***State of California***

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

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

Case Name: **FLOREEN ROOKS** (*employee name*) v **D'Veal Family & Youth Services** (*claims administrator name, or if none employer*)

Claim No.: **SIF10825285**

EAMS or WCAB Case No. (*if any*): ADJ10825285; ADJ7024643; ADJ7024645

I, **BRISEIDA CHAVEZ** (*Print Name*), declare:

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

| | |
|---|---|
| A | depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid. |
| B | placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid. |
| C | placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier. |
| D | placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)* |
| E | personally delivering the sealed envelope to the person or firm named below at the address shown below. |

| Means of service: (*For each addressee, enter A – E as appropriate*) | Date Served: | Addressee and Address Shown on Envelope: |
|---|---|---|
| A | 01/08/21 | Subsequent Injury Benefit Trust Fund-SENT ELECTRONICALLY |
| A | 01/08/21 | WORKERS DEFENDERS LAW GROUP 8018 East Santa Ana Canyon, Suite 100-215 Anaheim Hills, California 92808 |
| A | | |
| | | |

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 01/08/2021

Briseida Chavez
(*signature of declarant*)

BRISEIDA CHAVEZ
(*print name*)

QME Form 122
Rev. February 2009

# Lawrence M. Richman, M.D.
**Mailing Address:**
**1680 Plum Lane**
**Redlands, California 92374**
**(909) 335-2323**

December 14, 2020

DEPARTMENT OF INDUSTRIAL RELATIONS
Subsequent Injury Benefit Trust Fund
160 Promenade Circle, Suite 350
Sacramento, California 95834-2962
Attention: Victor Lladoc, Workers' Compensation Consultant

WORKERS DEFENDERS LAW GROUP
8018 East Santa Ana Canyon, Suite 100-215
Anaheim Hills, California 92808
Attention: Natalia Foley, Esquire

| | | |
|---|---|---|
| EMPLOYEE | : | **FLOREEN ROOKS** |
| EMPLOYER | : | D'Veal Family & Youth Services |
| D/INJURY | : | |
| SIBTF NO. | : | SIF10825285 |
| WCAB NO. | : | ADJ10825285; ADJ7024643; ADJ7024645 |
| DATE OF BIRTH | : | June 20, 1949 |
| EXAM DATE | : | December 14, 2020 |

**COMPREHENSIVE INDEPENDENT MEDICAL EVALUATION IN NEUROLOGY**
**SIBTF EVALUATION REPORT:**

Gentlepersons:

This examination was performed in the county of Los Angeles at 2760 East Florence Avenue, Huntington Park, California 90255 on December 14, 2020.

ML104 -95

| | |
|---|---|
| Causation is addressed per written request | |
| Apportionment between multiple injuries is addressed | |
| Face-to-face time | 2 hours |
| Review of medical records (192 pages) | 4 hours |
| Report preparation and review | 4 hours |
| Report editing | 2 hours |

THE TIME REQUIRED FOR THIS PHYSICIAN TO ISSUE THE REPORT: 12 hours.

Thank you for asking me to perform an Independent Medical Evaluation on December 14, 2020 in order to determine disability for the Subsequent Injury Benefits Trust Fund, pursuant to Labor Code 4751. I have personally evaluated this patient and prepared this report.

The focus of this report is to address the applicant's pre-existing impairment / disability of different body regions, other than the industrial injury and to note the effects of the following injuries. This evaluation was performed in my office in Huntington Park, California on December 14, 2020. The combination of the above complexity factors total 4.

This report is billed as a ML104 with Regulation 9795.

Per Labor Code 4751: If an employee, who is permanently and partially disabled receives a subsequent compensable injury resulting in additional permanent / partial disability, so that the degree of disability caused by the combination of both disabilities is greater than that which would have resulted from the subsequent injury alone, on the combined effect of the last injury on the previous disability or impairment, is a permanent disability equal to 70% or more of the total, he/she shall be paid in addition to the compensation due under the code for the permanent disability caused by the last injury, compensation of the remainder of the combined permanent disability existing up to the last injury, as provided in this article: provided, that either (a) the previous disability or impairment affected a hand, an arm, a foot, a leg or an eye, on the permanent disability resulting from the subsequent injury affects the opposite and corresponding member, and such allowed permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to 5% or more of the total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35% or more of the total.

## INITIAL SIBTF SUMMARY:

1. **Did the worker have an industrial injury?**
   Answer - Yes. The applicant sustained continuous trauma from December 30, 2014 through April 6, 2016 to her back, lower extremities and body systems abdomen, liver and kidneys. The patient reports that she slipped on a banana peel in 2004 while on a company outing fracturing her left toe and injuring her left knee.

2. **Did the industrial injury rate to a 35% disability without modification for age and occupation?**
   Answer – Yes. Per Panel Qualified Medical Evaluator, Dr. Heinen dated February 20, 2018 with a total whole person impairment of 38% for orthopedic injuries.

