MEDICAL DOCUMENTATION: DO NOT DETACH
Narrative Review - New Patient

U.S. HealthWorks
3200 Inland Empire Blvd.
Suite 100
Ontario CA 91764 - 5513
Ph: 909 945-5011

Date of Service:	07-20-2018	**Insurance:**	STATE COMP (FRESNO)SOUTH
Patient Name:	SOOHOO, GEROGE	**Claim #:**	
Patient Account Number:	124371402		
Date Of Injury:	07-06-2018 12:30		
Date Of Birth:	11-28-1953		
Employer Name:	CIM/CALIF. INSTITUTION MEN		
Chart #:	EMR LR		

History Of Present Illness:

A 64 year old male, working as a SUPU DENTIST, states "walked off grounds of cim july 6 stressed from embarrassment humility and open degradation in front of all dental staff felt fatigue drpressed loss of enery unable to sleep and no desire to do anything went to on7/13 blood pressure was 180/96." I have reviewed the patient's complete health history and the review of systems obtained on 07-20-2018 included in the medical record. No chemical or toxic exposure was reported. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. There was a specific event of an injury or illness. walked off grounds of cim july 6 stressed from embarrassment humility and open degradation in front of all dental staff felt fatigue drpressed loss of enery unable to sleep and no desire to do anything went to on7/13 blood pressure was 180/96. There are no known prior acute trauma or cumulative trauma to the affected body part. There has been no ongoing treatment for the prior trauma or exposure. There are no known related hobbies/sports complications.

Present complaint
Severity: On severity scale, the pain is 8 out of 10.

Psych Complaints/Symptoms
Complaint: Patient's complaint at this time is as follows: stress at work The primary presenting symptom is insomnia . He says it is moderately severe. He reports having symptoms for 14 days. The frequency is constant.
Associated Symptoms: The patient denies a history of suicidal ideations. The patient denies any suicide attempts. The patient states no history of self injurious behaviors. There is no history of homicidal ideations. The patient denies a history of mood swings. Patient denies increased incidents of crying. There is no history of anger or temperament issues. The patient denies auditory hallucinations. The patient denies visual hallucinations. There is no history of blackouts. The patient denies memory loss or forgetfulness. The patient denies confusion. The patient denies any difficulty with concentration. The patient has no complaints of myalgia. The patient denies headaches. The patient denies feeling tremulous or shaky. The patient denies insomnia or sleep disturbances. The patient denies a history of nausea and vomiting. There is no history of diarrhea or constipation. The patient states there is no loss of appetite. The patient denies abdominal pain. There is no history of chest pain or palpitations. The patient denies any dyspnea. The patient does not complain of any skin conditions.

Relevant History NOTES:
Dominant hand is right. Patient denies history of ulcers or gastritis.

Relevant History NOTES: Last tetanus - unk.

Occupational history: Length of employment is reported as 10 years or more. He works 40 hours per week. Main job characteristics include sit down job, prolonged standing or walking, kneeling or squatting, bending, climbing and operating hand tools/machinery,
He denies any lost work-time as a result of this injury. He denies any other source of employment.

Past Medical:
Surgeries: No Known Surgical History

Medical History:
Dominant hand is right. Patient denies history of ulcers or gastritis. High Blood Pressure () . Diabetes () . Permanent disabilities () hearing l ear .

Tetanus History:
Last tetanus - unk.

Family Social History:
Family History: Non-contributory Family History.
Social History: Alcohol or Tobacco use: He does not use tobacco. Denies alcohol use.

Review Of Systems:
A complete review of systems was performed as noted below.
Constitutional Symptoms: Constitutional Symptoms - current - not under treatment.
Cardiovascular symptoms: Cardiovascular symptoms - current - not under treatment.
Head: Trauma, injuries or frequent or severe headaches current - not under treatment.
Ear, nose, throat symptoms: Ear, nose, throat symptoms - current - under treatment.
Respiratory symptoms: No respiratory symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Hematological symptoms: No hematological symptoms.
Skin symptoms: Skin symptoms - in last 5 years but not currently.
Eye symptoms: Eye symptoms - current - not under treatment.
Genitourinary symptoms: No genitourinary symptoms.
Musculoskeletal symptoms: Musculoskeletal symptoms - current - not under treatment.
Endocrine symptoms: No endocrine symptoms.
Neurological symptoms: Neurological symptoms - current - not under treatment.
Men only: No penile discharge, prostate problems, genital pain or masses.

Current Medications at the start of Encounter:
amlodipine
clopidogrel
losartan
metformin
Allergies:
Lisinopril Allergy . Asprin Ec Low Dose Allergy .

Patient Report Of Injury
Injury Details: Patient states injury or condition was caused at work. Injury was reported to:: DR. JEFF LISSY Date: 07-18-2018. Time: 7:00 AM.

