LEFT ANKLE: Reveals evidence of mild tenderness in the anterolateral aspect of the ankle. No swelling or spasm is noted. Motor and sensory function is intact distally.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture, overall good position.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE SPRAIN.
3. LEFT ANKLE SPRAIN.

DISCUSSION:

I will recommend that Ms. Rooks at this time continue off of work. I will encourage her to continue the use of a Cam walker to allow the fractures to heal. A knee immobilizer will

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

be provided for her left knee and I will recommend that she weightbear as tolerated with the assistive devices. I will maintain her off of work and I would like to see her back for follow-up in four weeks' time, at which time x-rays will be taken to assess the healing fractures.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 12/20/2007.

TS:pf/tj

Name: ROOKS,FLOREEN
DOB : 06/20/1949
SS# : 130-38-8510
MRN : 32-295496
Case 80283

HealthCare PARTNERS MEDICAL GROUP

Occupational Medical Care

REFERRAL SLIP

DOI: 11/10/07

Requested by: ☒ Dr. Hadley ☐ Dr. Wilson
☐ Dave Weitzel, PA-C
☐ Other: ____________

Date of Request: ____________

'07 NOV 20 PM1:03

Employer: ____________ **Telephone:** ____________

Guarantor: ____________ **Telephone:** ____________

Contact/Adjuster: ____________ **Claim #:** ____________

REFERRED TO:
☒ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☐ Knee - Left____ Right____ ☐ Shoulder - Left____ Right____
☐ Head CT (no contrast) ☐ Bone Scan - Location:____________
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other____________

☐ Evaluation ONLY ☒ Evaluation and Treatment

DIAGNOSIS:
1) Fracture (R) Foot
2) Sprain (L) Ankle
3) Contusion (L) Knee

REASON FOR REQUEST: Radiographic [illegible] ... [illegible]

ACTIVITY:

Date	Comments:
1ST call ____	
2ND call ____	
3RD call ____	
4TH call ____	
5TH call ____	
6TH call ____	707·646·2609 fx

Yolanda Nelson

Authorized by: ____________ **Date Authorized:** ____________ X 7626

Referred to: ____________ **Appt Date & Time:** 818 291 7626

UR 818 350 6707

MGO-FO-014 (2/02) **WHITE** - Patient Chart **CANARY** - Referral Coordinator

8083

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BOULEVARD, #203
MONTEREY PARK, CALIFORNIA 91754
(626) 282-3577

Name: Rooks, Darlene Date: 07-11-08
Diagnosis:
Precautions:
Frequency: 2 x weekly for 4

☐ EVALUATE & TREAT

☐ SPECIFIC TREATMENT ORDER: Please ✓

HEAT / COLD
☑ Hot Packs
☐ Ultrasound
☐ Cold Packs

ELECTROTHERAPY
☐ Electrical Stimulation
☐ Iontophoresis
☐ TENS

HYDROTHERAPY
☐ Whirpool
☐ Contrast Bath

TRACTION
☐ Cervical
☐ Pelvic
☐ Inversion

PATIENT TEACHING
☐ Home Program

MASSAGE
☐ Therapeutic Massage
☐ Myofascial Release

EXERCISES
☐ Passive/Active ROM
☐ Stretches
☐ PNF's
☐ Therapeutic Ex
☐ Mobilization
☐ Isometrics

REHAB PROGRAM
☐ General Orthopedic
☐ Whiplash Syndrome
☐ Back Program
☐ Shoulder Problems

Other:

SIGNATURE _____, M.D.

MYRA GUEVARA
JUL 14 2008
LOS ANGELES CLAIMS

8083

SCAN AS ONE DOCUMENT

Name: ROOKS,FLOREEN
DOB : 06/20/1949
SS# : 130-38-8510
MRN : 32-295498 Case 80283

HealthCare PARTNERS MEDICAL GROUP

Occupational Medical Care

SCAN REFERRAL SLIP

DOI 11/10/07

Requested by: ☐ Dr. Hadley ☐ Dr. Wilson
☐ Dave Weitzel, PA-C
☒ Other: Dr. Curado

Date of Request: 2/21/08

Employer: Neal Family

Telephone:

Guarantor:

Telephone:

Contact/Adjuster:

Claim #:

RECEIVE
MAR 05 2008
L.A. D.O. GLENDALE I

REFERRED TO:

☐ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☒ Knee - Left ☐ Right ☐ Shoulder - Left ☐ Right
☐ Head CT (no contrast) ☐ Bone Scan - Location:
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other

☐ Evaluation ONLY ☐ Evaluation and Treatment

DIAGNOSIS:

1)

2)

3)

CP AXD 2-29-08 /Recon
CATHY SELLITTO
MAR 06 2008
L.A. GLENDALE LOC.

REASON FOR REQUEST:

ACTIVITY:

	Date	Comments:
1ST call		
2ND call		
3RD call		
4TH call		
5TH call		
6TH call		

ORIGINAL REC'D
POOR QUALITY
CLAIMS PROCESSING CENTER
BURBANK LOCATION

Authorized by: Date Authorized:

Referred to: Appt Date & Time:

MSO-FO-014 (2/02) WHITE - Patient Chart CANARY - Referral Coordinator

8083

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

02/21/2008

State Comp 92622
P.O. Box 92622
Los Angeles, CA 90009-2622

ATTN: Worker's Compensation Claims

RE:	ROOKS, FLOREEN
Age & Sex:	58 & F
Occupation:	MARRIAGE FAMILY THERAPIST
Employer:	D'VEAL FAMILY & YOUTH SERVICES
Date of Injury:	11/10/2007
Date of Exam:	02/21/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained a left ankle sprain and a left knee injury, and most recently her left knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her right lower extremity and putting all of the weight on her contralateral extremity, the pain has steadily gotten worse as a result of the initial injury as well as the underlying degenerative osteoarthritic changes from which the patient already suffers.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of medial joint line tenderness. There is notable swelling. There is notable effusion. Positive grind sign. Positive Apley sign. Positive McMurray's sign.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT.

DISCUSSION:

It appears quite evident that this patient has developed an increased level of pain and discomfort of her left knee as a result of favoring her right lower extremity. She initially incurred the injury of the left knee as well; however, it was certainly not as painful as it is now. I will recommend that an MRI of the left knee be ordered at the soonest possible time, although this apparently has already been denied due to lack of the ability to communicate with my office; however, that appears to be erroneous since I am always available either by cellphone or in our office. If you deem it necessary to communicate with any review of service, I would be more than happy to do so. With respect

Specialists
3144 Santa Anita Avenue, Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

to her right foot, it appears to be healing well and I am hopeful this will heal uneventfully. I would like to reexamine her in four weeks' time and I will continue her off of work until further progress is made.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 02/21/2008.

TS:pf/tj

SCIF RECD DTE:03/07/2008 BKSCAN 12:03/07/2008 03:07PM 025665 12/4

Leo Y. Nuiser Claims S. R. Marcelo

MAR-05-2008 16:42 HCP 6265827928 P.01

Fax Transmittal

HealthCare PARTNERS MEDICAL GROUP

RECEIVED
MAR 05 2008
LA D.O. GLENDALE LOC.

SCAN

DATE: 3/5/08

TO: UR Dept FROM: Ana Gomez

PHONE: (626) 582-7950

FAX #: 818-550-6707 FAX #: (626) 582-7928

CATHY SELLITTO
MAR 06 2008
GLENDALE LOC.

TOTAL # OF PAGES (INCLUDING COVER SHEET): 4

IF YOU DO NOT RECEIVE THE NUMBER OF SHEETS INDICATED ABOVE, PLEASE CONTACT OUR OFFICE IMMEDIATELY. THANK YOU.