3. **Did the worker have a pre-existing labor-disabling permanent disability?**
   Answer – Yes. The patient sustained a fracture to the left ankle in 1993 when she fell down a staircase, as well as sustaining a slip and fall injury with musculoskeletal

complaints when she slipped at a 99¢ Store on spilled water; to be addressed by the Panel Qualified Medical Evaluator in orthopedics.

The patient has been legally blind in her right eye since birth, which is lack of depth perception. She has no visual acuity. The patient has loss of visual fields. She has had a heart murmur since childhood with no known cardiac disease; to be addressed by a board certified internal medicine specialist / cardiologist.

She has a history of depression following separation of her parents at the age of 8, that has persisted to the present time. The patient has a history of anxiety during that same time frame, that has persisted to the present.

She has a history of two motor vehicular accidents with injuries to the cervical spine resulting in chronic cervical spine pain from both accidents, head injury from both accidents associated with diminished memory and concentration, as a result of the above noted accidents.

The patient responds to the Clinical Dementia Rating Scale, Table 13-5 from the AMA Fifth Edition. The patient reports that she forgets what to purchase at a store, has to keep a list of objects to purchase, forgets where she places her personal belongings, loses direction easily and forgets things and people that she should know. She has difficulty figuring out solutions for day-to-day problems, difficulty keeping track of time and time-relationships. She has loss of interest in hobbies, such as playing chess. She reports that these cognitive complaints have been present since both motor vehicular accidents.

The patient reports anxiety, depression, impaired concentration and dizziness. She believes that this is secondary to anxiety. She reports a history of headaches, rated between a 6 to 7 (out of 10) and is frequently present since both motor vehicle accidents.

4. **Did the pre-existing disability affect an upper or lower extremity or eye?**
Answer – No.

5. **Did the industrial permanent disability affect the opposite or corresponding body part?**
Answer – No.

6. **Is the total disability equal to or greater than 70% after modification?**
Answer – Yes. The patient's disability is equal to or greater than 70% taking into consideration both her orthopedic complaints, concussive-related complaints and visual impairment.

7. **Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?**

Answer – No. The patient is not disabled or unemployable from her pre-existing disability or work duties together.

8. **Is the employee 100% disabled from the industrial injury?**
Answer – No.

9. **Additional records reviewed?**
Answer – Yes. See summary below.

10. **Are evaluations or diagnostics needed?**
Answer – Yes. The patient should undergo neuropsychologic testing, an ophthalmologic evaluation, head imaging of the brain or a functional MRI scan of the brain.

## SUMMARY OF SURGICAL AND MEDICAL PROBLEMS:

The patient is a 71-year-old female Marriage & Family Therapist, who was previously employed by D'Veal Family & Youth Services for twelve years and four months through April 2016.

Her job required frequent climbing, occasional bending and stooping. She did occasional lifting up to 10 pounds. She performed repetitive fine manipulation of the right hand and she would use a computer keyboard.

The patient reports having sustained a slip and fall injury on a banana peel during a company outing. She sustained a fracture of the left toe and an injury to the left knee. The latter occurred on another occasion when she attempted to put on the brakes of a car before going into traffic.

In an orthopedic report of Dr. Heinen, orthopedist, dated February 28, 2018 refers to an injury date of April 16, 2006 and continuous trauma for twelve years due to repetitive use of the upper and lower limbs. The patient would frequently drive cars.

She reports being subjected to harassment from one of her coworkers. She reported constant aching of the bilateral shoulders and elbows. She is unable to walk at times. She complains of lower limbs and knees. She feels imbalance. The lumbar spine was found to be tender on examination. The patient was diagnosed with arthritis of the cervical spine, cervical spine pain, arthritis of the bilateral shoulders, thoracic spine, lumbar spine, lumbar radicular symptoms, arthritis of the bilateral knees, left greater than right, severe degenerative arthritic changes of the left knee, status-post surgery to the left knee, degenerative arthritis of the right ankle and fracture of the right foot.

Her shoulder complaints could not related to continuous trauma. She was provided with a 30% whole person impairment for complaints of the bilateral upper limbs, cervical, thoracic and lumbar spine, bilateral knees and bilateral lower limbs. It is reported that her hands were considered to be work related whereas the other orthopedic injuries were nonwork related.

The Panel Qualified Medical Evaluator did mention that there were multiple pre-existing nonorthopedic injuries that predated her employment. The patient's pre-existing longstanding orthopedic injuries should be addressed by a board certified orthopedic examiner to address her pre-existing orthopedic complaints and that this is beyond my scope of expertise.

The patient does have a pre-existing history of several medical problems preceding her date of hire. She has been legally blind in the right eye since birth. She has lack of depth perception. The cause of her ocular disorder was not known.

She has a prior history of a heart murmur since childhood, as well as a history of hypertension. Her heart condition and hypertension should be addressed by a board certified internal medical specialist / cardiologist.

She has a longstanding history of anxiety and depression, which has persisted to the present, that should be addressed by a board certified psychiatrist.

She sustained injuries in two motor vehicular accidents, both of which were associated with cerebral concussions, as well as muscular injuries. The musculoskeletal injuries should be addressed by a board certified orthopedist.

The patient does respond affirmatively to the Clinical Dementia Rating Scale consistent with a cognitive impairment. She has a history of headaches after both accidents.

