



July 19, 2019

David Black Santa Monica  
3201 Pico Blvd  
Santa Monica CA 90405

RE: Employee: MARVETTA JOHNSON  
Employee No.: 254656  
Dept. No./Name: County of Los Angeles/PROBATION  
Claim No: 419-01553-D  
DOI: 01/25/2019

Dear Counsel,

Sedgwick has been contracted by the County of Los Angeles to administer its workers' compensation claims. You will soon be contacted by defense counsel assigned to this claim.

Enclosed please find the following medical reports:

<u>Medical Provider's Name</u>	<u>Report Date(s)</u>
Rohan Kapoor MD	03/19/19, 02/13/19, 02/06/19

I look forward to working with you to achieve an early and full recovery for the injured worker, and a fair and expeditious resolution of this claim.

Sincerely,  
Sedgwick Claims Management Services, Inc.

A handwritten signature in black ink, appearing to read "CR", is located below the typed name.

CHRISTINE ROWNEY  
(909)942-8936

/Enclosures

**PROOF OF SERVICE BY MAIL  
COUNTY OF SAN BERNARDINO**

I, the undersigned, hereby declare that I am over the age of eighteen years and not a party to the within action. I am employed in the County of San Bernardino and my business address is P.O. Box 51350, Ontario, CA 91761.

On July 19, 2019, I served the medical records listed on the preceding letter.

On the parties in said action by placing a true copy thereof in a sealed envelope with postage thereon fully prepaid, in the United States Mail at Ontario, California, addressed as follows:

I declare under penalty of perjury that the foregoing is true and correct. Executed in Ontario, California, on July 19, 2019.

BHDePhillips

Name of Declarant

Sedgwick Claims Management Services, Inc.

Brandt H DePhillips

Signature of Declarant

Sedgwick Claims Management Services, Inc.

State of California

Additional pages attached

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

- Checkboxes for reasons: Periodic Report, Change in work status, Change in patient's condition, etc.

Patient

Patient information fields: Johnson, Marveta, 1022 W. 138TH ST., COMPTON, CA, 90222, Female, PROBATION OFFICER, 562-361-3048, Date of Birth 12/11/1967, Date of Injury 1/25/2019

SEDGWICK CLAIM MGMNT SVCS INC

Claims Administrator Name: SEDGWICK CLAIM MGMNT SVCS INC, Claim number: ONTARIO, CA, 91761, Claims Administrator Street Address: PO BOX 51350, Claims Administrator City: DEPARTMENT OF PROBATION, State: CA, Zip Code: 91761, Phone Number: 855-238-4936, Fax Number: 909-942-8919, Employer Name: DEPARTMENT OF PROBATION, Phone Number: 562-940-6411

The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints:

REASON FOR PR2: Change in treatment plan, Change in patients condition and Request for Authorization ... (continued on page 3)

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Vital Signs: There were no vitals taken for this visit. I confirm that I have performed the following examination(s): ... (continued on page 3)

Diagnoses:

- 1. LEFT THIGH CONTUSION, SUBSEQ ICD-10 S70.12XD
2. ICD-10
3. ICD-10
4. ICD-10
5. ICD-10
6. ICD-10
7. ICD-10
8. ICD-10
9. ICD-10
10. ICD-10
11. ICD-10
12. ICD-10

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify

consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Medications:  
  
The medication(s)/supplies/radiological studies ordered this visit: ... (continued on page 3)

Work Status: This patient has been instructed to:

- Remain off-work until \_\_\_\_\_
- Return to *modified* work on \_\_\_\_\_ with the following limitations or restrictions

(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Concurrent Treatment: PT/OT  
  
Full work today. ... (continued on page 3)

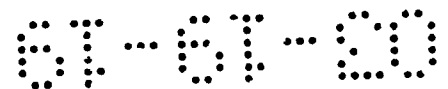
- Return to full duty on 3/18/2019 with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: 3/18/2019

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 Signature on File Cal. License Number: A157883  
Executed at: LOS ANGELES County, California Date (mm/dd/yyyy): 3/19/2019  
Physician Name Kapoor, Rohan (M.D.), M.D. Specialty: Occupational Medicine  
Physician address: 9353 Imperial Hwy Phone Number: 562-657-2200  
Downey, CA 90242-2812

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: [http://www.dir.ca.gov/od\\_pub/privacy.html](http://www.dir.ca.gov/od_pub/privacy.html)



**SUBJECTIVE COMPLAINTS**

**REASON FOR PR2:**

Change in treatment plan, Change in patients condition and Request for Authorization

**Chief Complaint:**

SHOULDER INJURY

Translation required: No

**CURRENT TREATMENT REVIEW FOR THIS INJURY/ILLNESS:**

Date of injury: 1/25/19

**Employer:**

Department Of Probation  
7285 E Quill Dr  
Downey CA 90242

Patient states, "stepped in between two youth engaging in physical fight. Attempted to separate and I was injured to my left upper arm and left lateral thigh."