SCAN

COMMENTS: Re: Brooks Florence
CL# 05170360

CONFIDENTIAL TRANSMISSION: YES_____ NO_____

8083

Name: ROOKS,FLOREEN
DOB : 06/20/1949
SS# : 130-38-8510
MRN : 32-295496 Case 80283

HealthCare PARTNERS MEDICAL GROUP
Occupational Medical Care

REFERRAL SLIP

DOI: 11/10/07

Requested by: ☐ Dr. Hadley ☐ Dr. Wilson ☐ Dave Weitzel, PA-C ☑ Other: DR Saucedo

Date of Request: 2/21/08

Employer: Deal Family

Telephone:

Guarantor:

Telephone:

Contact/Adjuster:

Claim #:

REFERRED TO:

☐ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☑ Knee - Left ☐ Right ☐ Shoulder - Left ☐ Right
☐ Head CT (no contrast) ☐ Bone Scan - Location:
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other

☐ Evaluation ONLY ☐ Evaluation and Treatment

DIAGNOSIS:

1)

2)

3)

SCIF - SA
RECEIVED
FEB 25 2008
LA GLENDALE LOC.

REASON FOR REQUEST:

ACTIVITY:

	Date	Comments:
1ST call		
2ND call		
3RD call		
4TH call		
5TH call		
6TH call		

Authorized by: Date Authorized:

Referred to: Appt Date & Time:

MGD-FO-014 (2/02) WHITE - Patient Chart CANARY - Referral Coordinator

8083

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

02/21/2008

State Comp 92622
P.O. Box 92622
Los Angelea, CA 90009-2622

ATTN: Worker's Compensation Claims

RE: ROOKS, FLOREEN
Age & Sex: 58 & F
Occupation: MARRIAGE FAMILY THERAPIST
Employer: D'VEAL FAMILY & YOUTH SERVICES
Date of Injury: 11/10/2007
Date of Exam: 02/21/2008

ORTHOPEDIC SUPPLEMENTAL REPORT (PR-2)

Gentlemen:

As you are well aware, this patient has sustained a fracture of her right foot consistent with a fracture of the fourth and fifth metatarsals. She also has sustained a left ankle sprain and a left knee injury, and most recently her left knee pain has steadily gotten worse. This has progressively gotten worse and it appears that as a result of favoring her right lower extremity and putting all of the weight on her contralateral extremity, the pain has steadily gotten worse as a result of the initial injury as well as the underlying degenerative osteoarthritic changes from which the patient already suffers.

PHYSICAL EXAMINATION:

RIGHT FOOT: There is evidence of mild tenderness. There is mild swelling. Motor and sensory function is intact distally.

LEFT KNEE: Reveals evidence of medial joint line tenderness. There is notable swelling. There is notable effusion. Positive grind sign. Positive Apley sign. Positive McMurray's sign.

RADIOGRAPHIC FINDINGS:

X-rays of the right foot reveal evidence of a healing fourth and fifth metatarsal fracture.

IMPRESSION:

1. HEALING RIGHT FOURTH AND FIFTH METATARSAL FRACTURE.
2. LEFT KNEE INTERNAL DERANGEMENT.

DISCUSSION:

It appears quite evident that this patient has developed an increased level of pain and discomfort of her left knee as a result of favoring her right lower extremity. She initially incurred the injury of the left knee as well; however, it was certainly not as painful as it is now. I will recommend that an MRI of the left knee be ordered at the soonest possible time, although this apparently has already been denied due to lack of the ability to communicate with my office; however, that appears to be erroneous since I am always available either by cellphone or in our office. If you deem it necessary to communicate with any review of service, I would be more than happy to do so. With respect

Specialists
3144 Santa Anita Avenue. Module A
El Monte, CA 91733

Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

to her right foot, it appears to be healing well and I am hopeful this will heal uneventfully. I would like to reexamine her in four weeks' time and I will continue her off of work until further progress is made.

Should there be any questions or concerns, please do not hesitate to contact me.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge."

"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."

Sincerely Yours,

Thomas Saucedo, M.D. _____
DATE

Executed in the County of Los Angeles on 02/21/2008.

TS:pf/tj

Name: ROOKS,FLOREEN
DOB : 06/20/1949
SS# 130-38-8510
MRN : 32-295496

05170360

Case 80283

HealthCare PARTNERS MEDICAL GROUP

Occupational Medical Care

REFERRAL SLIP

DOI: 11/10/04

Requested by: ☒ Dr/Hadley ☐ Dr. Wilson
☐ Dave Weitzel, PA-C
☐ Other:

Date of Request:

07 NOV 20 PM 1:03

Employer: Telephone:

Guarantor: Telephone:

Contact/Adjuster: Claim #:

SCIF RECEIVED DEC 18 2007 GLENDALE LOC

REFERRED TO:
☒ Ortho ☐ Hand Surg. ☐ NCV Only ☐ EMG Only ☐ EMG & NCV ☐ Neuro ☐ Derm. ☐ ENT
MRI: ☐ C1 - T1 ☐ L2 - S1 ☐ Knee - Left___ Right___ ☐ Shoulder - Left___ Right___
☐ Head CT (no contrast) ☐ Bone Scan - Location:
☐ Psych ☐ Gen. Surg ☐ Ophthal. ☐ Dentist ☐ Other

☐ Evaluation ONLY ☒ Evaluation and Treatment

DIAGNOSIS:
1) Bunion (R) foot
2) Spasm (L) Dorsal
3) Contusion (L) knee

REASON FOR REQUEST: Radiculopathy Bunionectomy
pt returned

ACTIVITY:

	Date	Comments:
1ST call		
2ND call		
3RD call		
4TH call		
5TH call		
6TH call		707 646 2609 fx Yolanda Nelson x 7626

Authorized by: Date Authorized:

Referred to: Appt Date & Time: 818 291 7626

UR 818 550 6707

MGO-FD-014 (2/02) WHITE - Patient Chart CANARY - Referral Coordinator

8083

Radiology/Diagnostics

Synergy Imaging Center
506 West Valley Blvd
San Gabriel, CA 91776
Phone: (626)308-9990
Fax: (626)308-9991

X-Ray Report

Patient Name:	ROOKS, FLOREEN
MRN:	613368
Date of Report:	03/23/2011
Date of Birth:	06/20/1949
Sex:	Female
Ref. Physician:	FELL, THOMAS M.D.

EXAMINATION: X-RAY LEFT KNEE

HISTORY: Evaluate for degenerative joint disease.

TECHNIQUE: An AP, oblique and lateral views are available to review.

FINDINGS: The bones are notable for medial marginal osteophytes as well as sclerosis of the subchondral bone of the lateral femoral condyle and lateral tibial plateau with narrowing of the lateral joint space compatible with primary lateral compartment degenerative disease. The lateral view does not reveal a significant effusion.
No definite fractures are visualized.
The soft tissues are unremarkable.

IMPRESSION:
Findings compatible with degenerative joint disease primarily involving the lateral compartment.

Thank you for your referral.

Crues, John M.D.
electronically signoff on March 24, 2011 08:56 am

Synergy Imaging Center
506 West Valley Blvd
San Gabriel, CA 91776
Phone: (626)308-9990
Fax: (626)308-9991

X-Ray Report

Patient Name:	ROOKS, FLOREEN
MRN:	613368
Date of Report:	03/23/2011
Date of Birth:	06/20/1949
Sex:	Female
Ref. Physician:	FELL, THOMAS M.D.

EXAMINATION: X-RAY LEFT ANKLE

HISTORY: Degenerative joint disease.

FINDINGS: The bones are notable for an old fracture involving the distal left fibula and medial malleolus with internal fixation. The lateral view reveals marked narrowing of the mortise joint space compatible with severe degenerative disease. The remainder of the bones is unremarkable. The soft tissues are notable for both medial and lateral soft tissue swelling.

IMPRESSION:

1. Old fractures with internal fixation as described above.
2. Severe degenerative disease of the mortise joint.
3. Soft tissue swelling.

Thank you for your referral.