There is also a prior slip and fall accident down a staircase in 1993 and another slip and fall incident while in a 99¢ Store, which should be addressed by an orthopedist.

The patient reports ongoing headaches at the back of the scalp; muscle tension in type. As mentioned, she responds affirmatively to the Conventional Rating Scale, which qualifies her for a rating from Table 13-6.

She complains of dizziness associated with anxiety.

## PAST MEDICAL HISTORY:

The past medical history is positive for hypertension, anxiety, depression, a heart murmur since childhood, visual loss in the right eye and two motor vehicular accidents.

## CHIEF COMPLAINTS:

From a neurological perspective, the patient states that she has ongoing difficulty with memory and concentration. She reports dizziness.

She reports frequent occipital tension headaches rated as a 7 (out of 10). The patient reports musculoskeletal complaints which I will defer to an orthopedic examiner. She reports frequent tingling and numbness in the right hand and a sensation of weakness in the lower limbs.

## CURRENT MEDICATIONS:

The patient is currently taking lisinopril and nabumetone.

## SOCIAL HISTORY:

| | | |
|---|---|---|
| HABITS: | Tobacco: | The patient does not smoke cigarettes. |
| | Alcohol: | The patient drinks alcohol "very occasionally." |

## ACTIVITIES OF DAILY LIVING:

The patient reports urinary frequency. She reports difficulty bathing, grasping, lifting, writing, flying, driving and impaired sleep due to pain, anxiety and depression. She averages four to five hours of sleep per night.

She has difficulty with vision, standing, sitting, walking, climbing stairs, writing and seeing.

She scores 8 (out of 24) on the Epworth Sleepiness Scale.

Her headache complaints are described as follows.

Table 18-4:
I – A7, B9, C4, D9 and E7.
II – A5, B7, C3, D4, E3, F7, G6, H5, I5, J5, K5, L5, M4, N3, O not applicable and P7.
III – A6, B5, C6, D6 and E8.

## NEUROLOGICAL EXAMINATION:

CRANIAL NERVE EXAMINATION:

Cranial nerves II-XII are serially tested. The patient shows external strabismus of the right eye. She can barely count fingers over the right superior, inferior and lateral temporal quadrants. She has no visual acuity / visual fields of the right nasal superior and inferior quadrants. The left eye shows full visual fields and visual acuity of 20/30.

MOTOR EXAMINATION:

There is a normal motor examination.

X

SENSORY EXAMINATION:

The patient shows diminished sensation of the bilateral upper limbs in the C7 distribution.

DEEP TENDON REFLEXES:

All reflexes are 1+.

COORDINATION:

Finger-to-nose testing was normal.

PATHOLOGIC REFLEXES:

Babinskis are absent.

GAIT AND STATION:

The patient has a broad-based gait. The gait is mildly unstable. Romberg tests are negative.

CERVICAL SPINE EXAMINATION:

There is straightening of the cervical lordosis with spasm and tenderness. Examination of the trapezius reveals bilateral spasm and tenderness in the trapezial musculature.

## REVIEW OF MEDICAL RECORDS:

***Pages Reviewed: 192***

Compromise and Release dated 11/06/18, w/DOI: CT: 12/30/14-04/16/16. Back, lower extremity, body system, abdomen, liver & kidney disease. Employed by D'Veal Family and Youth Services. as a Therapist. Settlement amount $24,000.00.

10/02/15 – Letter by Terre Jay Watson, DO/Optometrist at Kaiser. Pt was under this examiner's care for vision examination today. Due to concerns about best corrected visual acuity for each eye and limitations in peripheral vision. Recommended that pt self restrict driving to daytime and street, rather than night or freeway.

06/21/17 - F/u Orthopedic Eval Jonathan Nissanoff, MD/Orthopedic Surgeon at Advanced Ortho Ctr. DOI: 12/30/04-04/16/16. Pt worked as a marriage and family counselor therapist for 12 years. She sustained a CT injury while working there. She has pain from repetitive use of arms, neck and low back, sitting, standing, and walking. Has numbness in RUE. Has stiffness and swelling. Has pain, 9/10 and numbness in fingers. Uses cane, crutches and braces. Currently not