Physical Examination:

Height: 60 inches. Weight: 185 lbs. **BMI:** 36 Pulse: 87/min. Blood Pressure: 160/93 mmHg. Temperature: 98.8 deg

F Respiratory rate: 16 per min.

Constitutional: The patient is a well-developed, well-nourished male.
Psychiatric: He is alert and oriented to person, place and time . There is no history of psychiatric illness. There is no history of substance abuse.
Mental Status Exam: The patient's memory appears intact . The patient states their mood is not abnormal. The patient's affect is within normal limits . The patient denies insomnia . The patient has no complaints of appetite disturbance or eating disorder . There are no complaints regarding loss of energy . The patient denies loss of libido . The patient denies suicidal ideation . The patient states there is no homicidal ideation . The patient is not inappropriately dressed or disheveled. The exam reveals that the patient's behavior is not uncooperative, distant, or hostile . The patient states that thought processes are normal. The patient exhibits no abnormal thought content. The patient's speech is within normal limits .

Eyes: Pupils are equal and reactive to light and accommodation . The conjunctiva and sclerae show no signs of inflammation . There is no excessive lacrimation noted . There is no exopthalmos . Peripheral vision appears normal . The red reflex is present.

Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The chest cavity has no deformities; there is no kyphosis .

Skin: The patient is not diaphoretic. The patient is not cyanotic. There is no skin pallor . The patient has no rashes or dermatitis . There are no suspicious skin lesions noted.

Endocrine: The neck exam is negative for thyromegaly . The thyroid is non-tender on palpation . There is no evidence of thyroid nodules or masses .

Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities . The examination of the spine reveals no abnormality . Examination of the extremities is grossly within normal limits . There is no weakness of the lower extremities .

Cardiovascular: The heart rate is normal . Heart rhythm is not irregular. No heart murmur was auscultated . Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . There is no pretibial or pedal edema . Upper extremity pulses are within normal limits . Pulses of the lower extremities are within normal range .
Neurologic: Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits . There is no evidence of tremors, tics or muscle twitching . Motor retardation is not noted on the exam . There is no weakness of the upper extremities.

Diagnostic Tests:

Medical Necessity:

Internal Lab Orders:

External Lab Orders:

Diagnoses
Stress at work (Z56.6)

First Aid: This is not a first aid claim.

Causation: The findings on exam and diagnosis are consistent with the injury reported by patient. Prior factors such as injuries / medical conditions / diseases / prior activities or exposures are not contributing to the findings. The findings can not be possibly produced by natural progression of pre-existing conditions or aging. The reported injury / exposure is not causing an aggravation to the above pre-existing condition. In conclusion, the reported injury, more likely than not, is causing the current symptoms and findings.

Treatment Plan:

Last Saved By: Admin Admin 07-20-2018 11:03 PST

Dispensed Medications:
Prescribed Medications:
Current Medications at Close of Encounter:
amlodipine
clopidogrel
losartan
metformin
Medications Completed or Stopped:

Supplies:

Overhead Supplies:

Treatment Plan Narrative:

Expected Maximum Medical Improvement (MMI) date 09-07-2018. Narcotics were not prescribed. Pt engaged in several EOP claims against him as a supervisor. He is suffering embarrassment, stress, anxiety, insomnia and high blood pressure due to the conditions at work. I will ask his employer to transfer him to a different facility to help alleviate this stress. RTC 2 weeks.

Work Status:

Patient is advised to return to work without restrictions.

Work Restrictions:

Other restrictions: Pt is to avoid current work environment. Please transfer to a different facility..

Therapeutic Services:

Patient Education:
Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

Referral/Evaluation: A Psychiatry evaluation has been ordered. The reason for evaluation is work place stress.

Michael Fleming, P.A.
This has been electronically signed on 07-21-2018

Keith Wresch M.D.
Supervising Provider

Next Appointment with Fleming Michael on 08-10-2018 10:00 am.

Encounter Addendum Notes

US HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Date Generated: 07-20-2018 11:27:56

NAME: Last: SOOHOO	**First: GEROGE**	**Date of Exam: 07-20-2018**	**Case #: 124371402**
Occupation: SUPU DENTIST	**DOB: 11-28-1953**	**DOI: 07-06-2018 12:30**	**Claim #:**
Employer: CIM/CALIF. INSTITUTION MEN	**Contact: ROSALIND RIVAS [HEALTH & SAFETY]**	**Tel.: (909)597-1821**	**Fax: (909)606-7104**
Claims Administrator: STATE COMP (FRESNO)SOUTH		**Tel.: (888)782-8338**	**Fax: (707)573-6504**

DIAGNOSES

Stress at work (Z56.6)

TREATMENT

Physical Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Chiropractic Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Occupational Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Massage Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Acupuncture	() Start () Continue () Renew	() # of visits		() Cancel () Pending
Ergonomic Evaluation	() Start		Other: ()	

Medications:

Consult / Referral:

A Psychiatry evaluation has been ordered. The reason for consult is work place stress.

