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October 22, 2020

Natalia Foley, Esq.
Workers Defenders Law Group
8018 E. Santa Ana Canyon, Suite 100-215
Anaheim Hills, CA 92808

PATIENT:	Raymond Kendrick
DOB:	4/8/1956
OUR FILE #:	207770
SSN:	XXX-XX-1929
EMPLOYER:	Home Depot 2415 Cherry Avenue Signal Hill, CA 90755
WCAB #:	ADJ11362261; ADJ12926222
SIF #:	SIF11362261
CLAIM#:	WC608-D60865
DATE OF INJURY:	CT: 4/1/07 – 5/24/18; CT: 4/23/17- 7/12/19
DATE OF 1ST VISIT:	10/22/20
INSURER:	Liberty Mutual Insurance P.O. Box 7203 London, KY 40742
ADJUSTOR:	Alexandria Johnson
PHONE #:	(800) 821-2967
FAX #:	(603) 334-0221

Subsequent Injury Fund
Medical Legal Report
With Medical Record Review

Dear Ms. Foley,

Thank you for referring Raymond Kendrick, a 46-year-old male, to my office for consultation related to a Subsequent Injury Fund claim. The patient is specifically referred for evaluation and treatment of various musculoskeletal and other injuries that he sustained during the course of his employment with Home Depot.

ML 104-95: This is a Subsequent Injury Fund (SIF) Medical Legal Report. One and one half (1.5) hour was spent for face to face time with the patient. Two (2.0) hours were spent for medical record review. The time for dictating and organizing this report was four and one half (4.5) hours. A total of eight (8.0) hours were spent for this report.

Job Description:

The patient began working in the home and garden department of Home Depot on 7/22/07 and he continued working for the company until 2019. His work hours were from 7:00 am to 4:00 pm, five days per week. His job duties involved assisting customers with garden products, stocking shelves and moving trees. Physically, the job required for him to stand and walk for the most part of the day. At times he was required to knee and lift up to 50 pounds weight.

History of the Injury as Related by the Patient:

The patient filed a continuous trauma claim between the dates of 4/1/07 to 5/24/18 and 4/23/17 to 7/12/19, for injuries that he sustained during the course of his employment.

The patient states that throughout the course of his work, his job was very stressful while working for Home Depot. He would have to lift items that were heavy as he worked in the gardening center. The patient would also assist customers for customer service needs.

The patient, on one specific day in 2019, he had an argument with a supervisor. He states that this caused him to have a significant amount of stress in addition to the stress that he was already under. He states that he went home that evening and felt a strange feeling with weakness and tingling throughout his upper and lower extremities. The next day he went to work; however, he had some cognitive dysfunction. He then states that he was ultimately evaluated by a physician who referred him for an MRI of the brain. It was determined that the patient had suffered an acute stroke. The patient was started on various medications for the treatment of his stroke. The patient relates that he was hospitalized for approximately three weeks at Kaiser Permanente in Harbor City.

The patient relates that after he was discharged from Kaiser Permanente, he was started on rehabilitation including physical and speech therapy. He continues to take his medications, but unable to remember many of the events.

Since this time, he has had difficulty with ambulation. He states that after his stroke, he was able to return to work for a short period of time and states that since 2019, he has not been able to perform his job duties.

After the patient returned to work, he was sent on his lunch break and he tripped and sustained a fall on the curb. He fell onto his left side injuring his left knee and left shoulder.

Occupational Exposure:

The patient was exposed to chemicals, fumes, and dust during the course of his work. The patient was not exposed to excessive noise during the course of his work. He was exposed to excessive heat and cold depending on the weather.

Past Medical History:

The patient was diagnosed with hypertension and diabetes mellitus in 2000. He suffered a cerebrovascular accident on 4/23/19. He has undergone right shoulder surgery. He denies any other history of previous medical or surgical conditions. He has no known allergies. There is no history of prior accidents or injuries. There is no other significant medical history.

Social History:

The patient is single. He has no children. He does not smoke cigarettes, drink alcoholic beverages or use recreational drugs.

Family History:

The patient's parents have died. His mother died of complications of sepsis. His father died of cancer. He had five brothers and two sisters. Four brothers have died. On died in an accident, another died of cancer and one died of heart failure. The last brother died of unknown cause. His remaining siblings are alive and well. There is no other significant family medical history.