working secondary to pain. Had surgery on L ankle that she sustained from a non-industrial accident. Currently wearing a brace on L ankle that she feels has been aggravated since CT injury. She has been traumatized from work by her boss, who had threatened, her, and would like to have a psychiatric evaluation. Denies any prior injuries to claimed body parts. ROS: Has general fatigue, weight gain, and arthritis. Has high BP. Has anxiety and depression. Has numbness. Denies epilepsy, convulsions, or neurologic problems. PE: L/S: Gait and posture WNLs. Positive tenderness and spasming in lower lumbar region with pain on extension and lateral bend, and with full flexion. Negative tenderness in the posterior superior iliac spine region. Motor: 5/5 to all muscle groups of LE. Walking on the tiptoes is performed without difficulty. Walking on the heels is performed without difficulty. Deep tendon reflexes: L knee, R ankle and L ankle is +2. Flexion 60. Extension 30. Rotation: B/L 15. Lateral bend: B/L 30. BLE: Negative SLR B/L in supine and sitting position. Neurovascular status is intact. C/S: Tenderness and pain with extension and lateral bend. Negative Spurling's test. Negative tenderness over the paracervical musculature. Negative muscle spasms. Motor: 5/5 to all muscle groups of UE. Sensation is WNLs over UE. Reflexes: Biceps, triceps and brachial radialis +2 B/L. ROM: Flexion is chin to chest. Extension 30. Lateral Bend: B/L 30. Rotation: B/L 75. L Knee: Negative quads atrophy, effusion and crepitus. Positive medial and lateral joint line tenderness. Well-healed scar from meniscectomy. Negative patellofemoral facet tenderness, apprehension, varus valgus laxity, McMurray test, Lachman and pivot shift. ROM: Flexion: B/L 135. Extension: B/L 0. L Ankle/Foot: Positive medial and lateral joint line tenderness. Well-healed scar. Neurovascular status is intact. Negative swelling, too-many-toes sign, tenderness over the plantar fascia, tenderness over the anterior talofibular ligament, tenderness over the Achilles and Thompson test. ROM: Dorsiflexion an Inversion: B/L 30. Plantar Flexion: B/L 40. Eversion: B/L 10. Dx: 1) S/p non-industrial L ankle fracture. 2) S/p ORIF, L ankle. 3) Aggravation work-related injury for L ankle. 4) L knee non-industrial meniscectomy. 5) R/o arthrosis. Aggravated by work. 6) LBP. 7) Cervical pain. 8) R shoulder pain. 9) Rotator cuff tendonitis. 10) R elbow and wrist pain. Rx: Naprosyn 550 mg and Prevacid. Plan: Requested PT, pain management consult for CESI and LESI, psych eval and x-rays of B/L ankle, B/L knee, C/S, L/S, R shoulder and neck. Dispensed cam walker and TENS unit. TTD. Causation: Directly work related injury.

10/25/17 - WC Pain Management F/u Eval by Jonathan Nissanoff, MD. Pt c/o chronic LBP, 8/10. (Partial Document).

02/28/18 - PQME Comprehensive Orthopaedic Eval by Gregory T. Heinen, MD/Orthopedic Surgeon at California Sports and Cartilage Institute. DOI: 04/16/06. Pt sustained CT injury from 12 years of employment. Developed pain to from repetitive use of UE and LE. Drives significantly to clients homes going in and out of cars. Drives to clients 5 times per week. Have to climb up and down stairs of clients home 1-2 short flights of steps per day. Have to type intake reports everyday 2-3 hours/day. Also developed psyche issues. Seen a doctor for eyes. She did not like driving freeways as eyesight changed. She was getting nervous about this and joined carpools. She suffered harassment from one of her co-workers (CEO of the company). She states that he got into her face and pushed a phone to her face. Unable to go to work for the next 2 days. She is paranoid at this time if anyone gets close to her. CC: Intermittent neck pain, radiates

down back. She has to turn neck slowly. Back pain is debilitating. Unable to move when back gets stuck. She can have this shoot down her back. Sometimes can hardly walk. B/L shoulders have constant aching to the top of shoulders, radiates down to elbow for both shoulders. No N/T, locking/catching, or popping. B/L hands have stiffness, locking and painful. No N/T. Stiffen and she cannot move them. B/L knees has swelling and constant ache. Unable to walk at times and are more frequent. Feels instability in both knees. Feels balance is an issue. No numbness N/T. PMH: HTN. PSH: Eye surgery at 20 years, L ankle and L knee meniscectomy surgery. Current Meds: Ibuprofen 800 mg, Gabapentin 100 mg. Social Hx: Alcohol occasionally. Currently smokes 3 cigarettes/day. ROS: No N/T except sometimes into the hands. Vitals: BP 148/88 and Wt 213. PE: Alert and orientated. C/S: ROM: Flexion 42, extension 18, rotation B/L 60, lateral tilt right 28 and left 14. There is no tenderness, swelling, spasm or atrophy to the neck specifically. Tenderness to B/L trapezii muscles. Foraminal compression tests do not elicit any radicular symptoms. Spurling's test for cervical radiculopathy is negative B/L. Compression and percussion over the brachial plexus in the supraclavicular fossa, Adson's maneuver, modified Adson's maneuver and Roos' elevated arm stress tests are negative B/L for brachial plexopathy, including thoracic outlet syndrome. R shoulder: No atrophy or deformity. There is tenderness over the coracoacromial arch. Hawkins/Neer impingement signs are positive. Has minimal weakness of the rotator cuff. Jobe's test for supraspinatus tendinopathy is positive. Resisted external rotation with the arm at the side is negative for infraspinatus tendinopathy. Lumbar lift-off test is negative for subscapularis tendinopathy. No biceps TTP. Speed's test is negative for bicipital tendinitis. Testing for instability of the biceps tendon is negative. O'Brien's test is negative. No AC joint tenderness. Horizontal adduction and compression test is negative for AC joint arthritis. No scapular winging. Examination for anterior instability reveals there is a negative anterior drawer test and negative load/shift test. There is a negative Apprehension/Relocation test. There is no excessive anterior translational laxity. Testing for multi-directional instability shows there is a negative sulcus sign and no evidence of generalized ligamentous laxity. There is no excessive anterior or posterior translation. L shoulder: No atrophy or deformity. Negative Hawkins/Neer impingement sign. Has no weakness of the rotator cuff strength. Jobe's test for supraspinatus tendinopathy is negative. Resisted external rotation with the arm at the side is negative for infraspinatus tendinopathy. Lumbar lift-off test is negative for subscapularis tendinopathy. Speed's test is negative for bicipital tendinitis. Testing for instability of the biceps tendon is negative. Horizontal adduction and compression test is negative for AC joint arthritis. No scapular winging. Examination for anterior instability reveals there is a negative anterior drawer test and negative load/shift test. There is a negative Apprehension/Relocation test. There is no excessive anterior translational laxity. Testing for posterior instability shows the load/shift test is negative and there is a negative posterior apprehension sign. There is no excessive posterior translational laxity. Testing for multi-directional instability shows there is a negative sulcus sign and no evidence of generalized ligamentous laxity. B/L Elbow: There is no ulnar nerve instability. Passive elbow flexion and percussion tests are negative for cubital tunnel syndrome. There is no pain distal to the lateral epicondyle with resisted forearm supination and wrist extension found with radial tunnel syndrome. Resisted wrist flexion causes no discomfort over the medial epicondyle. The biceps tendon is intact at its insertion. There is no ligamentous instability to varus/valgus stressing of