WORK STATUS

This is not a first aid claim. Patient is advised to return to work without restrictions. Expected Maximum Medical Improvement (MMI) date 09-07-2018.

Work Restrictions:

Other restrictions: Pt is to avoid current work environment. Please transfer to a different facility..

TREATING PROVIDER

Name: **Michael . Fleming,P.A.** Lic. #: **PA21349** Signature (Original)

Specialty: **Occupational Medicine** Date of Exam: **07-20-2018**

M. Fleming PA-C

NEXT APPOINTMENT

Next Appointment with Fleming Michael on 08-10-2018 10:00 am.

Executed at: US HealthWorks 3200 Inland Empire Blvd., Suite 100, Ontario CA 91764 - 5513 Ph:909 945-5011

Check In Time: 09:42 am Check Out Time: 11:27 am

Encounter Addendum Notes

US HealthWorks MEDICAL GROUP

WORK STATUS REPORT

Date Generated: 07-20-2018 11:27:56

NAME: Last: SOOHOO	First: GEROGE	Date of Exam: 07-20-2018	Case #: 124371402
Occupation: SUPU DENTIST	DOB: 11-28-1953	DOI: 07-06-2018 12:30	Claim #:
Employer: CIM/CALIF. INSTITUTION MEN	Contact: ROSALIND RIVAS [HEALTH & SAFETY]	Tel.: (909)597-1821	Fax: (909)606-7104
Claims Administrator: STATE COMP (FRESNO)SOUTH		Tel.: (888)782-8338	Fax: (707)573-8604

DIAGNOSES

Stress at work (Z56.6)

TREATMENT

Physical Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Chiropractic Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Occupational Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Massage Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Acupuncture	() Start () Continue () Renew	() # of visits		() Cancel () Pending
Ergonomic Evaluation	() Start		Other: ()	

Medications:

Consult / Referral:

A Psychiatry evaluation has been ordered. The reason for consult is work place stress.

WORK STATUS

This is not a first aid claim. Patient is advised to return to work without restrictions. Expected Maximum Medical Improvement (MMI) date 09-07-2018.

Work Restrictions:

Other restrictions: Pt is to avoid current work environment. Please transfer to a different facility..

TREATING PROVIDER

Name: Michael . Fleming,P.A. Lic. #: PA21349 Signature (Original)

Specialty: Occupational Medicine Date of Exam: 07-20-2018

M. Fleming P.A.-C

NEXT APPOINTMENT

Next Appointment with Fleming Michael on 08-10-2018 10:00 am.

Executed at: US HealthWorks 3200 Inland Empire Blvd., Suite 100, Ontario CA 91764 - 5513 Ph:909 945-5011

Check In Time: 09:42 am Check Out Time: 11:27 am

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

1. Insurer Name and Address: SCIF. Adjuster: Taylor Sutherland. Fax: 707-646-2711

2. Employer Name: CA Dept. of Corrections & Rehab

5. Patient Name (first N., mid. ini.,last name)			6. Sex	7. Date of Birth	10. Occupation (Spec. job title)
George		Soohoo	M	11/28/1953	M.D. Supervising dentist

13. Date & hour of injury	14. Date last worked	15. Date & hour of 1st exam	16. Have you previously rendered treatment
07/06/2018	07/06/2018	08/27/2018 at 12:00pm	No

18. Subjective Complaints: depression, anxiety, concentration problems, anger, conduct grievances against the

19. Objective Findings: Psychological Examination: MSE, psych tests, Records

20. DIAGNOSES (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?

1. Adjustment Disorder — ICD-10 F43.2
2. — ICD-10
3. — ICD-10
4. — ICD-10

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? If "no," please explain below: Yes

22. Is there any other current condition that will impede or delay patient's recovery? If "yes," please explain below: no

23. TREATMENT RENDERED (Use reverse side if more space is required.): none

24. If further treatment required, specify treatment plan/estimated duration.: psych management

26. If hospitalized as inpatient, give hospital name and location: 0

26. WORK STATUS - Is patient able to perform usual work? ☐ Yes ☐ No

If "no", date when patient can return to: Regular work _____ Modified work precluded from work at CIM

Specify restrictions

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature: Lynne DeBoskey

Executed at: San Diego

Physician Name: Lynne DeBoskey, Ph.D.

Physician address: 2615 Camino del Rio S. #202, San Diego, CA 92108

Cal. License Number: PSY 11397

Date (mm/dd/yyyy): 8/27/18

Specialty: Psychologist

Phone Number (619)523-9225

Form 5021 (Rev. 8) 10/2015

8087

PSYCHOLOGICAL HEALTH CENTER

LYNNE P. DEBOSKEY, PH.D.
PSYCHOLOGIST PSY 11397
QUALIFIED MEDICAL EVALUATOR

2615 Camino del Rio
South #202
San Diego, CA 92108

PHONE: (619) 523-9225 · FAX: (619) 222-0230

1503 N. Imperial Ave.
Suite #103
El Centro, CA 92243

August 27, 2018

SCIF
Adjuster: Taylor Sutherland
Fax: 707-646-2711

Re: Soohoo, George
Claim: 06380832
DOI: 07/06/2018
DOB: 11/28/1953
Employer: CA Dept. of Corrections & Rehabilitation (CDCR)

Work Status Report

As of today and continuing through 60 days, Mr. Soohoo is psychologically able to perform his usual and customary duties as a supervising dentist for CA Dept. of Corrections & Rehabilitation with the restrictions of no patient care, and not working at CIM facility.