Crues, John M.D.
electronically signoff on March 24, 2011 08:56 am

Health Care Partners 95-4526112
3144 Santa Anita Avenue
Suite # 205
El Monte, CA 91733
Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	01/17/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

DEPARTMENT OF DIAGNOSTIC IMAGING - 01/17/2008

MRN: 32-295496
Case: 80283

RIGHT FOOT:
(THREE VIEWS)

The films dated 01/17/2008 are submitted for interpretation on 01/18/2008.

HISTORY: Follow-up fracture.

Comparison is made to prior radiographs of the right foot performed on 12/20/2007. There is continued healing of fractures involving the distal fourth and fifth metatarsals. The remaining visualized bony structures and joint spaces appear to be intact.

IMPRESSION:
1. NO SIGNIFICANT INTERVAL CHANGE.
2. THERE IS CONTINUED HEALING OF FRACTURE INVOLVING THE FOURTH AND FIFTH METATARSALS AS DESCRIBED ABOVE.

MICHAEL VO, M.D.

MV/pf/kg
D: 01/18/2008 R: 01/21/2008 T: 01/21/2008

Health Care Partners 95-4526112
3144 Santa Anita Avenue
Suite # 205
El Monte, CA 91733
Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	11/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

DEPARTMENT OF DIAGNOSTIC IMAGING 11/20/2007

MRN: 32-295496
Case: 80283

RIGHT FOOT:
(THREE VIEWS)

The films dated 11/20/2007 are submitted for interpretation on 11/21/2007.

There is minimally displaced comminuted fracture of the distal fourth metatarsal. In addition, there is a nondisplaced fracture of the shaft of the fifth metatarsal seen best in the oblique view. The remaining visualized osseous structures and joint spaces are intact. The fractures do not appear to extend into adjacent metatarsophalangeal joints.

IMPRESSION:
1. FRACTURES OF THE FOURTH AND FIFTH METATARSALS AS DESCRIBED ABOVE.
2. ABNORMAL REPORT. A PRELIMINARY REPORT WAS SENT TO DR. HADLEY'S OFFICE ON 11/21/2007.

LEFT ANKLE:
(THREE VIEWS)

There are postoperative findings of metallic plate and surgical screws in the distal fibula and two screws in the distal tibia in place. No acute fracture or dislocation is identified. There is significant degenerative narrowing of the ankle mortise.

IMPRESSION:
POSTOPERATIVE FINDINGS IN THE DISTAL TIBIA AND FIBULA AS DESCRIBED ABOVE. THERE IS SIGNIFICANT DEGENERATIVE NARROWING OF THE ANKLE MORTISE.

LEFT KNEE:
(THREE VIEWS)

No acute fracture or dislocation is identified. There are mild degenerative changes in the left knee. The visualized bony structures and joint spaces are intact. No joint effusion is seen. There is an approximately 0.8 cm density in the knee joint, seen only in the oblique view, questionable for a loose body.

IMPRESSION:
1. MILD OSTEOARTHROSIS IN THE LEFT KNEE.
2. QUESTIONABLE 0.8 CM LOOSE BODY.

MICHAEL VO, M.D.

MV/pf/kg
D: 11/21/2007 R: 11/27/2007 T: 11/27/2007

HealthCare PARTNERS

3144 Santa Anita Avenue, El Monte, CA 91733
(626) 444-0333 FAX (626) 582-7990

*Radiology Services Provided by Anthony Bledin, M.D., Inc.
Granada Hills (818) 832-3300 Oxnard (805) 988-1111

PATIENT:	ROOKS, FLOREEN
DOB:	06-20-49
CHART NUMBER:	32-295496
REFERRED BY:	DR. MICHAEL HADLEY
DATE:	03-19-08

MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE

HISTORY

Rule out internal derangement. No known surgery.

TECHNIQUE

The following imaging sequences were acquired on a General Electric Signa Horizon MRI scanner: Sagittal T1 localizer images. Axial T2 FSE images. Coronal proton density fat saturated and T1 images. Sagittal proton density fat saturated and proton density images. Oblique Coronal T2 FSE images parallel to the anterior cruciate ligament.

FINDINGS

Minimal osteoarthritic changes are present in the knee joint, predominantly involving the medial compartment. The osteoarthritic changes are manifest by joint space narrowing, denudation of the articular cartilage and small 1 to 2 mm anterior femoral condylar articular surface osteophytes.

There is fraying and irregularity of the apex of the posterior horn of the medial meniscus. This abnormality is associated with an oblique signal abnormality in the peripheral capsular half of the posterior horn of the medial meniscus. This oblique signal abnormality freely communicates with the inferior meniscal surface and is compatible with a tear of the posterior horn of the medial meniscus. The body and anterior horn of the medial meniscus appear normal and the lateral meniscus demonstrates no significant abnormality.

A knee joint effusion is present with fluid in the suprapatellar bursa. The volume of this effusion is less than 5 cc. There is no significant popliteal cyst.

The cruciate ligaments, the collateral ligaments, the patellar tendon, quadriceps tendon appear normal.

(Continued On Page Two)

IMPRESSION

1. **Tear, posterior horn, medial meniscus (Grade III).**
2. **Early osteoarthritic changes of the medial compartment of the knee joint.**
3. **Knee joint effusion.**

Anthony Bledin, M. D.
Diplomate American Board of Radiology

AGB/aj
D: 03/19/08
T: 03/20/08

Arrow = tear posterior horn medial meniscus (sagittal)

Health Care Partners 95-4526112
3144 Santa Anita Avenue
Suite # 205
El Monte. CA 91733
Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	03/20/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

DEPARTMENT OF DIAGNOSTIC IMAGING - 03/20/2008

MRN: 32-295496
Case: 80283

RIGHT FOOT:

The films dated 03/20/2008 are submitted for interpretation on 03/21/2008.

HISTORY: Follow-up fracture.

Comparison is made to prior radiographs of the right foot performed on 02/21/2008. There is continued healing of fractures involving the distal fourth and fifth metatarsals. The alignment is anatomic. The remainder of the examination is rather unremarkable.

IMPRESSION:
CONTINUED HEALING OF FOURTH AND FIFTH METATARSAL FRACTURES.

MICHAEL VO, M.D.

MV/pf/kg
D: 03/21/2008 R: 03/22/2008 T: 03/22/2008

HealthCare PARTNERS

3144 Santa Anita Avenue, El Monte, CA 91733
(626) 444-0333 FAX (626) 582-7990

*Radiology Services Provided by Anthony Bledin, M.D., Inc.
Granada Hills (818) 832-3300 Oxnard (805) 988-1111

PATIENT:	ROOKS, FLOREEN
DOB:	06-20-49
CHART NUMBER:	32-295496
REFERRED BY:	DR. MICHAEL HADLEY
DATE:	03-19-08

MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE

HISTORY

Rule out internal derangement. No known surgery.

TECHNIQUE

The following imaging sequences were acquired on a General Electric Signa Horizon MRI scanner: Sagittal T1 localizer images. Axial T2 FSE images. Coronal proton density fat saturated and T1 images. Sagittal proton density fat saturated and proton density images. Oblique Coronal T2 FSE images parallel to the anterior cruciate ligament.

FINDINGS

Minimal osteoarthritic changes are present in the knee joint, predominantly involving the medial compartment. The osteoarthritic changes are manifest by joint space narrowing, denudation of the articular cartilage and small 1 to 2 mm anterior femoral condylar articular surface osteophytes.

There is fraying and irregularity of the apex of the posterior horn of the medial meniscus. This abnormality is associated with an oblique signal abnormality in the peripheral capsular half of the posterior horn of the medial meniscus. This oblique signal abnormality freely communicates with the inferior meniscal surface and is compatible with a tear of the posterior horn of the medial meniscus. The body and anterior horn of the medial meniscus appear normal and the lateral meniscus demonstrates no significant abnormality.

A knee joint effusion is present with fluid in the suprapatellar bursa. The volume of this effusion is less than 5 cc. There is no significant popliteal cyst.

The cruciate ligaments, the collateral ligaments, the patellar tendon, quadriceps tendon appear normal.