Review of Systems Prior to Work Injury:

Prior to the work injury, the patient had complaints of anxiety, depression, difficulty concentrating, difficulty sleeping, difficulty making decisions, forgetfulness, and lumbar spine pain 5/10.

The patient denies complaints of visual difficulty, shortness of breath, headaches, dizziness, lightheadedness, eye pain, ear pain, hearing problems, sinus problems, sinus congestion, cough, throat pain, postnasal drip, jaw pain, jaw clenching, dry mouth, chest pain, palpitations, wheezing, hemoptysis, abdominal pain, cramping, burning symptoms, reflux symptoms, nausea, vomiting, diarrhea, constipation, weight gain, weight loss, cervical spine pain, thoracic spine pain, left hip pain, left knee pain, left ankle pain, peripheral edema or swelling of the ankles, hair loss, intolerance to excessive heat or cold, fever, diaphoresis, chills,

genitourinary complaints including dysuria, urinary urgency, urinary tract infections, or lymphadenopathy.

Review of Systems After Work Injury:

The patient complains of visual difficulty and shortness of breath. He denies any complaints of headaches, dizziness, lightheadedness, eye pain, ear pain, hearing problems, sinus problems, sinus congestion, cough, throat pain, postnasal drip, jaw pain, jaw clenching, dry mouth, chest pain, palpitations, wheezing, hemoptysis or expectoration. The patient denies any complaints of abdominal pain or cramping, burning symptoms, reflux symptoms, nausea, vomiting, diarrhea, constipation, weight gain or weight loss. The patient complains of urinary frequency, but denies any other genitourinary complaints including dysuria, urgency or urinary tract infections. The patient's musculoskeletal complaints involve cervical spine pain 6-7/10, thoracic spine pain 6-7/10, lumbar spine pain 5/10, left hip pain 8/10, left knee pain 8/10 and left ankle pain 7-8/10. There is no complaint of peripheral edema or swelling of the ankles. The patient's psychosocial complaints include anxiety, depression, difficulty concentrating, difficulty sleeping, difficulty making decisions and forgetfulness. There is no hair loss. There are dermatologic complaints. There is no intolerance to excessive heat or cold. There is no complaint of fever, diaphoresis, chills or lymphadenopathy.

Activities of Daily Living Before the Injury:

The patient was able to do the following without difficulty: dress himself including shoes, comb his hair, wash and dry himself, take a bath/shower, get on and off the toilet, brush his teeth, cut his food, lift a full cup/glass to his mouth, open a new milk carton, make a meal, write a note, type a message on the computer, see a television screen, use a telephone, speak clearly, feel what he touches, smell the food he eats, taste the food he eats, open car doors, open previously-opened jars, turn a faucet on and off, work outdoors on flat ground, climb up 1 flight of 10 steps, stand, sit, recline, rise from a chair, run errands, light housework, shop, get in and out of a car, sleep and engage in sexual activity.

The patient always: dressed himself, bathed himself, put on shoes, cooked, cleaned the kitchen, combed his hair, vacuumed, swept, put things away, shopped for groceries, carried in groceries, made the bed, did laundry, went to work, made love, climbed a ladder, washed the car, mowed grass, raked grass/leaves, sat in a chair longer than 20 minutes, stood in line longer than 15 minutes, pruned a tree/shrub, dug a ditch, repaired plumbing, walked, and drove a car.

The patient most often: lifted a child younger than 3 years old, lifted a child between 3 and 5 years old, and did not have a pain level higher than 5 (on a scale of 10).

The patient never: repaired the car, did light construction, hunted/fished, hiked/camped, danced, and operated heavy equipment.

The patient sometimes: felt depressed, felt sad for no reason, felt tearful for no reason, felt hopeless, felt anxious, felt forgetful, felt low self-esteem, felt concerns for the future, misplaced items, and had poor concentration.

The patient never: felt helpless, felt fatigued, felt worried, felt irritable, felt loss of interest in activities/hobbies, felt isolated, felt diminished libido, felt loss of control of life, had hallucinations, had thoughts of suicide with plan, had thoughts of suicide without plan, had recent weight loss, had recent weight gain, had a loss of appetite, had increased appetite, heard voices, saw images, napped during the day, spent most of the day in bed, needed medications to sleep, or had interrupted sleep.