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

Lynne DeBoskey, Ph.D.
Psychologist PSY 11397

Lynne DeB, PhD

U.S. HealthWorks
3200 Inland Empire Blvd., Suite 100,
Ontario CA 91764 - 5513
Ph: 909 945-5011

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Patient Name: Last: SOOHOO First: GEROGE MI: M DOB: 11-28-1953 Date of Service: 07-27-2018 Case #: 124371402

Occupation: SUPU DENTIST SS#: 562-78-4407 Date of Injury: 07-06-2018 12:30 Claim #: 06380832

Employer: CIM/CALIF. INSTITUTION MEN Contact: ROSALIND RIVAS [HEALTH & SAFETY] Tel. (909)597-1821 Fax. (909)606-7104

Claims Administrator: STATE COMP (FRESNO)SOUTH Tel. (888)782-8338 Fax. (707)573-6504

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "OTHER" applies, this report qualifies as mandatory)

() Change in patient's condition () Need for referral or consultation () Information requested by:
() Change in work status () Need for surgery or hospitalization () Released from care () Request for authorization
() Change in treatment plan () Periodic Report (45 days after last report) ()Other:

PATIENT STATUS Since the last exam, this patient's condition has:

() improved as expected () improved, but slower than expected (X) not improved significantly
() worsened () reached plateau and no further improvement is expected () been determined to be non-work related

SUBJECTIVE COMPLAINTS

History Of Present Illness: Patient is here for follow up visit for injury sustained on 07-06-2018 12:30. Patient's injury is the same, . Patient is currently on modified duty. There are no new symptoms.

Psych Complaints/Symptoms

Complaint: Patient's complaint at this time is as follows: anxiety continues

Associated Symptoms: The patient denies a history of suicidal ideations. The patient denies any suicide attempts. The patient states no history of self injurious behaviors. There is no history of homicidal ideations. The patient denies a history of mood swings. Patient denies increased incidents of crying. There is no history of anger or temperament issues. The patient denies auditory hallucinations. The patient denies visual hallucinations. There is no history of blackouts. The patient denies memory loss or forgetfulness. The patient denies confusion. The patient denies any difficulty with concentration. The patient has no complaints of myalgia. The patient denies headaches. The patient denies feeling tremulous or shaky. The patient denies insomnia or sleep disturbances. The patient denies a history of nausea and vomiting. There is no history of diarrhea or constipation. The patient states there is no loss of appetite. The patient denies abdominal pain. There is no history of chest pain or palpitations. The patient denies any dyspnea. The patient does not complain of any skin conditions.

Occupational history: Length of employment is reported as 10 years or more. He works 40 hours per week. Main job characteristics include sit down job, prolonged standing or walking, kneeling or squatting, bending, climbing and operating hand tools/machinery.

He denies any lost work-time as a result of this injury. He denies any other source of employment.

OBJECTIVE FINDINGS

Physical Examination:

Pulse: 80/min. BP: 152/79 mmHg. Temperature: 98.2 deg F Respiration: 16 per min.

Severity: The severity of the pain was 8/10.

Psychiatric: He is alert and oriented to person, place and time . There is no history of psychiatric illness. There is no history of substance abuse.
Mental Status Exam: The patient's memory appears intact . The patient states their mood is not abnormal. The patient's affect is within normal limits . The patient denies insomnia . The patient has no complaints of appetite disturbance or eating disorder . There are no complaints regarding loss of energy . The patient denies loss of libido . The patient denies suicidal ideation . The patient states there is no homicidal ideation . The patient is not inappropriately dressed or disheveled. The exam reveals that the patient's behavior is not uncooperative, distant, or hostile . The patient states that thought processes are normal. The patient exhibits no abnormal thought content. The patient's speech is within normal limits .

Eyes: Pupils are equal and reactive to light and accommodation . The conjunctiva and scleras show no signs of inflammation . There is no excessive lacrimation noted . There is no exopthalmos . Peripheral vision appears normal . The red reflex is present.

Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The chest cavity has no deformities; there is no kyphosis .

Skin: The patient is not diaphoretic. The patient is not cyanotic. There is no skin pallor . The patient has no rashes or dermatitis . There are no suspicious skin lesions noted.

Cardiovascular: The heart rate is normal . Heart rhythm is not irregular. No heart murmur was auscultated . Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . There is no pretibial or pedal edema . Upper extremity pulses are within normal limits . Pulses of the lower extremities are within normal range .
Neurologic: Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits . There is no evidence of tremors, tics or muscle twitching . Motor retardation is not noted on the exam .