(Continued On Page Two)

IMPRESSION

1. **Tear, posterior horn, medial meniscus (Grade III).**
2. **Early osteoarthritic changes of the medial compartment of the knee joint.**
3. **Knee joint effusion.**

Anthony Bledin, M. D.
Diplomate American Board of Radiology

AGB/aj
D: 03/19/08
T: 03/20/08

Arrow = tear posterior horn medial meniscus (sagittal)

Health Care Partners 95-4526112
3144 Santa Anita Avenue
Suite # 205
El Monte, CA 91733
Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	02/21/2008		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

DEPARTMENT OF DIAGNOSTIC IMAGING - 02/21/2008

MRN: 32-295496
Case: 80283

RIGHT FOOT:
(TWO VIEWS)

The films dated 02/21/2008 are submitted for interpretation on 02/22/2008.

HISTORY: Follow-up fracture.

Comparison is made to prior radiographs of the right foot performed on 01/17/2006. There is continued healing of fractures involving the distal fourth and fifth metatarsals. There is near anatomic alignment of the fracture fragments of the fourth metatarsal fracture.

IMPRESSION:
CONTINUED HEALING OF FRACTURES INVOLVING THE FOURTH AND FIFTH METATARSALS.

MICHAEL VO, M.D.

MV/pf/kg
D: 02/22/2008 R: 02/23/2008 T: 02/23/2008

Health Care Partners 95-4526112
3144 Santa Anita Avenue
Suite # 205
El Monte. CA 91733
Phone: (626) 582-7989 Fax: (626) 582-7953

DATE	12/20/2007		
PATIENT	ROOKS,FLOREEN	DATE OF INJURY:	11/10/2007
EMPLOYER	D'Veal Family & Youth Services	SOC. SEC.#	130-38-8510
CASE #	80283	CLAIM #	05170360/Yolanda Nielsen

DEPARTMENT OF DIAGNOSTIC IMAGING - 12/20/2007

MRN: 32-295496
Case: 80283

RIGHT FOOT:
(THREE VIEWS)

The films dated 12/20/2007 are submitted for interpretation on 12/21/2007.

HISTORY: Follow-up fracture.

Comparison is made to prior radiographs of the right foot performed on 11/20/2007. There are healing fractures involving the distal fourth metatarsal and the distal shaft of the fifth metatarsal. There is near anatomic alignment of the fourth metatarsal fracture. There is good anatomic alignment of the fifth metatarsal fracture. The rest of the examination is rather unremarkable.

IMPRESSION:
HEALING FRACTURES OF THE FOURTH AND FIFTH METATARSALS AS DESCRIBED ABOVE.

MICHAEL VO, M.D.

MV/pf/kg
D: 12/21/2007 R: 12/24/2007 T: 12/24/2007

[redacted]

ASSOCIATED SPORT[illegible]ERAPY

DR: Sweed

ICD9.

☐WC ☐PVT ☐CASH

Account Number: 7675

Patient Name [redacted] Rooks, Noreen

CLAIM:

DOB:

DOI: 11-10-07

	INITIAL VISITS	EVALUATION & MANAGEMENT	98772	98773	98774	[illegible]	98777	98778	95857	95851	THERAPEUTIC PROCEDURES	97110	97112	97032	97116	97124	97250	97601	97128	97530	97120	97114	97145	MODALITIES	97012	97014	97022	97035	97026	SUPPLIES	99070	99070	99070
			963	97	97	[illegible]	97	98	95	95		97	97	97	97	97	97	97	97	97	97	97	97		97	97	97	97	97		A4	A4	A4
			Intermediate (New PT)	Extended (New PT)	Comprehensive (New PT)	Intermediate (Est PT)	Extended (Est PT)	Comprehensive (Est PT)	Home Management Report	Manual Muscle Test / Report		Electric Stim Therapy	Neuromuscular Re-Education	Manual Therapy	Gait Training	Therapeutic Massage	Myofascial Release	Joint Mobilization	Ultrasound	Soft Tissue Mobilization	Iontophoresis	Functional Activities	Each Additional Hour		Mechanical Traction	Electrical Stimulation	Whirlpool	Paraffin Bath	Cont Mat Heat		Electrodes	Thermoseal	Therapeutic
AUG 14 2008	6											1					1									1							
AUG 15 2008	5											1					1									1							
AUG 21 2008	4											1					1									1							
AUG 22 2008	3											1					1									1							
SEP 04 2008	1											CA																					
SEP 05 2008	2											1					1									1							

RX Date: 08-08-08 (x / wk X wks) Total Visits Auth To:

Auth Date: Pre-Cert #:

Authorized by (Adj / RN): Start Date: End Date:

Ph #:

Fax #:

Next MD Appt: (time / date) Progress Report:

Also Authorizeu. Progress Report Supplies: Tx Body Area(s):

Comments / Notes:

SCIF RECD DTE 10/16/2008 BKSCAN 7 10/16/2008 10:44 AM 032952 4 4

8083

SCIF RECD DTE 10/16/2008 BKSCAN 7 10/16/2008 10:44 AM 032957 4 5

[redacted] [redacted]

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: Ⓛ Knee ē I&D.

DATE	AUG 22 2008	SEP 0 5 2008			
Initial Evaluation					
Re-Eval/Progress Report					
Treatment Modalities:					
Hot Packs	✓	20			
Cold Packs					
Ultrasound					
Whirlpool					
Paraffin					
Massage / STM / DTM / MFR	MM	DTM			
E-Stim / TENS / IF / NMES	HW	HW			
Neuromuscular Re-ed	✓	✓			
Therapeutic Activities					
Gait Training					
Joint Mobilization Techniques	✓	✓			
Posture Education					
Body Mechanics					
Work Simulation					
Home Exercise Program (HEP)					
Other:					
Therapeutic Procedures:					
Stationary Bike	20	10			
Squats (by the wall)	15X2	15x2			
Heel Raises	15X2	15x2			
Progressive Resistive Ex's (PRE's)					
-Theraband/Theratube	15X2	15x2			
-Ankle Weight	15X3	15x3			
-Swiss Ball	15X3	15x3			
-Step ups	10X3	15x3			
-SAQ's/LAQ's/SLR's					
Stretching Exercises					
-QS/HS/GS	10x3	10x3			
-Heelcord Stretch					
-Manual Stretch					
Other:					
Therapist Initials	JQ	JQ			

Date: AUG 22 2008 S= pt c/o pain not doing well today. O: tx per flow chart A: tolerated well P: pt tolerated [illegible]

Date: SEP 0 5 2008 S: pt c/o Ⓛ knee pain – [illegible] WBAT to [illegible] O: Tx per Flow chart A: pt tol tx [illegible] PT plan P: continue [illegible]

Date:

Date:

Date:

Therapist Name/ Title	Initials
Albert Q. Escobar, RPT PT19096	

Patient Name: Rooks, Florence

Patient Account #: 7679

Physician's Name: Dr, Saucedo

Treatment Flow Chart
(Hip and/or Knee)

8083

ASSOCIATED SPORT. [illegible]ERAPY

DR: Sewell

ICD9. ______ ☐ WC ☐ PVT ☐ CASH

Account Number: 7675

Patient Name: Rooks, Floreen

CLAIM: ______

DOB: ______

DOI: 11·10·07

Date	TOTAL VISITS	EVALUATION & MANAGEMENT	940 Intermediate (New Pt) 98772	905 Extended (New Pt) 98773	907 Comprehensive (New Pt) 98774	908 Intermediate (Est Pt) 98776	910 Extended (Est Pt) 98777	912 Comprehensive (Est Pt) 98778	940 Reassessment/Repeat 95057	934 Manual Muscle Test / Report 95831	THERAPEUTIC PROCEDURE	928 Exercise (Range & Flexibility) 97110	946 Neuromuscular Re-Education 97112	947 Manual Traction 97122 / 949 [illegible] 97116	951 Therapeutic Massage 97124	950 Myofascial Release 97250	966 Joint Mobilization 97265	933 Ultrasound 97128	969 Soft Tissue Mobilization 97610	961 Iontophoresis 97028	914 Functional Activities 97114	977 Each Additional 15 min. 97145	MODALITIES	911 Mechanical Traction 97012	916 Electrical Stimulation 97014	919 Whirlpool 97022	921 Paraffin Bath 97018	963 Contrast Bath 97126	SUPPLIES	600 Electrodes 99070	604 Thermal 99070	567 Theraputty 99070
AUG 14 2008	6											/				/									/							
AUG 15 2008	5											/				/									/							
AUG 21 2008	4											/				/									/							
AUG 22 2008	3											/				/									/							