**Current prescribed/advised treatment detail:**

NSAIDS and Physical Therapy

NSAIDS: Ibuprofen

**TREATMENT PROGRESS:**

The patient's symptoms from the previous visit are:

Improving

**Treatment Since Last Visit:**

She has completed 5 sessions of physical therapy for the left thigh with approximately 50-60% improvement of her pain

Marvetta L Johnson is a 51 year old female with the following subjective factors:

**Patient Complaints:**

Marvetta L Johnson complains of intermittent slight sharp sometimes dull type of pain in left lateral thigh. She reports that the physical therapy and home exercise program is helping with her pain. She has been working full duty. She reports that last week she had a wrist a new another inmate and that caused her to have recurrence of the left lateral thigh pain. She reports that the pains are improved with topical IcyHot. She would like to refill today. She denies any numbness, tingling, weakness of the left lower extremity.

**REVIEW OF SYSTEMS:**

I have reviewed the following systems:

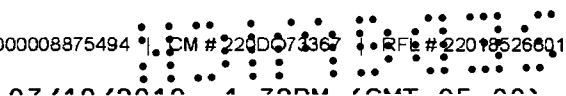
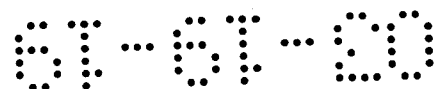
**General:** No fever, chills, or sweats

**Respiratory:** No wheezing, cough, or shortness of breath

**Skin:** No rash, redness, or swelling

**SOCIAL HISTORY:**

Work Status before this visit: Full Duty



**OBJECTIVE FINDINGS**

**Vital Signs:**

There were no vitals taken for this visit.

I confirm that I have performed the following examination(s):

**Constitutional:** Well developed and well nourished and Alert and conversant

**Respiratory:** No respiratory distress

**Skin:** Clear warm and dry

**Psychiatric:** Pleasant, alert, no distress, mood and affect normal

**PHYSICAL EXAMINATION:**

**Musculoskeletal:**

Legs:

**TREATMENT RENDERED**

**Medications:**

The medication(s)/supplies/radiological studies ordered this visit:

**Orders Placed This Encounter**

**REFERRAL PHYSICAL THERAPY**

**Order Comments:**

Reason: Additional Physical Therapy

The patient is being referred for additional physical therapy for left thigh.

Frequency: 2 times a week for 3 weeks - total of 6 treatments.

Patient has completed 5 therapy treatments to date and reported decrease in pain and improved function in ADLs, decreased medication usage, and decrease work restrictions. Patient reports decrease in pain by 50%. Physical therapy is appropriate per MTUS Chronic Pain Medical Treatment guidelines, Physical Medicine Treatment.

**Methyl Salicylate-Menthol (ICY HOT) 30-10 % Top Crea**

Sig: APPLY TO AFFECTED AREA(S) NO MORE THAN QID PRN MUSCLE OR JOINT PAIN

Dispense: 85

Refill: 0

**Treatment Rendered:**

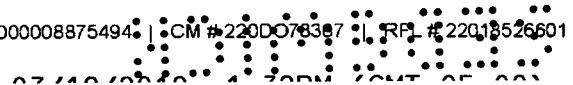
I have refilled her topical medications today

I have placed a referral for authorization of an additional 6 sessions of physical therapy for the left thigh

She will continue with full duty in follow-up in 3 weeks

Future treatment plan : yes

Anticipated date of Full duty release : working full duty



Anticipated date of Maximal medical Improvement (MMI) : 4-6 weeks

**FACTORS OF CARE:**

Treatment Plans and Integration: Discussion with patient regarding return to work (full, modified or off work)

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**WORK STATUS: Restrictions for Modified Work**

Concurrent Treatment: PT/OT

Full work today.

Other Needs/Restrictions:

Additional Comments:

Next Appointment: 3 Weeks

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01-01-00

State of California

Additional pages attached

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

- Checkboxes for reasons: Periodic Report, Change in work status, Change in patient's condition, etc.

Patient

Johnson, Marveta L MI
1022 W. 138TH ST. COMPTON CA 90222 Female
PROBATION OFFICER 562-361-3048 12/11/1967
Claims Administrator Date of Injury 1/25/2019

SEDGWICK CLAIM MGMNT SVCS INC

Claims Administrator Name: SEDGWICK CLAIM MGMNT SVCS INC
Claim number:
PO BOX 51350 ONTARIO CA 91761
855-238-4936 909-942-8919 DEPARTMENT OF PROBATION 562-940-6411

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

REASON FOR PR2:
Change in treatment plan, Change in patients condition and Request for Authorization
... (continued on page 3)

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Vital Signs:
There were no vitals taken for this visit.