Activities of Daily Living After the Injury:

The patient is able to do the following without difficulty: dress himself including shoes, comb his hair, wash and dry himself, take a bath/shower, get on and off the toilet, brush his teeth, cut his food, lift a full cup/glass to his mouth, open a new milk carton, make a meal, use a telephone, feel what he touches, open car doors, open previously-opened jars, turn a faucet on and off, climb up 1 flight of 10 steps, stand, sit, recline, rise from a chair, run errands, shop, get in and out of a car, sleep and engage in sexual activity.

The patient is able to do the following with some difficulty: write a note, smell the food he eats, and taste the food he eats.

The patient is able to do the following with much difficulty: type a message on the computer, see a television screen, speak clearly, work outdoors on flat ground, and light housework.

The patient always: dresses himself, bathes himself, puts on shoes, cleans the kitchen, combs his hair, vacuums, sweeps, puts things away, shops for groceries, carries in groceries, makes the bed, washes a car, and does the laundry.

The patient most often: cooks, mows the grass, rakes the leaves, walks, and drives a car.

The patient sometimes: makes love and climbs a ladder.

The patient never: goes to work, lifts a child <3 years old, lifts a child 3-5 years old, repairs a car, does light construction, can sit in a chair longer than 20 minutes, can stand in line longer than 15 minutes, prunes a tree/shrub, digs a ditch, fixes the plumbing, hunts or fishes, hikes or camps, dances, operates heavy machinery, and does not have a pain level higher than 5 (on a scale of 10).

The patient always: feels depressed, feels sad for no reason, feels tearful for no reason, feels hopeless, feels helpless, feels fatigued, feels worried, feels anxious, feels forgetful, feels irritable, feels isolated, feels loss of control of life, feels concerns for the future, misplaces items, and has poor concentration.

The patient most of the time: feels loss of interest in activities/hobbies, feels diminished libido, and feels low self-esteem.

The patient sometimes: has thoughts of suicide with plan, has thoughts of suicide without plan, naps during the day, spends most of the day in bed, needs medication to sleep, and has interrupted sleep.

The patient never: has recent weight loss, has recent weight gain, has a loss of appetite, has increased appetite, hears voices, sees images, or has hallucinations.

Current Medications:

The patient is not currently taking any medications.

Physical Examination:

The patient is a left handed 46-year-old alert, cooperative and oriented African/American male, in no acute distress. The following vital signs and measurements are taken today on examination: Weight: 184 lbs. Blood Pressure: 104/58 mmHg. Pulse: 65 bpm. Respiration: 16 bpm. Temperature: 97.0$^{\circ F}$.

Skin:

No abnormalities were detected.

Head:

The patient's head is normocephalic and atraumatic. The patient's facial muscles show good contour and symmetry. There is no scleral icterus and no tenderness of the skull noted on examination. There is bilateral TMJ tenderness.

EENT:

Pupils are equally reactive to light and accommodation. Extraocular movements are intact. The throat is clear. Hearing appears to be uninvolved. The nasal passages are clear and the mucosa is normal in appearance. The patient's neck is overall supple with no evidence of lymphadenopathy, thyromegaly or bruits.

Thorax:

The patient exhibits good bilateral rib excursion during respiration. Lungs are clear during percussion and auscultation. The heart reveals a regular rate and rhythm and no murmurs are noted.

Abdomen:

The abdomen is globular, non-tender without organomegaly. Normoactive bowel sounds are present.

Genitalia and Rectal:

Examination is deferred.

Musculoskeletal Examination:

The patient is ambulatory. There are no grossly visible abnormalities of the upper or lower extremities or the axial skeleton. There are no deformities. There is tenderness of the left side of the cervical spine and left shoulder. There is lumbar spine tenderness. There is mild tenderness of the left knee.