RX Date: 08·08·08 (x / wk X wks) Total Visits Auth To:

Auth Date: Pre-Cert #:

Authorized by (Adj / RN): Start Date: End Date:

Ph # :

Fax #:

Next MD Appt: (time / date) Progress Report:

Also Authorized: Progress Report Supplies: Tx Body Area(s):

Comments / Notes:

8083

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: Ⓛ Knee ō I&D

DATE	AUG 22 2008					
Initial Evaluation						Date: AUG 22 2008 S= pt c/o pain not doing well today.
Re-Eval/Progress Report						Otx per flow chart
Treatment Modalities:						A= tol well s̄ Dr
Hot Packs	✓					Pcontd s̄ pt -JD
Cold Packs						
Ultrasound						
Whirlpool						
Paraffin						Date:
Massage / STM / (DTM) / MFR	[illegible]					
E-Stim / TENS / IF / NMES	[illegible]					
Neuromuscular Re-ed	✓					
Therapeutic Activities						
Gait Training						
Joint Mobilization Techniques	✓					
Posture Education						
Body Mechanics						Date:
Work Simulation						
Home Exercise Program (HEP)						
Other:						
Therapeutic Procedures:						
Stationary Bike	20					
Squats (by the wall)	15X2					Date:
Heel Raises	15X2					
Progressive Resistive Ex's (PRE's)						
-Theraband/Theratube	15X2					
-Ankle Weight	15X3					
-Swiss Ball	15X3					
-Step ups	10X3					
-SAQ's/LAQ's/SLR's						
Stretching Exercises						Date:
-QS/HS/GS	10X3					
-Heelcord Stretch						
-Manual Stretch						
Other:						
Therapist Initials	JD					

Therapist Name/ Title	Initials
Albert Q. Escobar, RPT PT19096	

Patient Name: Rooks, Florence

Patient Account #: 7679

Physician's Name: Dr. Saucedo

Treatment Flow Chart
(Hip and/or Knee)

8083

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) Knee [illegible]

DATE	JUL 16 2008	AUG 14 2008	AUG 15 2008	AUG 21 2008	
Initial Evaluation					
Re-Eval/Progress Report	✓				
Treatment Modalities:					
Hot Packs	✓	✓	JD	✓	
Cold Packs					
Ultrasound					
Whirlpool					
Paraffin					
Massage / STM / DTM / MFR	STM	STM	STM	STM	
E-Stim / TENS / IF / NMES	HM	HM	HM	HM	
Neuromuscular Re-ed	✓		✓	✓	
Therapeutic Activities					
Gait Training					
Joint Mobilization Techniques	✓				
Posture Education					
Body Mechanics					
Work Simulation					
Home Exercise Program (HEP)		✓			
Other:					
Therapeutic Procedures:					
Stationary Bike	15'	15'	20	20	
Squats (by the wall)	15X2	15X2	15X2	15X2	
Heel Raises	15X2	15X2	15X2	15X2	
Progressive Resistive Ex's (PRE's)					
-Theraband/Theratube	15X2	15X2	15X2	15X2	
-Ankle Weight	15X2	15X2	10X3	15X2	
-Swiss Ball	15X2	15X2	15X3	15X2	
-Step ups	15X2	15X2	15X2	15X2	
-SAQ's/LAQ's/SLR's	15X2	15X2	15X2	15X2	
Stretching Exercises					
-QS/HS/GS	15X2	15X2	15X2	15X2	
-Heelcord Stretch					
-Manual Stretch		5X1	5X1		
Other:					
Therapist Initials	AE	AE	JD	AE	

Date: JUL 16 2008
Pt was last seen today for this period. Rec'd PT per flow chart & tolerated well. Has made progress & has good potential to improve. Status: well planned. Cont skilled PT to further improve & restore function. Will hold PT pending authorization. — AE

Date: AUG 14 2008
Resumed PT Rx today per MD order & per authorized by WC. Rec'd PT per flow chart & tol. well. Reviewed & reinforced HEP. Will cont — AE

Date: AUG 15 2008 [illegible] (L) knee stiffness, [illegible] weakness [illegible] — JD

Date: AUG 21 2008
Cont to rec'd PT Rx per flow chart & tol. well. Cont to need verbal cue for HEP. Cont — AE

Therapist Name/ Title	Initials
AQEscobar, PT Albert Q. Escobar, RPT PT19096	AE

Patient Name: ROOKS, FLORENE

Patient Account #: 7679

Physician's Name: DR. SAUCEDO

Treatment Flow Chart

(Hip and/or Knee)

8083

#05170360
LD Yolanda Nelsen
Unit 5 Rowena Marcelo

ASSOCIATED SPORTS THERAPY
880 S. ATLANTIC BLVD STE 203
MONTERAPARK, CA 91754
OFFICE (626) 282-3577 FAX (826) 284-4276

FAX COVER SHEET

SCAN AS ONE DOCUMENT

DATE: JUL 11 2008

ATTN: Yolanda Nelson

INS: State Comp

FAX: (818) 291-7115

RE: Rook, Floren

CLAIM #: 80283 **DOI:** 11 10 07

MESSAGE: ***AUTHORIZATION REQUEST FOR PHYSICAL THERAPY***

Please review request for Physical Therapy 2X4 for Lt knee.

Thank you,

ENCLOSED, FOR YOUR REVIEW:

- ✓ PRESCRIPTION: (DATED) JUL 11 2008
- ✓ EVAL/REPORT;PROGRESS NOTE;RE-EVAL:(DATED) _____
- ✓ WORK STATUS SHEET: _____
- ✓ DOCTORS SUPPLEMENTAL REPORT: _____

FROM: Sonia De La Torre

NUMBER OF PAGES 6
(INCLUDING COVER SHEET)

MYRA GUEVARA
JUL 14 2008
LOS ANGELES CLAIMS

ASSOCIATED SPORT THERAPY
880 S. ATLANTIC BLVD, SUITE 203
MONTEREY PARK, CA. 91754
PHONE (626) 282-3577 FAX (626) 284-4276

Physical Therapy Progress Report

Patient Name: Rooks, Florence
Referring Physician: Dr. Saucedo
Diagnosis: (L) Knee Sp I & D
Claim Number: 80283

Date: JUN 1 8 2008
Visits: 11
Account #: 761
D.O.I.: 11-10-07

Chief Complain(s): 0-10 pain scale
C/S PAIN
T/S PAIN
L/S PAIN
Radicular Symptoms Ø
Extremity Pain (L) Knee pain 4-5/10
Other

Improvement(s) Noted: Δ = change ↑ = increased ↓ = decreased
(no Δ-↑-↓) ROM ↑'d R (L) Knee flexion to 0-115
(no Δ-↑-↓)Strength ↑'d strength in (L) LE post 1gr. level
(no Δ-↑-↓)Function ↑'d overall function + able to walk longer distance
(no Δ-↑-↓)Radiculopathy Ø
(no Δ-↑-↓)Pain (L) Knee 4-5/10
(no Δ-↑-↓)Other Her Ud tenderness on (L) Knee significantly.

General Assessment: Pt has showed significant improvement + has improved dynamic balance + endurance, Cont to have residual pain + weakness + would benefit from Cont PT treatment.