I confirm that I have performed the following examination(s): ... (continued on page 3)

Diagnoses:

- 1. LEFT THIGH CONTUSION, SUBSEQ ICD-10 S70.12XD
2. ICD-10
3. ICD-10
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11. ICD-10
12. ICD-10

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify



consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Medications:  
The medication(s)/supplies/radiological studies ordered this visit:  
Orders Placed This Encounter... (continued on page 3)

Work Status: This patient has been instructed to:  
 Remain off-work until \_\_\_\_\_  
 Return to *modified* work on \_\_\_\_\_ with the following limitations or restrictions  
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

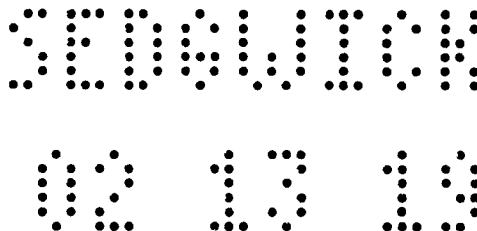
Concurrent Treatment: PT/OT  
Full work today. ... (continued on page 3)  
 Return to full duty on 2/12/2019 with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: 2/12/2019

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 Signature on File Cal. License Number: A157883  
Executed at: LOS ANGELES County, California Date (mm/dd/yyyy): 2/13/2019  
Physician Name Kapoor, Rohan (M.D.), M.D. Specialty: Occupational Medicine  
Physician address: 9353 Imperial Hwy Phone Number: 562-657-2200  
Downey, CA 90242-2812

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**SUBJECTIVE COMPLAINTS**

**REASON FOR PR2:**

Change in treatment plan, Change in patients condition and Request for Authorization

**Chief Complaint:**

SHOULDER INJURY

Translation required: No

**CURRENT TREATMENT REVIEW FOR THIS INJURY/ILLNESS:**

Date of injury: 1/25/19

**Employer:**

Department Of Probation  
7285 E Quill Dr  
Downey CA 90242

Patient states, "stepped in between two youth engaging in physical fight. Attempted to separate and I was injured to my left upper arm and left lateral thigh."

Current prescribed/advised treatment detail:

**TREATMENT PROGRESS:**

The patient's symptoms from the previous visit are:  
Improving

Treatment Since Last Visit:

Marvetta L Johnson is a 51 year old female with the following subjective factors:

**Patient Complaints:**

Marvetta L Johnson complains of intermittent slight dull type of pain in left lateral thigh. Her pain gets better with rest / Medications. She is requesting refills of the topical medications. Her pain gets worse with activities, standing for long periods of time, kneeling over.. She denies any numbness or weakness in the extremity. Denies any radicular symptoms. She reports the left upper arm pain has resolved but she continues to have some stiffness-sore type of pain in the left lateral thigh.

**REVIEW OF SYSTEMS:**

I have reviewed the following systems:

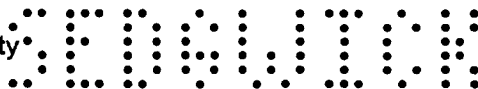
General: No fever, chills, or sweats

Respiratory: No wheezing, cough, or shortness of breath

Skin: No rash, redness, or swelling

**SOCIAL HISTORY:**

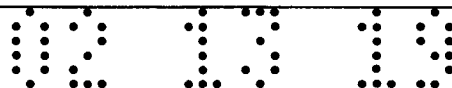
Work Status before this visit: Full Duty



**OBJECTIVE FINDINGS**

**Vital Signs:**

There were no vitals taken for this visit.



I confirm that I have performed the following examination(s):

Constitutional: Well developed and well nourished and Alert and conversant

Respiratory: No respiratory distress

Skin: Clear warm and dry

Psychiatric: Pleasant, alert, no distress, mood and affect normal

**PHYSICAL EXAMINATION:**

Musculoskeletal:

Legs:

**TREATMENT RENDERED**

Medications:

The medication(s)/supplies/radiological studies ordered this visit:

Orders Placed This Encounter

PHYS SPECIAL REPORT, PR-2 TREATING PHYS'S PROGRESS REPORT  
REFERRAL PHYSICAL THERAPY

Order Comments:

Reason: Initial Physical Therapy

The patient is being referred for physical therapy for left thigh.

Frequency: 2 times a week for 3 weeks - total of 6 treatments.

Physical Therapy is appropriate to help improve function, increase strength, range of motion, flexibility, and help minimize discomfort.

This is appropriate per MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine Treatment.