Diagnostic Tests:

Internal Lab orders:

External Lab Orders:

DIAGNOSES:

Work stress (Z56.6)

TREATMENT PLAN

Office Visit / Injury Treatment:

Physical Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Chiropractic Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Occupational Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Massage Therapy	() Start () Continue () Renew	() times / week for	() weeks	() Cancel () Pending
Acupuncture	() Start () Continue () Renew	() # of visits		() Cancel () Pending
Ergonomic Evaluation	() Start		Other: ()	

Treatment Plan

Treatment Plan Narrative: Expected Maximum Medical Improvement (MMI) date 09-07-2018. Narcotics were not prescribed. Pt continues to be in his stressful work environment. He is here today to close out this claim as he has obtained an attorney and will be going through the attorney chosen QME and Psychiatrist instead of making a Workers Comp claim. He will need a copy of all his medical records for his attorney.

Patient was seen by Mr. Fleming, Michael ,P.A., Physician Assistant at this encounter.

On the initial encounter, the patient was seen by Fleming Michael, P.A., Physician Assistant. Mechanism of Injury was recorded as follows:

A 64 year old male, working as a SUPU DENTIST, states "walked off grounds of cim july 6 stressed from embarrassment humility and open degradation in front of all dental staff felt fatigue drpressed loss of enery unable to sleep and no desire to do anything went to on7/13 blood pressure was 180/96." I have reviewed the patient's complete health history and the review of systems obtained on 07-20-2018 included in the medical record. No chemical or toxic exposure was reported. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. There was a specific event of an injury or illness. walked off grounds of cim july 6 stressed from embarrassment humility and open degradation in front of all dental staff felt fatigue drpressed loss of enery unable to sleep and no desire to do anything went to on7/13 blood pressure was 180/96. There are no known prior acute trauma or cumulative trauma to the affected body part. There has been no ongoing treatment for the prior trauma or exposure. There are no known related hobbies/sports complications.

I have reviewed the Mechanism of Injury as stated in the initial visit. Physician Comments:

On the initial visit, the Treatment Plan was recorded as follows:

Expected Maximum Medical Improvement (MMI) date 09-07-2018. Narcotics were not prescribed. Pt engaged in several EOP claims against him as a supervisor. He is suffering embarrassment, stress, anxiety, insomnia and high blood pressure due to the conditions at work. I will ask his employer to transfer him to a different facility to help alleviate this stress. RTC 2 weeks.

I have reviewed the Treatment Plan as stated in the initial visit. Physician Comments:

Patient Education:

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

WORK STATUS:

Patient is advised to return to work without restrictions. Expected Maximum Medical Improvement (MMI) date 09-07-2018.
Work Restrictions:

Other restrictions: Pt is to avoid current work environment. Please transfer to a different facility..

DISCHARGE STATUS:

() Released from care. Return to full duty on () with no limitations or restrictions.

() Patient discharged as permanent and stationary with either impairment, work restrictions, and/or need for future medical care. A PR-4 to follow.

() NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

I declare under penalty of perjury that this report is true and correct, to the best of my knowledge, and that I have not violated Labor Code 139.3.

Signature (Original)

Signature (Original)

Name: Michael Fleming, P.A.

Cal. Lic. #: PA21349

Specialty: Occupational Medicine

Date of Exam: 07-27-2018

Keith Wresch M.D.

Supervising Provider

Cal. Lic. #: A90435

NEXT APPOINTMENT

Next Appointment with on .

Executed at: US HealthWorks 3200 Inland Empire Blvd., Suite 100, Ontario CA 91764 - 5513 Ph:909 945-5011

Check In Time: 07-27-2018 10:57 am

MEDICAL DOCUMENTATION : DO NOT DETACH
Followup Patient Narrative

U.S. HealthWorks
3200 Inland Empire Blvd.
Suite 100
Ontario CA 91764 - 5513
Ph: 909 945-5011

Date of Service:	07-27-2018	**Insurance:**	STATE COMP (FRESNO)SOUTH
Patient Name:	SOOHOO, GEROGE	**Claim #:**	06380832
Patient Account Number:	124371402		
Date Of Injury:	07-06-2018 12:30		
Date Of Birth:	11-28-1953		
Employer Name:	CIM/CALIF. INSTITUTION MEN		
Chart #:	EMR LR		

Patient Status: Since the last exam, this patient's condition has: Not improved significantly

History Of Present Illness:
Patient is here for follow up visit for injury sustained on 07-06-2018 12:30. Patient's injury is the same, . Patient is currently on modified duty. There are no new symptoms. .