Range of Motion Testing:

Cervical Spine:	Normal
Flexion	40/50
Extension	50/60
Right Rotation	70/80
Left Rotation	70/80
Right Lateral Flexion	30/45
Left Lateral Flexion	30/45

Thoracic Spine:

Flexion	60/60
Right Rotation	30/30

Left Rotation	30/30

Lumbo-Sacral Spine:

Flexion	50/60
Extension	15/25
Right Lateral Flexion	15/25
Left Lateral Flexion	15/25

Shoulder:	*Right*	*Left*
Flexion	150/180	130/180
Extension	40/50	40/50
Abduction	140/180	140/180
Adduction	40/50	40/50
Internal Rotation	80/90	80/90
External Rotation	80/90	80/90

Hips:	*Right*	*Left*
Flexion	100/140	100/140
Extension	0/0	0/0
Abduction	30/45	30/45
Adduction	20/30	20/30
Internal Rotation	30/45	30/45
External Rotation	30/45	30/45

Elbow:	*Right*	*Left*
Flexion	100/140	100/140

Forearm	*Right*	*Left:*
Pronation	60/80	60/80
Supination	60/80	60/80

Wrist:	*Right*	*Left*
Dorsiflexion	40/60	40/60
Palmar Flexion	40/60	40/60
Radial Deviation	10/20	10/20
Ulnar Deviation	20/30	20/30

Knee:	*Right*	*Left*
Flexion	100/130	100/130

Ankle/Foot:	*Right*	*Left*
Dorsiflexion	10/15	10/15
Plantar Flexion	30/40	30/40
Inversion	20/30	20/30
Eversion	10/20	10/20

Neurological Examination:

Cranial nerves 2-12 are intact. Deep tendon reflexes are 2+ bilaterally. Superficial reflexes are found to be within normal limits. There are no abnormal reflexes detected and there is no abnormality of sensation or coordination.

Special Diagnostic Testing:

A pulmonary function test is performed revealing an FVC of 3.36 L (75.1%), an FEV 1 of 2.57 L (83.5%), and an FEF of 2.38 L/s (102.0%). There was a 1.5% increase in FVC and a 3.7% increase in FEV 1 after the administration of Albuterol.

A 12-lead electrocardiogram revealed sinus rhythm, a pulse of 63 bpm, possible inferior infarct, probable old anteroseptal infarct, and an age indeterminate infarct.

A pulse oximetry test is performed today and is recorded at 98%.

A visual acuity test is performed today and reveals the following:

Right eye: 20/40
Left eye: 20/30

An audiogram is performed today and reveals the following:

	500 Hz	1,000 Hz	2,000 Hz	3,000 Hz
Right:	25	30	25	50
Left:	35	20	35	20

Laboratory Testing:

A random blood sugar is performed today and is recorded at 233 mg/dL. The urinalysis performed by dipstick method was reported as normal.

Review of Medical Records: (Exactly 111 pages of medical records were reviewed, which took two (2.0) hours to complete. Below is a summary of the pertinent findings as it pertains to this case).

HAROLD ISEKE CHIROPRACTIC PROFESSIONAL CORPORATION:

The 6/25/18 Doctor's First Report of Occupational Injury or Illness, by Dr. Harold Iseke DC, was reviewed. The patient was seen for: "While performing his usual and customary duties as a customer service worker Mr. Raymond Kendrick sustained traumatic injuries to the back" (p. 1). The objective findings included lumbar spine motor weakness and lumbar spine tenderness. The patient was diagnosed with chronic pain due to trauma and lumbar radiculopathy. The treatment plan included infrared therapy, manual manipulation, and chiropractic sessions.

The 12/17/18 Permanent and Stationary report, by Dr. Harold Iseke DC, was reviewed. The patient was seen for subjective complaints of lower back pain, insomnia, and anxiety. The objective findings included a weight of 191 pounds, a blood pressure of 127/86 mmHg, decreased grip strength on the right, lumbar spine tenderness, bilateral hip tenderness, and a MRI of the lumbar spine. The patient was diagnosed with lumbar spine enthesopathy, lower back pain, sleep disorder, anxiety disorder, myositis, and chronic pain.