Capsicum Oleoresin-Menth-Camph (TIGER BALM) 16-24-80 mg Top PTMD Patch

Sig: APPLY 1 PATCH TO AFFECTED AREA DAILY as needed for PAIN. REMOVE OLD PATCH BEFORE APPLYING THE NEW ONE

Dispense: 20

Refill: 0

Methyl Salicylate-Menthol (ICY HOT) 30-10 % Top Crea

Sig: Apply to affected area(s) no more than 4 times a day as needed for muscle or joint pain

Dispense: 85

Refill: 0

Treatment Rendered:

I have refilled her topical medications today

I have placed a referral for authorization of 6 sessions of physical therapy for the left thigh

She will continue with full duty in follow-up in 3 weeks

Future treatment plan : yes

Anticipated date of Full duty release : working full duty :  
Anticipated date of Maximal medical Improvement (MMI) : 6 weeks:

CHART PREP FOR NURSES FOR NEXT VISIT :

Physical Therapy

Claims Examiners : For any referral or report issues, please call (844) 789-0172 and press option 1 for the Tri-Central Medical Center Area unit."

**FACTORS OF CARE:**

Treatment Plans and Integration: Discussion with patient regarding return to work (full, modified or off work)

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**WORK STATUS: Restrictions for Modified Work**

Concurrent Treatment: PT/OT

Full work today.

Other Needs/Restrictions:

Additional Comments:

Next Appointment: 3 Weeks

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SENTINEL  
02 13 19

Occupational Medicine
9353 Imperial Hwy
Downey, CA 90242-2812
Phone: 562-657-2200

Kaiser Permanente
Southern California Permanente Medical Group
Kaiser MRN: 000008875494

State of California

Additional pages attached [X]

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

- Periodic Report (required 45 days after last report) [X] Change in treatment plan [ ] Released from care [ ]
Change in work status [ ] Need for referral or consultation [ ] Response to request for information [ ]
Change in patient's condition [X] Need for surgery or hospitalization [X] Request for authorization [ ]
Other: [ ]

Patient

Johnson Marvetta L
Patient last name Patient first name MI
1022 W. 138TH ST. COMPTON CA 90222 Female
Patient Street Address/PO Box Patient City State Zip Code Sex
PROBATION OFFICER 562-361-3048 Date of Birth 12/11/1967
Occupation Phone Number
Claims Administrator Date of Injury 1/25/2019

SEDGWICK CLAIM MGMNT SVCS INC

Claims Administrator Name Claim number
PO BOX 51350 ONTARIO CA 91761
Claims Administrator Street Address Claims Administrator City State Zip Code
855-238-4936 909-942-8919 DEPARTMENT OF PROBATION 562-940-6411
Phone Number Fax Number Employer Name Phone Number

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REASON FOR PR2.
Change in treatment plan, Change in patients condition and Request for Authorization
... (continued on page 3)

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Vital Signs:
There were no vitals taken for this visit.
I confirm that I have performed the following examination(s): ... (continued on page 3)

Diagnoses:

- 1. LEFT THIGH CONTUSION, SUBSEQ ICD-10 S70.12XD
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11. ICD-10

Occupational Medicine  
9353 Imperial Hwy  
Downey, CA 90242-2812  
Phone: 562-657-2200  
Date of Injury: 1/25/2019

**Kaiser Permanente**  
Southern California Permanente Medical Group  
Kaiser MRN: 000008875494  
Patient Name: Johnson, Marvetta L

STATE OF CALIFORNIA  
**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**

12. \_\_\_\_\_ ICD-10 \_\_\_\_\_

**Treatment Plan:** (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes in treatment plan?** If so, why?)

Medications:  
  
The medication(s)/supplies/radiological studies ordered this visit:  
Orders Placed This Encounter... (continued on page 3)

**Work Status:** This patient has been instructed to:  
 Remain off-work until \_\_\_\_\_  
 Return to *modified* work on \_\_\_\_\_ with the following limitations or restrictions  
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Concurrent Treatment: PT/OT  
  
Full work today. ... (continued on page 3)

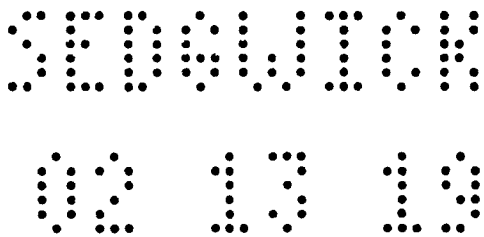
Return to full duty on 2/12/2019 with no limitations or restrictions.