the elbow. Has full active flexion and extension of elbow against resistance without difficulty. Provocative testing for medial nerve entrapment by lacertus fibrosis, pronator teres or flexor digitorum superficialis is negative. Pronator compression and percussion tests are negative for proximal forearm median nerve entrapment. B/L Wrist: No stiffness today. There is no swelling. Minimal volar tenderness about the wrist but without provocative testing today. There is no tenderness along the first extensor compartment and Finkelstein's test is negative for de Quervain's tenosynovitis. Has no pain over the 1st, 2nd or 3rd extensor compartments or in the area of intersection syndrome. There is no pain, crepitus or hypermobility with manipulation of the distal radioulnar joint. Has no tenderness over the triangular fibrocartilage. Has no pain with forced ulnar deviation of the wrist found with ulnar abutment syndrome. Triquetrolunate ballottement, Pisotriquetral grind, Watson's scaphoid shift test are negative. Thumb metacarpal axial grind test is negative for CMC arthritis. No Tinels or Phalens. Distally neurovascularly intact. T/S: Tenderness from T8-T10. No spasm is noted. Lumbosacral Spine: L/S is tender at lumbosacral junction. There is mild spasm. There is sacroiliac joint tenderness. FABER test is equivocal. ROM: Flexion and extension with pain and lateral bend right 26, left 32. Seated SLR is negative B/L to 60 degrees. Supine SLR is negative B/L in that there is no leg pain with SLR maneuver. Passive hip ROM is symmetric and painless. No tenderness or buttock pain. R Knee: ROM: Extension 0/0, and flexion 110/130. There is no effusion. While standing, does not have excessive varus or valgus alignment. There is patellofemoral crepitus. No patellar instability. Patella tracks well clinically. There is no tenderness around the patellofemoral joint. Patellofemoral compression test is negative. Q-angle is normal. Has no instability to varus/valgus test in full extension, 30 degrees or 90 degrees of flexion. Testing for anterior cruciate ligament instability shows that the Lachman, anterior drawer and pivot shift tests are negative. Testing for posterior cruciate ligament instability shows that the posterior drawer test, posterior sag sign and quadriceps active tests are negative. There is no tenderness over the medial or lateral joint line. Negative McMurray's test. Compression/rotation test is negative for a meniscal tear. Has full extension against resistance without difficulty. L Knee: Reduced flexion. There is no effusion. While standing, does not have excessive varus or valgus alignment. There is patellofemoral crepitus no patellar instability. Patella tracks well clinically. There is tenderness around the patellofemoral joint. Patellofemoral compression test is positive. Q-angle is normal. Has no instability to varus/valgus test in full extension, 30 degrees or 90 degrees of flexion. Testing for anterior cruciate ligament instability shows that the Lachman, anterior drawer and pivot shift tests are negative. Testing for posterior cruciate ligament instability shows that the posterior drawer test, posterior sag sign and quadriceps active tests are negative. There is tenderness over the medial > lateral joint line. Negative McMurray's test when loading the compartments. Compression/rotation test is positive for a meniscal tear. Has full extension against resistance without difficulty. R Ankle: Full ROM and normal examination no provocative testing. No tenderness. L Ankle: Stiff ROM with crepitation. There is crepitus with motion. Healed scars noted. There is medial and lateral tenderness and swelling. No atrophy or palpable abnormalities. The anterior drawer test is negative. There is no lateral ligamentous laxity but does elicit some pain. Foot: There is no deformity of the feet. There is a flat longitudinal arch. There are no areas of tenderness of the foot proper. Toes are all warm and pink with brisk capillary refill. Thompson's test is negative for Achilles tendon rupture. Has good/intact dorsiflexion and plantar