Psych Complaints/Symptoms
Complaint: Patient's complaint at this time is as follows: anxiety continues
Associated Symptoms: The patient denies a history of suicidal ideations. The patient denies any suicide attempts. The patient states no history of self injurious behaviors. There is no history of homicidal ideations. The patient denies a history of mood swings. Patient denies increased incidents of crying. There is no history of anger or temperament issues. The patient denies auditory hallucinations. The patient denies visual hallucinations. There is no history of blackouts. The patient denies memory loss or forgetfulness. The patient denies confusion. The patient denies any difficulty with concentration. The patient has no complaints of myalgia. The patient denies headaches. The patient denies feeling tremulous or shaky. The patient denies insomnia or sleep disturbances. The patient denies a history of nausea and vomiting. There is no history of diarrhea or constipation. The patient states there is no loss of appetite. The patient denies abdominal pain. There is no history of chest pain or palpitations. The patient denies any dyspnea. The patient does not complain of any skin conditions.

Relevant History NOTES: Patient denies history of ulcers or gastritis. **He has a history of Diabetes.**

Occupational history: Length of employment is reported as 10 years or more. He works 40 hours per week. Main job characteristics include sit down job, prolonged standing or walking, kneeling or squatting, bending, climbing and operating hand tools/machinery,
He denies any lost work-time as a result of this injury. He denies any other source of employment.

Past Medical:
Surgeries: No Known Surgical History

Medical History: Patient denies history of ulcers or gastritis. **He has a history of Diabetes.** High Blood Pressure () . Diabetes () . Permanent disabilities () hearing I ear .

Tetanus History:
Last tetanus - unk.

Family Social History:
Family History: Non-contributory Family History.
Social History: Alcohol or Tobacco use: He does not use tobacco. Denies alcohol use.

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a complete review of systems obtained from the health history completed on 07-20-2018 was done and any interval changes are noted.
Constitutional Symptoms: Constitutional Symptoms - current - not under treatment.
Cardiovascular symptoms: Cardiovascular symptoms - current - not under treatment.
Head: Trauma, injuries or frequent or severe headaches current - not under treatment.
Ear, nose, throat symptoms: Ear, nose, throat symptoms - current - under treatment.
Respiratory symptoms: No respiratory symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Hematological symptoms: No hematological symptoms.
Skin symptoms: Skin symptoms - in last 5 years but not currently.
Eye symptoms: Eye symptoms - current - not under treatment.
Genitourinary symptoms: No genitourinary symptoms.
Musculoskeletal symptoms: Musculoskeletal symptoms - current - not under treatment.
Endocrine symptoms: No endocrine symptoms.
Neurological symptoms: Neurological symptoms - current - not under treatment.
Men only: No penile discharge, prostate problems, genital pain or masses.

Current Medications at the start of Encounter:
amlodipine
clopidogrel
losartan
metformin
Allergies:
Lisinopril Allergy . Asprin Ec Low Dose Allergy .

Patient Report Of Injury

Physical Examination:

Pulse: 80/min. Blood Pressure: 152/79 mmHg. Temperature: 98.2 deg F Respiratory rate: 16 per min.

On a severity scale the pain is 8 out of 10.

Psychiatric: He is alert and oriented to person, place and time . There is no history of psychiatric illness. There is no history of substance abuse.
Mental Status Exam: The patient's memory appears intact . The patient states their mood is not abnormal. The patient's affect is within normal limits . The patient denies insomnia . The patient has no complaints of appetite disturbance or eating disorder . There are no complaints regarding loss of energy . The patient denies loss of libido . The patient denies suicidal ideation . The patient states there is no homicidal ideation . The patient is not inappropriately dressed or disheveled. The exam reveals that the patient's behavior is not uncooperative, distant, or hostile . The patient states that thought processes are normal. The patient exhibits no abnormal thought content. The patient's speech is within normal limits .

Eyes: Pupils are equal and reactive to light and accommodation . The conjunctiva and sclerae show no signs of inflammation . There is no excessive lacrimation noted . There is no exopthalmos . Peripheral vision appears normal . The red reflex is present.

Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The chest cavity has no deformities; there is no kyphosis .

Skin: The patient is not diaphoretic. The patient is not cyanotic. There is no skin pallor . The patient has no rashes or dermatitis . There are no suspicious skin lesions noted.

Cardiovascular: The heart rate is normal . Heart rhythm is not irregular. No heart murmur was auscultated . Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . There is no pretibial or pedal edema . Upper extremity pulses are within normal limits . Pulses of the lower extremities are within normal range .
Neurologic: Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits . There is no evidence of tremors, tics or muscle twitching . Motor retardation is not noted on the exam .

Diagnostic Tests:

Medical Necessity:

Internal Lab Orders:

External Lab Orders:

Diagnoses:
Work stress (Z56.6)

First Aid: This is not a first aid claim.

Treatment Plan:

Last Saved By: Admin Admin 07-27-2018 11:31 PST

Dispensed Medications:
Prescribed Medications:
Medications Completed or Stopped:

Treatment Plan Narrative:

Expected Maximum Medical Improvement (MMI) date 09-07-2018. Narcotics were not prescribed. Pt continues to be in his stressful work environment. He is here today to close out this claim as he has obtained an attorney and will be going through the attorney chosen QME and Psychiatrist instead of making a Workers Comp claim. He will need a copy of all his medical records for his attorney.