**Primary Treating Physician:** (original signature, do not stamp) \_\_\_\_\_ Date of exam: 2/12/2019

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 Signature on File \_\_\_\_\_ Cal. License Number: A157883  
Executed at: LOS ANGELES County, California \_\_\_\_\_ Date (mm/dd/yyyy): 2/13/2019  
Physician Name Kapoor, Rohan (M.D.), M.D. \_\_\_\_\_ Specialty: Occupational Medicine  
Physician address: 9353 Imperial Hwy \_\_\_\_\_ Phone Number: 562-657-2200  
Downey, CA 90242-2812 \_\_\_\_\_

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Occupational Medicine  
9353 Imperial Hwy  
Downey, CA 90242-2812  
Phone: 562-657-2200  
Date of Injury: 1/25/2019

**Kaiser Permanente**  
Southern California Permanente Medical Group  
Kaiser MRN: 000008875494  
Patient Name: Johnson, Marvetta L

STATE OF CALIFORNIA  
**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**

**SUBJECTIVE COMPLAINTS**

**REASON FOR PR2:**

Change in treatment plan, Change in patients condition and Request for Authorization

**Chief Complaint:**

SHOULDER INJURY

Translation required: No

**CURRENT TREATMENT REVIEW FOR THIS INJURY/ILLNESS:**

Date of injury: 1/25/19

**Employer:**

Department Of Probation  
7285 E Quill Dr  
Downey CA 90242

Patient states, "stepped in between two youth engaging in physical fight. Attempted to separate and I was injured to my left upper arm and left lateral thigh."

Current prescribed/advised treatment detail:

**TREATMENT PROGRESS:**

The patient's symptoms from the previous visit are:

Improving

Treatment Since Last Visit:

Marvetta L Johnson is a 51 year old female with the following subjective factors:

**Patient Complaints:**

Marvetta L Johnson complains of intermittent slight dull type of pain in left lateral thigh. Her pain gets better with rest / Medications. She is requesting refills of the topical medications. Her pain gets worse with activities, standing for long periods of time, kneeling over.. She denies any numbness or weakness in the extremity. Denies any radicular symptoms. She reports the left upper arm pain has resolved but she continues to have some stiffness-sore type of pain in the left lateral thigh.

**REVIEW OF SYSTEMS:**

I have reviewed the following systems:

**General:** No fever, chills, or sweats

**Respiratory:** No wheezing, cough, or shortness of breath

**Skin:** No rash, redness, or swelling



**SOCIAL HISTORY:**

Work Status before this visit: Full Duty



Occupational Medicine  
9353 Imperial Hwy  
Downey, CA 90242-2812  
Phone: 562-657-2200  
Date of Injury: 1/25/2019

**Kaiser Permanente**  
Southern California Permanente Medical Group  
Kaiser MRN: 000008875494  
Patient Name: Johnson, Marvetta L

STATE OF CALIFORNIA  
**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**

**OBJECTIVE FINDINGS**

**Vital Signs:**

There were no vitals taken for this visit.

I confirm that I have performed the following examination(s):

**Constitutional:** Well developed and well nourished and Alert and conversant

**Respiratory:** No respiratory distress

**Skin:** Clear warm and dry

**Psychiatric:** Pleasant, alert, no distress, mood and affect normal

**PHYSICAL EXAMINATION:**

**Musculoskeletal:**

Legs:

**TREATMENT RENDERED**

**Medications:**

The medication(s)/supplies/radiological studies ordered this visit:

**Orders Placed This Encounter**

PHYS SPECIAL REPORT, PR-2 TREATING PHYS'S PROGRESS REPORT

REFERRAL PHYSICAL THERAPY

**Order Comments:**

Reason: Initial Physical Therapy

The patient is being referred for physical therapy for left thigh.

Frequency: 2 times a week for 3 weeks - total of 6 treatments.

Physical Therapy is appropriate to help improve function, increase strength, range of motion, flexibility, and help minimize discomfort.

This is appropriate per MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine Treatment.

Capsicum Oleoresin-Menth-Camph (TIGER BALM) 16-24-80 mg Top PTMD Patch

Sig: APPLY 1 PATCH TO AFFECTED AREA DAILY as needed for PAIN. REMOVE OLD PATCH BEFORE APPLYING THE NEW ONE

Dispense: 20

Refill: 0

Methyl Salicylate-Menthol (ICY HOT) 30-10 % Top Crea

Sig: Apply to affected area(s) no more than 4 times a day as needed for muscle or joint pain

Dispense: 85

Refill: 0

**Treatment Rendered:**

I have refilled her topical medications today.