Treatment Plan/Recommendations: Cont. scheduled PT intervention
☑ Continue with same treatment plan. ☐ Add

GOAL:(S): 1) perform V pain a (L) knee to 1-2/10 2) ↑ strength in (L) LE to gr. tolerance 3) Improve/normalize gait pattern. 4) To ambulate in community I/D + independently

PHYSICAL THERAPIST Angelica Ramirez JUN 1 8 2008

MYRA GUEVARA
JUL 1 4 2008

Associated Sports Therapy (AST)
880 South Atlantic Blvd., Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

Patient Name: BOOKS, FLORENCE
Diagnosis: (L) knee TKA I & D
Account Number:
Date Of Injury:

Date	MAY 22 2008	JUN 18 2008			
Objective Findings:	Evaluation	Summary 1	Summary # 2	Summary # 3	Summary # 4
ROM					
(L) knee flexion	5°-80°	0°-115°			
(L) hip/Ankle	WNL	WNL			
Strength:					
hip flexors	3+/5	4+/5			
(L) Quads	3-/5	4/5			
(L) Hams	3/5	4/5			
(L) Ankle muscles	4-/5	5/5			
Pain level:					
(L) knee	10/10	4-5/10			
Therapist Initials:	AE	AE			
Therapist Name/Title:	Notes	Notes:	Notes:	Notes:	Notes:
Albert Q Escobar, RPT	PT Eval Completed today.	Significant improvement noted.			
Signature/Initials:					
AQEscobar PT [AE]	AE			MYRA GUEVARA JUL 14 2008 LOS ANGELES	
Therapist Name/Title:					
Signature/Initials:					

Progress Flow Sheet

ASSOCIATED SPORT THERAPY
880 S. ATLANTIC BLVD, SUITE 203
MONTEREY PARK, CA. 91754
PHONE (626) 282-3577 FAX (626) 284-4276

Physical Therapy Progress Report

Patient Name: Rooks, Florence
Referring Physician: Dr. Saucedo
Diagnosis: (L) knee S/P [illegible]
Claim Number: 80283

Date: JUN 18 2008
Visits: 11
Account #: 7619
D.O.I.: 11-10-07

Chief Complain(s): 0-10 pain scale
C/S PAIN
T/S PAIN
L/S PAIN
Radicular Symptoms Ø
Extremity Pain (L) knee joint 4-5/10
Other

Improvement(s) Noted: ^ = change ↑ = increased ↓ = decreased
(no ^-↑-↓) ROM ↑'d (L) knee flexion to 0°-115°
(no ^-↑-↓) Strength ↑'d strength on (L) LE about 1/2 gr. level
(no ^-↑-↓) Function ↑'d overall function + able to walk longer distance
(no ^-↑-↓) Radiculopathy Ø
(no ^-↑-↓) Pain (L) knee 4-5/10
(no ^-↑-↓) Other ↓'d tenderness on (L) knee significantly.

General Assessment: Pt has shown significant improvement + has improved dynamic balance + endurance, cont to have residual pain + weakness + would benefit from cont PT treatment.

Treatment Plan/Recommendations: Cont. skilled PT intervention
☑ Contine with same treatment plan ☐ Add

GOAL(s): 1) further ↓ pain on (L) knee to 1-2/10 2) ↑ strength on (L) LE 1/2 gr. higher 3) improve/promote normal gait pattern. 4) to ambulate in community s̄ AD + independent

PHYSICAL THERAPIST: [signature] PT JUN 18 2008

6/19/08

☐ ASSOCIATED SPORTS THERAPY
880 S. Atlantic Blvd #3
Monterey Park, CA 91754

☐ EASTSIDE ORTHOPEDIC MEDICAL ASSOCIATES
880 S. Atlantic Blvd., 205
Monterey Park, CA 91754

ACC# 19475
NEW ☐
UPDATE ☐

PATIENT/PACIENTE

Patient last Name/Apellido	First Name/Nombre	Initial/Inicial	(Maiden Name) (Nombre de Soltera)
ROOKS	FLOREEN		
Street Address/Direccion	City/Ciudad / State/Estado	ZIP/Zone Postal	
1315 S. Gladys Ave.	San Gabriel CA	91776	
Home Telephone/Telefono (HM)	Message Telephone/Numero de Mensajes	Birthplace/Lugar de Nacimiento	
(626) 573-1906	626 354 4900 (cell)	New York City	
Sex/Sexo / Birthdate . Fecha de Nacimiento	Driver's License Number/Licencia	Social Security Number/Seguro Social	
☐M ☒F 06/20/1949		130-38-8510	
Marital Status/Estado Civil	Occupation/Ocupacion	Date Employment Began/Fecha de Empleo	
☐S ☐M ☐W ☐D	Marriage & Family Therapist Intern	12/2004	
Employer Name/Nombre de Empleo		Employer Telephone/Telefono de Empleo	
D'VEAL FAMILY & YOUTH SVS		(626) 296-8900x	
Street Address/Direccion	City/Ciudad	ZIP/Zone Postal	
845 N. Fair Oaks	Pasadena		

RESPONSIBLE PERSON SPOUSE PARENT/PERSONA RESPONSABLE

Patient Last Name/Apellido	First Name/Nombre	Initial/Inicial	(Maiden Name) (Nombre de Soltera)
Street Address/Direccion	City/Ciudad / State/Estado	ZIP/Zone Postal	
Home Telephone/Telefono	Message Telephone/Numero de Mensajes	Birthplace/Lugar de Nacimiento	
Sex/Sexo ☐M ☐F / Birthdate/Fecha de Nacimiento	Driver's License Number/Licencia	Social Security Number/Seguro Social	
Marital Status/Estado Civil ☐S ☐M ☐W ☐D	Occupation/Ocupacion	Date Employment Began/Fecha de Empleo	
Employer Name/Nombre de Empleo		Employer Telephone/Telefono de Empleo	
Street Address/Direccion	City/Ciudad / State/Estado	ZIP/Zone Postal	

INSURANCE INFORMATION/INFORMACION DE SEGURO

HMO ☐ _____ ☐ Group Insurance ☐ Industrial ☐ Medi-Cal ☐ Medicare ☐ PPO		Effective Date/Fecha Seguro Effect.	Acct. type/Cuer. No. WC
Group Number/Numero de Grupo	Member Number/Numero de Miembro		
Insurance Comp. Name-Primary/Nombre de Aseguranza	Cert. Number/Numero de Certificado	Relationship/Relacion al Paciente	
Street Address/Direccion de la Aseguranza	City/Ciudad / State/Estado	ZIP/Zone Postal	
Telephone/Telefono	Plan Name/Nombre del Plan	Plan Number/Numero del Plan	
Insurance Company Name/Nombre de Aseguranza (Segunda)	Insured/Asegurado	Relationship/Relacion al Paciente	
Street Address/Direccion	City/Ciudad / State/Estado	ZIP/Zone Postal	
Telephone/Telefono	Policy/Numero Polisa	Group Number/Numero de Grupo	I.D. Number/# de Identificacion

PAMELA SELEVICH
MAY 14 2008
LOS ANGELES CLAIMS

RELATIVE FRIEND/PARIENTE AMISTAD

Last Name/Apellido	First Name/Nombre	Initial/Inicial	Relationship . Relacion	Telephone/Telefono
CARROLL	JUDITH		Friend	626 572-1611
Street Address/Direccion	City/Ciudad		ZIP/Zone Postal	
204 N. Olive	Alhambra		91801	
NAME OF PRIVATE PHYSICIAN Dr. Sauceda		DATE 4/23/08		
NOMBRE DE SU DOCTOR PRIVADO		INITIALS		

8083

Richard Zapanta, M.D., Inc.
Tomas Saucedo, M.D., Inc.
Dana J. Primo, P.A.C.