flexion strength against resistance. Distally neurovascularly intact. Dx: 1) C/S degenerative arthritis without radicular symptoms. 2) Reported C/S strain/pain. 3) B/L shoulder degenerative arthritis right greater than left. 4) B/L hand CMC joint mild degenerative arthritis/numbness. 5) T/S degenerative arthritis. 6) L/S degenerative arthritis with radicular symptoms. B/L knee degenerative arthritis left greater than right. 7) L ankle severe degenerative arthritis s/p fracture s/p surgical intervention and fixation. 8) R ankle mild degenerative changes. 9) S/p R foot metatarsal fractures. 10) Reported stress reaction-stress associated pain. 11) Reported visual changes. Discussion: Clearly the arthritis and issues to claim body parts are preexistent to the reported CT. Pt has diffuse arthritis throughout her body. This even in places that are unlikely to develop that, such as shoulders. Body habitus is noted, which is a significant contributing factor to development of arthritis. Pt's preexistent arthritis, associated limp, and resultant malalignment is also a further contributing factor due to the pt's LE. Unable to give a specific mechanism of injury to cause further injury to BLE or spine at work. In reviewing pt's job duties with the description provided, this examiner was not impressed that this was very physical. There is no overwhelmingly repetitive job activity or significant lifting that can account for her issues. Do not have a mechanism to account for the C/S, T/S and L/S arthritis except for those things that are specific to pt and her personal lifestyle and unrelated to work related activities. Care for the pt's B/L ankles, R foot and knees should be treated directly as result of 2007 injury that has been settled by C&R. This examiner does not recognize her shoulder injuries as result of CT. Pt did do several hours of paperwork in computer work per day and this examiner believes this is a reasonable mechanism to contribute to both CMC joint arthritis as well as the possibility of CTS in her hands. Work Restrictions: Hands and wrists should be precluded from very forceful use of B/L hands. Shoulders should be precluded from repetitive over shoulder activities. Spine should be precluded from very heavy work. LLE should be precluded from prolonged standing and walking, no squatting and kneeling or climbing. Vocational Rehabilitation: If the restrictions for the hands cannot be met, pt would be considered a qualified injured worker. Impairment: R arm: 9%. RUE: 5%. LUE: 5%. C/S: 6%. T/S: 0%. L/S: 7%. R knee: 7%. RLE: 3%. L knee: 28%. LLE: 20%. UE: 8%. LE: 22%. Spine: 13%. Total WPI: 38%. Apportionment: Shoulders, spine, knees, ankles and feet are 100% to non-industrial issues, or are the result of her previous injuries and subsequent C&R. Hands felt work related by the Trier of Fact, 70% to work activities and 30% to personal non industrial issues. Future Medical Care: Should have evaluation from orthopedic surgeon, meds, injections, PT, diagnostic studies and possible surgical intervention.

**10/19/17 - Deposition of Floreen Sharon Rooks, Volume 1 (77 pages)**

Page 7: The patient prepared for 45 minutes to an hour with Miss Foley for today's deposition who drove her to the deposition. She is currently unemployed.
Page 10: She testified to have a previous deposition many years ago.
Page 11: In the previous deposition, she was a party bringing a claim. About 30 years ago, she slipped at a 99 Cents Store because there was water on the floor and sustained injury to her left leg.

Page 12: She fully recovered from the injury. She was currently having health insurance with Medicare and Medicaid. Currently, her personal medical physician was Dr. Ching, with Kaiser in Pasadena, California.
Page 13: She had been visiting her personal medical physician for about 10 years. She started working for D'Veal Family Youth Services in Pasadena in December 2004 and last worked on April 16, 2016 and had not been employed since then. Her occupation was Marriage and Family Child Therapist. She first started working at Fair Oaks Avenue and then switched to 855.
Page 15: She worked 5 days a week, Monday through Friday.
Page 16: She had a fixed time schedule from 9:30 to 6:00, sometimes she would stay later. She worked in an intake department where lots of clients came in and also had community clients come in, total of around five to seven. She did intake for new patients coming to D'Veal Family and Youth Services.
Page 17: She had more than one job in intake and had different jobs. Particular job in intake was when a person comes in she had to qualify them to receive mental health service for person coming in with psychological history or medical history.
Page 20: She traveled all over. She would give therapies at job location as well as people's home. She concurrently worked at the University of Phoenix teaching a class for three to four months, called Facilitating a class.
Page 21: She took classes about intakes and family therapy in Pasadena. She was no longer working for D'Veal Family Youth Services.
Page 22: She was terminated. She felt she was being discriminated against.
Page 24: She had an accident on her job and injured her left foot.
Page 25: She was currently treating with Dr. Nissanoff and started seeing him from June of this year. She had complaints with neck, low back, right shoulder, right upper arm, right hand, right wrist, right thumb, left ankle and right foot. She has more pain in left foot than right foot. Due to injury at D'Veal Family and Youth Services, she started having headaches.
Page 26: Her shoulder was hurting, arms and fingers got stiff, got lot of stress in her lower back, hard to bend down. The strain on the left side of her legs was causing more pain on the right side.
Page 27: She had stress in the entire back. She had nuts and bolts in the left ankle, which hurts and was causing more stress in the right side of her body.
Page 28: She had a work-related accident in 2006, while working at D'Veal, where she broke toe in her left foot in two places and ended up having a torn meniscus in her left knee.
Page 29: She had issues to the right side of her body. She had problems with headaches, both shoulders, both arms, fingers on both hands, entire back; neck gets stiff, left ankle and both feet.
Page 30: She had a lot of stress, psychologically as she was harassed by the CEO. She suffered with PTSD symptoms and has nightmares when she thinks about this man and had to leave her job for a couple of days before she came back to work. She alleged psychological injury.
Page 32: She had a change in vision since she started working at D'Veal. She noticed worsening of sight in distance and close by or one of the two. She visited Optometry at Kaiser Permanente in Pasadena.
Page 33: She claimed that certain injuries accumulate over time. She never felt having these symptoms before being hired for this job. At a specific incident at work, she injured her left foot, broke two toes, her left knee and torn meniscus.