I have placed a referral for authorization of 6 sessions of physical therapy for the left thigh

She will continue with full duty in follow-up in 3 weeks



Occupational Medicine  
9353 Imperial Hwy  
Downey, CA 90242-2812  
Phone: 562-657-2200  
Date of Injury: 1/25/2019

**Kaiser Permanente**  
Southern California Permanente Medical Group  
Kaiser MRN: 000008875494  
Patient Name: Johnson, Marvetta L

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STATE OF CALIFORNIA  
**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)**

Future treatment plan : yes

Anticipated date of Full duty release : working full duty  
Anticipated date of Maximal medical Improvement (MMI) : 6 weeks

CHART PREP FOR NURSES FOR NEXT VISIT :

Physical Therapy

Claims Examiners : For any referral or report issues, please call (844) 789-0172 and press option 1 for the Tri-Central Medical Center Area unit."

**FACTORS OF CARE:**

Treatment Plans and Integration: Discussion with patient regarding return to work (full, modified or off work)

---

**WORK STATUS: Restrictions for Modified Work**

Concurrent Treatment: PT/OT

Full work today.

Other Needs/Restrictions:

Additional Comments:

Next Appointment: 3 Weeks

SEBASTIAN  
02 13 19

Occupational Medicine  
9353 Imperial Hwy  
Downey, CA 90242-2812  
Phone: 562-657-2200

**Kaiser Permanente**  
Southern California Permanente Medical Group  
Kaiser MRN: 000008875494

STATE OF CALIFORNIA  
**DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Department of Industrial Relations, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. Insurer Name and Address

SEDGWICK CLAIM MGMT SVCS INC, PO BOX 51350, ONTARIO, CA 91761

2. Employer Name

DEPARTMENT OF PROBATION

3. Address No. and Street

7285 E QUILL DR

City

DOWNEY

Zip Code

90242

4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.)

5. Patient Name (first Name, middle initial, last name)

Marvetta

L

Johnson

6. Sex

Female

7. Date of Birth

12/11/1967

8. Address No. and Street

1022 W. 138TH ST.

City

COMPTON

Zip Code

90222

9. Phone Number

562-361-3048

10. Occupation (Specific job title)

PROBATION OFFICER

11. Social Security Number

546-19-7076

12. Address No. and Street Where Injury Occurred

7285 QUILL DR

City Where Injury Occ.

DOWNEY

County

LOS ANGELES

13. Date and hour of injury or onset of illness

1/25/2019 12 AM

14. Date last worked

15. Date and hour of 1st exam or treatment

2/5/2019

16. Have you or your office previously rendered treatment

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. Describe how the accident or exposure happened. (Give specific object, machinery or chemical. Use reverse side if more space is required.)

Marvetta L Johnson is a 51 year old right handed female who has worked as a(n) PROBATION OFFICER for the past 10 years. The patient's job responsibilities include prolonged walking, upper extremity repetitive motion and prolonged standing.  
... (continued on sheet 4)

18. SUBJECTIVE COMPLAINTS

Treatment History for This Injury:  
Marvetta L Johnson states her symptoms started immediately. ... (continued on sheet 4)

19. Objective Findings

A. Physical Examination

Vital Signs:  
There were no vitals taken for this visit.  
... (continued on sheet 4)

B. X-ray and laboratory results (State if none or pending.)

no ... (continued on sheet 4)

Occupational Medicine  
9353 Imperial Hwy  
Downey, CA 90242-2812  
Phone: 562-657-2200  
Date of Injury: 1/25/2019

**Kaiser Permanente**  
Southern California Permanente Medical Group  
Kaiser MRN: 000008875494  
Patient Name: Johnson, Marvetta L

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20 **DIAGNOSES**(if occupational illness specify etiologic agent and duration of exposure ) Chemical or toxic compounds involved?  No

1. LEFT THIGH CONTUSION, INIT	ICD-10	S70.12XA
2. LEFT UPPER ARM CONTUSION, INIT	ICD-10	S40.022A
3.	ICD-10	
4.	ICD-10	
5.	ICD-10	
6.	ICD-10	
7.	ICD-10	
8.	ICD-10	
9.	ICD-10	
10.	ICD-10	
11.	ICD-10	
12.	ICD-10	

21 Are your findings and diagnosis consistent with patient's account of injury or onset of illness?  Yes  No If "no," please explain below:  
  
Yes  
In the absence of any other injury , and based on the patient's clinical history, measurable object... (continued on sheet 4)

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

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)  
... (continued on sheet 4)

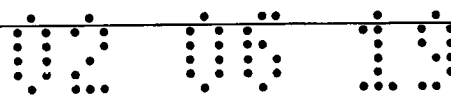
24. If further treatment required, specify treatment plan/estimated duration.  
More than likely the patient's condition is expected to improve or reach maximum medical improvem... (continued on sheet 4)

25. If hospitalized as inpatient, give hospital name and location  
no... (continued on sheet 4)

Date Admitted  Estimated length of stay

26. WORK STATUS - Is patient able to perform usual work?  Yes  No  
If "no", date when patient can return to  Regular Work  Modified Work  
2/5/2019