EOMA
Eastside Orthopedic Medical Associates
Diplomates of the American Board of Orthopedic Surgeons
Fellows of the American Academy of Orthopedic Surgeons
Qualified Medical Examiners

Total Joints Arthroplasty
Industrial Medicine
Sports Medicine

SURGERY AUTHORIZATION REQUEST

Date FAXED 03.26.08

Patient: ROOKS, Floreen *D.O.B.* 04.20.49

S.S.# 130-38-8510 *Claim#* 05170240

DX: medial meniscus tear internal derrangement knee *ICD-9 CODE:* 836.0, 717.9

Procedure: LT knee Arthroscopy *CPT CODE:* 29877, 29881

Dr.: Tomas Saucedo

Asst Dr./Physician:

Facility: Plaza surgical center

Address: 850 S. Atlantic Blvd. Ste#211

City/State/Zip: Monterey Park CA 91754

Phone# (626) 289-2894 *Fax#:* (626) 289-2840

RECEIVED
APR 02 2008
LA DO GLENDALE LOC.

Out Patient Procedure: Y *Inpatient procedure:* *Days stay:*

DME Equip: Crutches, Ice Therapy Unit

Physical Therapy:

Surgery has not been scheduled. We will schedule a surgery date once patient has been approved for surgery. If you have any questions or need further assistance feel free to call me at (626) 588-1990 or you may Fax me at (626) 308-2083. Hope to here from you soon.

Thank You,

Jamie Ramos
Jamie Ramos
Work Comp Coordinator

880 South Atlantic Boulevard, Suite 205, Monterey Park, California 91754 • (626) 289-0178 • FAX (626) 308-2083

ASSOCIATED SPORT THERAPY
880 S. ATLANTIC BLVD, SUITE 203
MONTEREY PARK, CA. 91754
PHONE (626) 282-3577 FAX (626) 284-4276

Physical Therapy Progress Report

Patient Name: Rock Florene
Referring Physician: Saucedo
Diagnosis:
Claim Number: 902283

Date: JUL 16 2008
Visits: 4
Account #: 7679
D.O.I.: 11-10-07

Chief Complain(s): 0-10 pain scale
C/S PAIN
T/S PAIN
L/S PAIN 7 Ø
Radicular Symptoms Ø
Extremity Pain (L) knee pain 2-3/10
Other

Improvement(s) Noted: Δ = change ↑ = increased ↓ = decreased
(no Δ-↑-↓) ROM ↑ of (L) knee flexion to 0° 120° c pain @ end of range
(no Δ-↑-↓) Strength ↑'d (L) LE strength about 1/2 grade more
(no Δ-↑-↓) Function ↑'d function noted occasional use of cane needed to manage pain
(no Δ-↑-↓) Radiculopathy Ø
(no Δ-↑-↓) Pain ↓ (L) knee pain to 2-3/10
(no Δ-↑-↓) Other ↓ incidence of feet occasionally on medial side of (L) knee joint

General Assessment: Pt has completed approx 4 PT Rx sessions & has cont to demonstrate considerable progress c/b ↑ in (L) knee flexibility (5° less than (R) knee) & improved gait pattern & noted ↓ limping. Pt is now I & HEP exercise program

Treatment Plan/Recommendations: Would cont benefit from skilled PT
☒ Contine with same treatment plan. ☒ Add high level activities

GOAL:(S) 1) to further ↓ pain to 0-1/10 2) further ↑ strength to normal 3) to enable normal gait pattern 4) Ambulate in community independently without cane c good confidence

PHYSICAL THERAPIST Alejandra PT JUL 16 2008

8083

880 S. ATLANTIC BLVD, SUITE 203
MONTEREY PARK, CA. 91754
PHONE (626) 282-3577 FAX (626) 284-4276

Physical Therapy Progress Report

Patient Name: Rooks, Florence
Referring Physician: Dr. Saucedo
Diagnosis: (L) Knee S/P I & D
Claim Number: 90283

Date: JUN 18 2008
Visits: 11
Account #: 7619
D.O.I.: 11-10-07

Chief Complain(s): 0-10 pain scale
C/S PAIN 4/0
T/S PAIN 4/0
L/S PAIN 4/0
Radicular Symptoms 0
Extremity Pain (L) knee joint 4-5/10
Other

Improvement(s) Noted: Δ = change ↑ = increased ↓ = decreased
(no Δ-↑-↓) ROM ↑ of (L) knee flexion to 0-115
(no Δ-↑-↓)Strength ↑'d strength on (L) LE about 1/2 level
(no Δ-↑-↓)Function ↑'d overall function + able to walk longer distance
(no Δ-↑-↓)Radiculopathy 0
(no Δ-↑-↓)Pain (L) knee 4-5/10
(no Δ-↑-↓)Other Has ↓'d tenderness on (L) knee significantly.

General Assessment: Pt has showed significant improvement has improved dynamic balance + endurance, Cont to have residual pain + weakness + would benefit from Cont PT treatment.

Treatment Plan/Recommendations: Cont. scheduled PT intervention
☑ Contine with same treatment plan. ☐ Add

GOAL: (S) 1) further ↓ pain in (L) knee to 1-2/10 2) ↑ strength in (L) LE to gr. degree 3) improve/normalize normal gait pattern 4) to ambulate in community I AD + independently.

PHYSICAL THERAPIST. Rosicela PT JUN 18 2008

ASSOCIATED SPORT. IERAPY

DR: Savelli

☑WC ☐PVT ☐CASH

ICD9.

Account Number: 7679

Patient Name: Books, Florene

CLAIM: 80283

DOB: 6.20.49

DOI: 11.10.07

	Total Visits	EVALUATION & MANAGEMENT	98771 Intermediate (New Pt)	98773 Extended (New Pt)	98774 Comprehensive (New Pt)	98776 Intermediate (Est Pt)	98777 Extended (Est Pt)	98778 Comprehensive (Est Pt)	95852 Range of Motion Measurement/Report	95831 Manual Muscle Test / Report	THERAPEUTIC PROCEDURE	97110 Exercise (Remedial/Therapeutic)	97112 Neuromuscular Re-Education	97122 Manual Therapy	97116 Gait Training	97124 Therapeutic Massage	97250 Myofascial Release	97124 Joint Mobilization	97035 Ultrasound	97039 Soft Tissue Mobilization	97150 Isokinetics	97114 Functional Activities	97145 Each Additional 15 min.	MODALITIES	97032 Mechanical Traction	97034 Electrical Stimulation	97022 Whirlpool	97026 Paraffin Bath	97126 Contrast Bath	SUPPLIES	99070 Electrodes	99070 Theraband	99070 Therapy
JUL 02 2008	4											1					1															
JUL 07 2008	3											1					1															
JUL 11 2008	2											1					1								1							
JUL 16 2008												1					1								1							

RX Date: 6.06.08 (3 x/wk X 4 wks) 12 Total Visits Auth 9 To:

Auth Date: 6.26.08

Pre-Cert #:

Authorized by (Adj / RN):

Start Date: End Date:

Ph # :

Fax #:

Next MD Appt: (time / date) Progress Report:

Also Authorized: Progress Report Supplies: Tx Body Area(s):

Comments / Notes:

8083

ASSOCIATED SPORT. ...RAPY

DR: Saucedo

ICD9. 717.9 ☒ WC ☐ PVT ☐ CASH

CLAIM: 86283

DOB: 6-20-49

DOI: 11-9-07

Account Number 7679

Patient Name Rooks, Flosiene

	INITIAL VISITS	EVALUATION & MANAGEMENT PT	98772	98773	98774	98776	98777	98778	98857	97161	97110	97112	97113	97116	97124	97250	97546	97530	97124	97545	97546	97112	97014	97022	97032	97036	97035	97140	97110	97530
			963 Intermediate (New Pt)	965 Extended (New Pt)	967 Comprehensive (New Pt)	968 Intermediate (Est Pt)	969 Extended (Est Pt)	972 Comprehensive (Est Pt)	938 Reassessment/Report	934 Manual Muscle Test / Report	THERAPEUTIC PROCEDURES	928 Exercise (Group & Flexibility)	946 Neuromuscular Re-Education	947 Manual Therapy	949 Gait Training	951 Therapeutic Massage	950 Myofascial Release	955 Joint Mobilization	933 Ultrasound	959 Soft Tissue Mobilization	961 Iontophoresis	964 Functional Activities	977 Each Additional 15 min	MODALITIES	911 Mechanical Traction	916 Electrical Stimulation	919 Whirlpool	923 Paraffin Bath	963 Contrast Bath	SUPPLIES	4266 Electrodes	4870 Theraband	5871 Therapunity
MAY 22 2008	12																													
MAY 26 2008	11																													
MAY 30 2008	10																													
JUN 03 2008	9																													
JUN 04 2008	8																													
JUN 06 2008	7																													
JUN 09 2008	6																													
JUN 11 2008	5																													
JUN 13 2008	4																													
JUN 16 2008	3																													
JUN 18 2008	2																													
JUN 20 2008	1																													