Work Status:

Patient is advised to return to work without restrictions.

Work Restrictions:

Other restrictions: Pt is to avoid current work environment. Please transfer to a different facility..

Therapeutic Services:

Patient Education:
Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

Michael Fleming, P.A.
This has been electronically signed on 07-27-2018

Keith Wresch M.D.
Supervising Provider

SCIF RECD DATE :07/26/2018

MEDICAL DOCUMENTATION: DO NOT DETACH
Narrative Review - New Patient

U.S. HealthWorks
3200 Inland Empire Blvd.
Suite 100
Ontario CA 91764 - 5513
Ph: 909 945-5011

Date of Service:	07-20-2018	**Insurance:**	STATE COMP (FRESNO)SOUTH
Patient Name:	SOOHOO, GEROGE	**Claim #:**	
Patient Account Number:	124371402		
Date Of Injury:	07-06-2018 12:30		
Date Of Birth:	11-28-1953		
Employer Name:	CIM/CALIF. INSTITUTION MEN		
Chart #:	EMR LR		

History Of Present Illness:

A 64 year old male, working as a SUPU DENTIST, states "walked off grounds of cim july 6 stressed from embarrassment humility and open degradation in front of all dental staff felt fatigue drpressed loss of enery unable to sleep and no desire to do anything went to on7/13 blood pressure was 180/96." I have reviewed the patient's complete health history and the review of systems obtained on 07-20-2018 included in the medical record. No chemical or toxic exposure was reported. No previous occupational injuries are cited by the patient. There are no known pre-existing conditions that might interfere with the treatment or delay/impede the recovery process. There was a specific event of an injury or illness. walked off grounds of cim july 6 stressed from embarrassment humility and open degradation in front of all dental staff felt fatigue drpressed loss of enery unable to sleep and no desire to do anything went to on7/13 blood pressure was 180/96. There are no known prior acute trauma or cumulative trauma to the affected body part. There has been no ongoing treatment for the prior trauma or exposure. There are no known related hobbies/sports complications.

Present complaint
Severity: On severity scale, the pain is 8 out of 10.

Psych Complaints/Symptoms
Complaint: Patient's complaint at this time is as follows: stress at work The primary presenting symptom is insomnia . He says it is moderately severe. He reports having symptoms for 14 days. The frequency is constant.
Associated Symptoms: The patient denies a history of suicidal ideations. The patient denies any suicide attempts. The patient states no history of self injurious behaviors. There is no history of homicidal ideations. The patient denies a history of mood swings. Patient denies increased incidents of crying. There is no history of anger or temperament issues. The patient denies auditory hallucinations. The patient denies visual hallucinations. There is no history of blackouts. The patient denies memory loss or forgetfulness. The patient denies confusion. The patient denies any difficulty with concentration. The patient has no complaints of myalgia. The patient denies headaches. The patient denies feeling tremulous or shaky. The patient denies insomnia or sleep disturbances. The patient denies a history of nausea and vomiting. There is no history of diarrhea or constipation. The patient states there is no loss of appetite. The patient denies abdominal pain. There is no history of chest pain or palpitations. The patient denies any dyspnea. The patient does not complain of any skin conditions.

SCIF RECD DATE :07/26/2018

Relevant History NOTES:
Dominant hand is right. Patient denies history of ulcers or gastritis.

Relevant History NOTES: Last tetanus - unk.

Occupational history: Length of employment is reported as 10 years or more. He works 40 hours per week. Main job characteristics include sit down job, prolonged standing or walking, kneeling or squatting, bending, climbing and operating hand tools/machinery,
He denies any lost work-time as a result of this injury. He denies any other source of employment.

Past Medical:
Surgeries: No Known Surgical History

Medical History:
Dominant hand is right. Patient denies history of ulcers or gastritis. High Blood Pressure () . Diabetes () . Permanent disabilities () hearing l ear .

Tetanus History:
Last tetanus - unk.

Family Social History:
Family History: Non-contributory Family History.
Social History: Alcohol or Tobacco use: He does not use tobacco. Denies alcohol use.

Review Of Systems:
A complete review of systems was performed as noted below.
Constitutional Symptoms: Constitutional Symptoms - current - not under treatment.
Cardiovascular symptoms: Cardiovascular symptoms - current - not under treatment.
Head: Trauma, injuries or frequent or severe headaches current - not under treatment.
Ear, nose, throat symptoms: Ear, nose, throat symptoms - current - under treatment.
Respiratory symptoms: No respiratory symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Hematological symptoms: No hematological symptoms.
Skin symptoms: Skin symptoms - in last 5 years but not currently.
Eye symptoms: Eye symptoms - current - not under treatment.
Genitourinary symptoms: No genitourinary symptoms.
Musculoskeletal symptoms: Musculoskeletal symptoms - current - not under treatment.
Endocrine symptoms: No endocrine symptoms.
Neurological symptoms: Neurological symptoms - current - not under treatment.
Men only: No penile discharge, prostate problems, genital pain or masses.