Specify restrictions  
... (continued on sheet 4)



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**Physician Signature:** *(original signature, do not stamp)*

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	<u>Signature on File</u>	Cal. License Number:	<u>A157883</u>
Executed at:	<u>LOS ANGELES County, California</u>	Date (mm/dd/yyyy):	<u>2/6/2019</u>
Physician Name	<u>Kapoor, Rohan (M.D.), M.D.</u>	Specialty:	<u>Occupational Medicine</u>
Physician address:	<u>9353 Imperial Hwy</u> <u>Downey, CA 90242-2812</u>	Phone Number:	<u>562-657-2200</u>

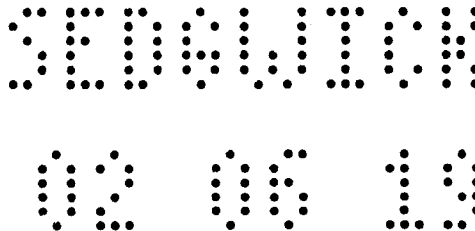
Any person who makes or causes to be made any knowingly fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

**PRIVACY NOTICE** The Administrative Director is authorized to maintain the records of the Division of Workers' Compensation (DWC). (Cal Lab Code § 126.) The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide this notice to individuals who submit information to the DWC pertaining to a workers' compensation claim. (Cal. Civ. Code § 1798.17; Public Law 93-579.)

The principal purpose for requesting information from injured workers, dependents, lien claimants, physician, employers or their representatives is to administer the California workers' compensation system. Each form shows which fields are required to be completed for DWC to process the form. If a required field in a form is incomplete or unreadable, the DWC may return the form to the individual for correction or may reject the form. Providing a social security number is required on this form pursuant to Labor Code § 6409. If you do not provide your security number, the DWC may return the form to you for correction or reject the form. If you do not have a social security number, indicate this in the space provided for the injured worker's social security number. As permitted by law, social security numbers are used to help properly identify injured workers and to conduct statistical research as allowed under the Labor Code.

As authorized by law, information furnished on this form may be given to you, upon request, the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records. (Cal. Civ. Code §§ 1798.34-1798.3.) You may request a copy of the DWC's policies and procedures for inspection of records at the address below. Copies of the procedures and all records are ten cents (\$0.10) per page, payable in advance. (Cal. Civ. Code § 1798.33.) Requests should be sent to: Division of Workers' Compensation- Medical Unit, P.O. Box 71010, Oakland, CA 94612. Tel. (510) 286-3700 or (800) 794.6900. Fax. (510) 622-3467.



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**17. Describe how the accident or exposure happened.**

Marvetta L Johnson is a 51 year old right handed female who has worked as a(n) PROBATION OFFICER for the past 10 years.

The patient's job responsibilities include prolonged walking, upper extremity repetitive motion and prolonged standing.

**MECHANISM OF INJURY:**

Assault and sprain/strain

Origin of Injury:

Injury Date: 1/25/19

Mechanism of Injury: Patient states, "stepped in between two youth engaging in physical fight. Attempted to separate and I was injured to my left upper arm and left lateral thigh."

Translation required: No

**18. SUBJECTIVE COMPLAINTS**

**Treatment History for This Injury:**

Marvetta L Johnson states her symptoms started immediately.

The patient was initially seen for the injury by this provider.

X-rays performed relative to this visit: none

Diagnostic tests: none

**Chief Complaint:**

SHOULDER INJURY; ARM INJURY; and HIP INJURY

Nursing notes reviewed by ROHAN KAPOOR MD.

**Current Complaints Today:**

**Patient Complaints:**

Marvetta L Johnson is a 51 year old female who works as PROBATION OFFICER

Chief complaint: Left lateral thigh pain, left upper arm pain

Marvetta L Johnson complains of intermittent, mild-moderate soreness in left lateral thigh and left upper arm. Symptom onset has been acute for a time period of 1 week. Symptoms improve with rest, ibuprofen, massages. Symptoms are worse with touch and activity. The patient denies numbness, weakness, or radicular symptoms in the extremity. Overall her pain has been improving since the incident. She has been working full duty.

**REVIEW OF SYSTEMS:**

The patient completed the Regional Review of Systems Questionnaire and I reviewed.