RX Date: 5.09.08 (3 x/wk X 4 wks) Total Visits Auth 12 To:

Auth Date: 5-19-08 Pre-Cert #: Start Date: 5/19/08 End Date: 6-09-08 7/18/08

Authorized by (Adj / RN):

Ph #:

Fax #: Progress Report:

Next MD Appt: (time / date) Supplies: Tx Body Area(s):

Progress Report

8083

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) Knee OA I & D

DATE	JUL 16 2008					
Initial Evaluation						Date: JUL 16 2008
Re-Eval/Progress Report	✓					
Treatment Modalities:						
Hot Packs	✓					
Cold Packs						
Ultrasound						
Whirlpool						
Paraffin						Date:
Massage / STM / DTM / MFR	STM					
E-Stim / TENS / IF / NMES	IFM					
Neuromuscular Re-ed	✓					
Tharapeutic Activities						
Gait Training						
Joint Mobilization Techniques	✓					
Posture Education						
Body Mechanics						Date:
Work Simulation						
Home Exercise Program (HEP)						
Other:						
Therapeutic Procedures:						
Stationary Bike	15'					
Squats (by the wall)	15x2					Date:
Heel Raises	15x2					
Progressive Resistive Ex's (PRE's)						
-Theraband/Theratube	15x2					
-Ankle Weight	15x2					
-Swiss Ball	15x2					
-Step ups	15x2					
-SAQ's/LAQ's/SLR's	15x2					
Stretching Exercises						Date:
-QS/HS/GS	15x2					
-Heelcord Stretch						
-Manual Stretch						
Other:						
Therapist Initials	AE					

Therapist Name/ Title	Initials
AEscobar PT *Albert Q. Escobar, RPT* PT19096	AE

Patient Name: ROOKS, FLORENE

Patient Account #: 7679

Physician's Name: DR. SALCEDO

Treatment Flow Chart
(Hip and/or Knee)

8083

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) Knee p̄ I & D

DATE	JUN 18 2008	JUN 20 2008	JUL 02 2008	JUL 07 2008	JUL 11 2008
Initial Evaluation					
Re-Eval/Progress Report	✓				
Treatment Modalities:					
Hot Packs	✓	✓	20'	✓	✓
Cold Packs					
Ultrasound					
Whirlpool					
Paraffin					
Massage / STM / DTM / MFR	STM	STM	STM	STM	MFR
E-Stim / TENS / IF / NMES	HW	HW	HW	HW	HW
Neuromuscular Re-ed	✓	✓	✓	✓	✓
Therapeutic Activities					
Gait Training					
Joint Mobilization Techniques	✓	✓	✓	✓	✓
Posture Education					
Body Mechanics					
Work Simulation					
Home Exercise Program (HEP)	✓				
Other:					
Therapeutic Procedures:					
Stationary Bike	15'	15'	15'	15'	20'
Squats (by the wall)	10X2	10X2	10X2	10X3	10X3
Heel Raises	10X2	10X2	10X2	10X3	10X3
Progressive Resistive Ex's (PRE's)					
-Theraband/Theratube				10X3	10X3
-Ankle Weight	10X2	10X2	10X2	10X3	10X3
-Swiss Ball	10X2	10X2	10X2	10X3	10X3
-Step ups	10X2	10X2	10X2	10X3	10X3
-SAQ's/LAQ's/SLR's	10X2	10X2	10X2	10X3	10X3
Stretching Exercises					
-QS/HS/GS	10X2	10X2	10X2	10X3	10X3
-Heelcord Stretch					
-Manual Stretch					
Other:					
Therapist Initials	AE	AE	[illegible]	AE	JO

Date: JUN 18 2008
Pt states she can't do well, except pain seemed to ↑'d @ night. Rec'd PT Tx per flow chart & tol. well. Will benefit from skilled PT — AE

Date: JUN 20 2008
Can't to rec'd PT Tx per flow chart. Pain ↓'d today as pt described. She had made good progress so far & would benefit from cont skilled PT. — AE

Date: JUL 02 2008 Pt c/o weakness to (L) knee — pain ↓ ~ flex-ex.
O: Tx per flow chart & pt tol Tx fair.
P: continue PT plan — [illegible]

Date: JUL 07 2008
c/o pain on (L) knee 3-4/10. Rec'd PT Tx per flow chart to reinforce HEP. Tol. Tx well. Will cont — AE

Date: JUL 11 2008 S: pt c/o [illegible] inflammation to (L) knee area. Pt's performing [illegible]
A: tol well
P: cont. PT — JO

Therapist Name/ Title	Initials
A. Escobar PT *Albert Q. Escobar, RPT* PT19096	AE

Patient Name: ROOKS, FLORENCE
Patient Account #: 7679
Physician's Name: DR. SAUCEDO

Treatment Flow Chart
(Hip and/or Knee)

8083

Associated Sports Therapy (AST)
880 South Atlantic Blvd, Suite 203, Monterey Park, CA 91754
Phone: (626) 282-3577 Fax: (626) 284-4276

DIAGNOSIS: (L) Knee [illegible]

DATE	JUN 08 2008	JUN 09 2008	JUN 11 2008	JUN 13 2008	JUN 16 2008
Initial Evaluation					
Re-Eval/Progress Report					
Treatment Modalities:					
Hot Packs	20	20	20	✓	✓
Cold Packs	✓	✓			
Ultrasound					
Whirlpool					
Paraffin					
Massage / STM / DTM / MFR	STM	Stm	STM	STM	STM
E-Stim / TENS / IF / NMES	HW	HW	HW	HW	HW
Neuromuscular Re-ed	✓	✓	✓	✓	✓
Therapeutic Activities					
Gait Training					
Joint Mobilization Techniques					
Posture Education					
Body Mechanics					
Work Simulation					
Home Exercise Program (HEP)	✓	✓			
Other:					
Therapeutic Procedures:					
Stationary Bike		30'	30	30'	20'
Squats (by the wall)		x15	[illegible]	10x2	10x2
Heel Raises				10x2	10x2
Progressive Resistive Ex's (PRE's)					
-Theraband/Theratube					
-Ankle Weight					
-Swiss Ball	10x1	10x1		10x2	10x2
-Step ups	10x1	10x1		10x2	10x2
-SAQ's/LAQ's/SLR's	10x1	10x1		10x2	10x2
Stretching Exercises					
-QS/HS/GS	10x1	10x2	✓	10x2	x2
-Heelcord Stretch					
-Manual Stretch					
Other:					
Therapist Initials	JD	JD	[illegible]	AE	JD

Date: JUN 06 2008 [illegible] — JD

Date: JUN 09 2008 [illegible] — JD

Date: JUN 11 2008 S: Pt c/o [illegible] O: Tx per flow chart. [illegible] PT plan [illegible]

Date: JUN 13 2008 Cont to rec'd PT Tx per flow chart. Requires some encouragement to [illegible] fully. Pt. tol. well. Will cont. AE

Date: JUN 16 2008 [illegible] — JD

Therapist Name/ Title	Initials
[signature] Albert Q. Escobar, RPT PT19096	AE

Patient Name: Books, Florence

Patient Account #: 7679

Physician's Name: Dr. Saucedo

Treatment Flow Chart
(Hip and/or Knee)

8083