Current Medications at the start of Encounter:
amlodipine
clopidogrel
losartan
metformin
Allergies:
Lisinopril Allergy . Asprin Ec Low Dose Allergy .

Patient Report Of Injury
Injury Details: Patient states injury or condition was caused at work. Injury was reported to:: DR. JEFF LISSY Date: 07-18-2018. Time: 7:00 AM.

Physical Examination:

Height: 60 inches. Weight: 185 lbs. **BMI:** 36 Pulse: 87/min. Blood Pressure: 160/93 mmHg. Temperature: 98.8 deg

SCIF RECD DATE :07/26/2018
F Respiratory rate: 16 per min.

Constitutional: The patient is a well-developed, well-nourished male.
Psychiatric: He is alert and oriented to person, place and time . There is no history of psychiatric illness. There is no history of substance abuse.
Mental Status Exam: The patient's memory appears intact . The patient states their mood is not abnormal. The patient's affect is within normal limits . The patient denies insomnia . The patient has no complaints of appetite disturbance or eating disorder . There are no complaints regarding loss of energy . The patient denies loss of libido . The patient denies suicidal ideation . The patient states there is no homicidal ideation . The patient is not inappropriately dressed or disheveled. The exam reveals that the patient's behavior is not uncooperative, distant, or hostile . The patient states that thought processes are normal. The patient exhibits no abnormal thought content. The patient's speech is within normal limits .

Eyes: Pupils are equal and reactive to light and accommodation . The conjunctiva and sclerae show no signs of inflammation . There is no excessive lacrimation noted . There is no exopthalmos . Peripheral vision appears normal . The red reflex is present.

Respiratory: The patient's respiratory rate is normal. Lungs are clear to auscultation . The chest cavity has no deformities; there is no kyphosis .

Skin: The patient is not diaphoretic. The patient is not cyanotic. There is no skin pallor . The patient has no rashes or dermatitis . There are no suspicious skin lesions noted.

Endocrine: The neck exam is negative for thyromegaly . The thyroid is non-tender on palpation . There is no evidence of thyroid nodules or masses .

Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities . The examination of the spine reveals no abnormality . Examination of the extremities is grossly within normal limits . There is no weakness of the lower extremities .

Cardiovascular: The heart rate is normal . Heart rhythm is not irregular. No heart murmur was auscultated . Exam of the carotids reveals strong pulses, without bruits . There is no jugular venous distention noted . There is no pretibial or pedal edema . Upper extremity pulses are within normal limits . Pulses of the lower extremities are within normal range .
Neurologic: Cranial nerves II-XII are grossly intact . Deep tendon reflexes are within normal limits . There is no evidence of tremors, tics or muscle twitching . Motor retardation is not noted on the exam . There is no weakness of the upper extremities.

Diagnostic Tests:

Medical Necessity:

Internal Lab Orders:

External Lab Orders:

SCIF RECD DATE :07/26/2018

Diagnoses

Stress at work (Z56.6)

First Aid: This is not a first aid claim.

Causation: The findings on exam and diagnosis are consistent with the injury reported by patient. Prior factors such as injuries / medical conditions / diseases / prior activities or exposures are not contributing to the findings. The findings can not be possibly produced by natural progression of pre-existing conditions or aging. The reported injury / exposure is not causing an aggravation to the above pre-existing condition. In conclusion, the reported injury, more likely than not, is causing the current symptoms and findings.

Treatment Plan:

Last Saved By: Admin Admin 07-20-2018 11:03 PST

Dispensed Medications:
Prescribed Medications:
Current Medications at Close of Encounter:
amlodipine
clopidogrel
losartan
metformin
Medications Completed or Stopped:

Supplies:

Overhead Supplies:

Treatment Plan Narrative:

Expected Maximum Medical Improvement (MMI) date 09-07-2018. Narcotics were not prescribed. Pt engaged in several EOP claims against him as a supervisor. He is suffering embarrassment, stress, anxiety, insomnia and high blood pressure due to the conditions at work. I will ask his employer to transfer him to a different facility to help alleviate this stress. RTC 2 weeks.

SCIF RECD DATE :07/26/2018

Work Status:

Patient is advised to return to work without restrictions.

Work Restrictions:

Other restrictions: Pt is to avoid current work environment. Please transfer to a different facility..

Therapeutic Services:

Patient Education:
Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

Referral/Evaluation: A Psychiatry evaluation has been ordered. The reason for evaluation is work place stress.

Michael Fleming, P.A.
This has been electronically signed on 07-21-2018

Keith Wresch M.D.
Supervising Provider

Next Appointment with Fleming Michael on 08-10-2018 10:00 am.