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Page 34: At work, in the process of transporting clients to an event, she torn meniscus and broke toes in left foot.
Page 35: In the event, her car was rolling, getting ready to roll into the street, she had to jump in her car and pull up the brake more, while doing that her left foot flipped over and her knee hit the ground.
Page 36: She believed that the issues with her shoulders, arms, spine, fingers and feet are the result of physical nature of the job duties and stress at work.
Page 37: Her job was fluctuating from week to week. She could be spending more time outside the office and other weeks more inside the office. She used personal vehicle to visit clients and was reimbursed.
Page 38: She does not require much lifting, just the books and files.
Page 39: Her job required climbing a two story building, which got difficult at a point.
Page 40: She would sometimes climb upstairs to the second floor practically to MIS department. Sometimes she would need help.
Page 41: She sometimes had to do climbing outside office. They had a client that worked at the racetrack. She typed every day. She had to type notes, reports and her intakes all the time.
Page 42: She is a right-handed dominant. After being hired at D'Veal, she first noticed symptoms in her back in the last couple of years.
Page 43: Patient has problems bending down which she noticed in the last couple of years. She cannot trace any particular event when it started.
Page 44: Her neck pain was like a gradual, insidious onset pain that started about two years ago.
Page 45: She complained about back and neck pain to her colleagues and started monitoring in between 2014 to 2016 and she developed shoulder pain around the same time. She has an insidious onset of shoulder pain.
Page 46: She had stiffness in her fingers, they would lock up. She was referring to her right hand middle and index finger and thumb locking up and feels stiffness.
Page 47: She had stiffness and locking up in her left hand middle and index finger and thumb, which started several years before she was terminated. She also has issues with her upper arms. Noticed tightness, an ache and a sharp pain that happened gradually.
Page 48: She was stressed out on a particular day due to tingling pain. She feels achy in her upper arm.
Page 49: She had symptoms in her left foot since the event where she had to jump onto the car as it was moving. She had pain in the right side of her body.
Page 50: She testified that she had difficulty walking like to hold on certain things. On the other day, she was trying to walk down the street trying, she tried to grasp on things that she could hold onto.
Page 51: She felt the entire right side of her leg was going off balance and hard to walk. She is unable to do stuff she used to do before like dancing and feels difficult to walk even one block.
Page 52: She used to drive for her job during the day. She feels off balance while walking.
Page 53: She feels off balance even at home while doing activities while walking or standing. When she took pain killers, she felt like getting ready to stumble.
Page 54: She experienced pain in her right foot while working for D'Veal and nowadays. She had a surgery to her left knee when she had torn meniscus in 2006.

Page 55: She had left ankle surgery on her left foot in 2006 when she had an incident with a moving car. Her foot was casted and fractures were healed.
Page 56: The accident that happened at her job, she injured her two toes and knee.
Page 57: She had a surgery in her left ankle before she worked for D'Veal, as she broke her ankle, had screw and plate installed. Ever since surgery she had swelling in her left ankle. Sometimes she had difficulty walking without holding onto something. She sometimes uses a cane.
Page 58: She is using a cane to balance ever since she has been working with D'Veal. Did not use the cane when she was first hired, but started using it after being hired. It helped her with walking.
Page 59: She was hired at D'Veal in 2004 and met with an accident in 2006. Until her accident with the car, she did not use the cane. Since 2006 accident, she had been having symptoms in her left ankle
Page 60: Her accident was covered by Workers' Comp. Before the patient was fired at D'Veal, she had treatment for her left knees and toes of her left foot because of her 2006 accident.
Page 61: Whenever patient would visit a doctor at Kaiser for her back, neck, and shoulder, she would complain about stress and have some days off from that.
Page 62: She had stress that was attributed to the symptoms of neck, back and shoulder.
Page 63: She stated that she had stress emotionally and also physical stress.
Page 65: Currently, she was seeing Dr. Nissanoff due to the complaint of back pain. She reported stress to her regular physician. She had stiffness and locking of fingers altogether.
Page 66: She received Workers' Comp settlement for the case from 2006.
Page 68: Before she was fired, she complained verbally to her supervisor, Rafaela about her symptoms in her back, neck, eyes, shoulders, hands, fingers feet and her vision. She showed a letter from the eye doctor. She also complained about her harassment at her job.
Page 70: She complained about her to her supervisor, Rafaela Velgado in 2015 or early 2016.
Page 71: Due to the eye issue, doctor gave limitations of not to drive at night, as her work was to drive at night.
Page 73: Currently, she was having back pain, not being able to walk up the steps.