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**General:** No fever, chills, or sweats  
**Eyes:** No eye pain, blurry vision, double vision, or visual disturbances  
**Ears, Nose, Throat, and Mouth:** No pain, hearing loss, or ear ringing  
**Cardiovascular:** No chest pain or palpitations  
**Respiratory:** No wheezing, cough, or shortness of breath  
**Gastrointestinal:** No nausea, vomiting, or abdominal pain  
**Genitourinary:** No painful urination  
**Skin:** No rash, redness, or swelling  
**Psychiatric:** No anxiety or depression  
**Hematology:** No easy bruising or bleeding  
**Allergy:** No known environmental allergies

**Extended Musculoskeletal:**  
I reviewed with the patient the following extended musculoskeletal systems.

**Past Medical, Family, and Surgical History:**  
Reviewed Electronic Medical Records: Yes  
Patient did not have a prior work related injury to the same body part(s).  
Patient did not have a prior non-work related injury to the same body part(s).  
Family History Reviewed: Reviewed but does not apply to this Workers' Compensation injury or illness.  
Past Surgical History Reviewed: Reviewed but does not apply to this Workers' Compensation injury or illness.

**SOCIAL HISTORY:**  
Work Status before this visit: Full Duty  
  
Claim Information: pending.

**19A. Objective Findings - Physical Examination**

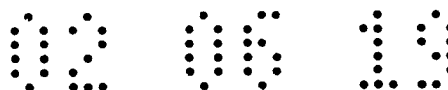
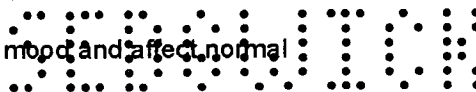
**Vital Signs:**  
There were no vitals taken for this visit.

I confirm that I have performed the following examination(s):

**Constitutional:** Well developed and well nourished and Alert and conversant  
**Ears, Nose, Throat, and Mouth:** No signs of trauma, or deformity  
**Eyes:** Conjunctivae and EOMs are normal  
**Cardiovascular:** Normal pulse and rhythm  
**Respiratory:** No respiratory distress  
**Neurological:** No muscle wasting, tremor, or coordination deficits  
**Skin:** Clear warm and dry  
**Psychiatric:** Pleasant, alert, no distress, mood and affect normal

**PHYSICAL EXAMINATION:**

**Musculoskeletal:**  
Arms:  
Legs:



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**19B. Objective Findings - X-ray and laboratory results**

no

**21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? - Yes**

Yes

In the absence of any other injury , and based on the patient's clinical history, measurable objective findings, and medical records review, it is my medical opinion that the patient's condition listed below in the diagnosis , is more likely than not , work related.

**23. TREATMENT RENDERED**

Marvetta L Johnson has been advised to continue the following previous medication(s):

The medication(s)/supplies/radiological studies ordered this visit:

**Orders Placed This Encounter**

Capsicum Oleoresin-Menth-Camph (TIGER BALM) 16-24-80 mg Top PTMD Patch

Sig: APPLY 1 PATCH TO AFFECTED AREA DAILY AS NEEDED FOR PAIN. REMOVE OLD PATCH BEFORE APPLYING THE NEW ONE

Dispense: 20

Refill: 0

Order Specific Question: Is this medication for a workers' compensation condition?

Answer: Yes

Ibuprofen (MOTRIN) 800 mg Oral Tab

Sig: 1 TAB PO TID WITH FOOD PRN PAIN

Dispense: 30

Refill: 1

Order Specific Question: Is this medication for a workers' compensation condition?

Answer: Yes

Methyl Salicylate-Menthol (ICY HOT) 30-10 % Top Crea

Sig: APPLY TO AFFECTED AREA(S) NO MORE THAN QID PRN MUSCLE OR JOINT PAIN

Dispense: 85

Refill: 0

Order Specific Question: Is this medication for a workers' compensation condition?

Answer: Yes

Supplies ordered during this encounter were dispensed and fitted by the staff. Appropriate directions for use were provided.

Treatment and Supplies:

Treatment Plan:

- 1. Prescribed: Ibuprofen and tiger balm patches

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- 2. Work restrictions: Full duty
- 3. Follow-up: 1 weeks

**CHART PREP FOR NURSES FOR NEXT VISIT :**

none

Claims Examiners : For any referral or report issues, please call (844) 789-0172 and press option 1 for the Tri-Central Medical Center Area unit."

**FACTORS OF CARE:**

**Diagnoses:** BMI: obesity, 30 or higher (comorbid)

**Medication:** Medication prescribed/ordered with pertinent risks and benefits explained to the patient

**Treatment Plans and Integration:** Discussion with patient regarding return to work (full, modified or off work)

**24. If further treatment required, specify treatment plan/estimated duration.**

More than likely the patient's condition is expected to improve or reach maximum medical improvement or full recovery in week(s).

**25. If hospitalized as inpatient, give hospital name and location.**

no

**26. WORK STATUS - Restrictions for Modified Work**

Full work today.

Other Needs/Restrictions:

Additional Comments:

Next Appointment: 1 Week

SEBASTIAN  
02 05 19