## CLINICAL IMPRESSIONS:

1. Blindness in the right eye.
2. History of post-traumatic head syndrome, no industrial causation.
3. Post-traumatic headaches, no industrial causation.
4. Bilateral cervical radiculopathy, no industrial causation.
5. Gait instability, no industrial causation.
6. Lack of depth perception, no industrial causation.
7. Heart murmur and hypertension, no industrial causation.
8. Anxiety and depression, no industrial causation.
9. Multiple orthopedic complaints to be addressed by a board certified orthopedist.

## DISCUSSION AND RECOMMENDATIONS:

This is a 71-year-old female with multiple longstanding orthopedic and neurologic complaints, as well as internal medical complaints, unrelated to her employment.

The Panel Qualified Medical Evaluator in orthopedic surgery identified pre-existing nonindustrial complaints related to arthritis of the spine, knees and shoulders. He states that she had significant visual impairment of the right eye, cognitive complaints from two motor vehicle accidents, in which she sustained concussions, headaches and the unstable gait. She shows evidence of bilateral C7 radiculopathy which qualifies for a Diagnosis-Related Estimate Category III rating.

The patient's deposition was reviewed in which she described her employment and job activities. She did admit to a history of headaches, multiple musculoskeletal complaints, a prior left foot injury from work and emotional distress at work which should be evaluated by a board certified psychiatrist of the parties choosing. She described shoulder pain, upper limb pain and gait difficulty likely related to lack of visual depth perception.

She was also evaluated by an orthopedist on June 21, 2017, Dr. Nissanoff, who reported numbness of the right upper limb. She showed full motor strength. She had a nonindustrial left knee injury and also a left ankle injury that was aggravated by her work.

With respect to the patient's nonwork related injuries, in my opinion the patient qualifies for a 12% whole person impairment due to a class 1 metal status impairment (Table 13-6) with 100% apportionment of permanent disability due to the patient's nonindustrial motor vehicular accidents.

For the patient's post-traumatic headaches, in my opinion she qualifies for a 3% whole person impairment per chapter 18, with 100% apportionment of permanent disability to the injury of her two nonindustrial motor vehicular accidents.

For cervical radiculopathy, in my opinion the patient qualifies for a Diagnosis-Related Estimate Category III rating from Table 15-5 with a 17% whole person impairment and 100% apportionment of permanent disability to long standing degenerative arthritis of the cervical spine.

For the patient's visual loss of the right eye, as well as loss of visual fields, both impairment are addressed from Tables 13-9 and 13-10 for visual acuity loss of the right eye. Practically speaking, the right eye is blind and qualifies for a Class III rating of 49% which also takes into consideration the patient's visual field loss. This can further be addressed by a board certified ophthalmologist.

For the patient's gait disturbance, in my opinion this is related to loss of depth perception. In my opinion, she qualifies for a 5% whole person impairment from Table 13-15.

In my opinion, given the magnitude of the patient's impairments and synergistic effect addition, rather than combined values as allowed for by the Kite case should be utilized to address her visual disturbance, cognitive disturbance and headaches, as well as gait disturbance, all of which can impact each other.

Forty-nine percent plus 12% equals 61%. Sixty-one percent plus 5% equals 66%. Sixty-six percent plus 3% equals 69%. Sixty-nine percent is combined with 17% which equals 73%. The patient's final whole person impairment is 73%.

KITE provides a more accurate assessment of the patient's impairments by adding rather than combining.

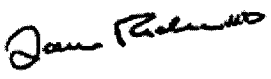
If I can be of further assistance regarding this case, please do not hesitate to contact this office.

## SOURCE OF ALL FACTS AND DISCLOSURE:

The source of all facts was the history given by the examinee and review of the previous examiner's medical reports. I personally interviewed the examinee, performed the physical examination, reviewed the history with the examinee, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions and recommendations. Face-to-face time conformed with DWC Guidelines. I declare under penalty of perjury that the information contained in this report and its attachments, if any, are true and correct to the best of my knowledge and belief, except as to the information that I have indicated and received from others. As to this 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. Labor Code 139.3 was not violated. Assistance with preparation of this report was provided by Isabel Mendoza, Assistant and Rapid Care, Record Summarizer, each of whom were trained by Arrowhead Evaluation Services, Incorporated. Please note that all times listed reflect physician time spent and not staff time.

Date of Report: December 14, 2020. Signed this 7th day of January, 2021 at San Bernardino County, California.

Yours truly,



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