Dr. Iseke determined the causation: "It is within a reasonable degree of medical probability that Mr. Kendric's permanent disability to the low back arose out of, in the course of his employment (AOE/COE) with the Home Depot, on a cumulative trauma injury from 4/1/07 to 5/24/18, based on the provided historical information, subjective complaints, objective factors, review of medical records and information available to me at this time" (p. 9). Dr. Iseke determined the apportionment: "With regard to his lumbar spine, I apportioned 80% of his lumbar spine disability was apportioned to the cumulative trauma injury from 4/1/07 to 5/24/18 and 20% to underlying degenerative changes based on the MRI study obtained on 9/18/18" (p. 9). Dr. Iseke calculated the permanent impairment ratings and gave 7% WPI for the lumbar spine and 2% WPI for the sleep.

EXPERT MRI:

The 9/18/18 MRI of the lumbar spine report, by radiologist Dr. Adil Mazhar MD, was reviewed. This study revealed: "Grade I anterolisthesis of L4 on L5. This finding appears stable in the extension position. Hemangioma at L1. Disc

desiccation involving the entire lumbar spine. Disc herniation seen in the lower thoracic level. A 26.1 x 29.x mm left renal cyst seen. T12-L1; a broad based disc protrusion is identified. Disc material abuts the thecal sac. There is bilateral neural foraminal narrowing. Disc measures 3.5 mm in neutral and 3.3 mm in extension position. L3-4; a broad based disc protrusion with a focal left paracentral component is identified. Disc material indents the thecal sac. There is bilateral neural foraminal narrowing. Concurrent left lateral recess stenosis is seen. Annular fissure is identified. Disc measures 4.2 mm in neutral and 4.6 mm in extension position. L4-5; a broad based disc protrusion is identified. This finding together with bilateral facet and ligamentum flavum hypertrophy cause narrowing of the bilateral neural foramen. There is contact on the bilateral exiting nerve roots. Annular fissure is identified. Disc measures 3.5 mm in neutral and 3.3 mm in extension position. L5-S1; a focal right paracentral disc protrusion is identified. Disc material indents the thecal sac. Concurrent right lateral recess stenosis is seen. Associated deviation of right transiting nerve root is noted. Annular fissure is identified. Disc measures 3.7 mm in neutral and 4.8 mm in extension position" (p. 7).

GLOBAL PSYCHOLOGICAL SERVICES:

The 10/25/18 Initial Psychological Evaluation Report, by Dr. Jo Anne Kaplan PhD, was reviewed. The patient was seen for subjective complaints of depression, nausea, crying spells, anxiety, rapid heartbeats, tension, insomnia, fatigue, dizziness, suicidal thoughts, homicidal thoughts, and irritability. The patient underwent a battery of psychological testing including the Mini Mental Status Examination, 16 Personality Factor Subset Scales, Patient Pain Profile, Incomplete Sentence Form, Bender Gestalt Test, the Beck Depression Inventory, the Beck Anxiety Inventory, and the Epworth Sleepiness Scale. The patient was diagnosed with depressive disorder and anxiety disorder (GAF: 55). The treatment plan included psychotherapy session, biofeedback sessions, and a sleep study.

The 11/29/18 PR-2 Progress Report, by Dr. Kaplan, was reviewed. The patient was seen for subjective complaints of anxiety and depression. The patient was diagnosed with depressive disorder and anxiety disorder. The treatment plan was not specified.

Diagnoses:

1. **STATUS-POST 4/23/19 CEREBROVASCULAR ACCIDENT (CVA)**
    - **A. COGNITIVE DYSFUNCTION (SEVERE)**
    - **B. VISUAL DEFICIT**
    - **C. LEFT UPPER EXTREMITY HEMIPARESIS**
    - **D. LEFT LOWER EXTREMITY HEMIPARESIS**
2. **HISTORY OF TRAUMATIC BRAIN INJURY (TBI)**

3. **SENSORINEURAL HEARING LOSS (SNHL), RIGHT WORSE THAN LEFT**
4. **LUMBAR DEGENERATIVE DISC DISEASE**
    A. **DISC PROTRUSIONS AT L4-5 AND L5-S1**
    B. **LUMBAR RADICULOPATHY**
5. **RIGHT SHOULDER INTERNAL DERANGEMENT**
    A. **STATUS-POST ARTHROSCOPIC REPAIR**
6. **METABOLIC CONDITIONS:**
    A. **ESSENTIAL HYPERTENSION, STAGE I (2000)**
    B. **DIABETES MELLITUS TYPE-II (2000)**
        i. **DIABETIC NEUROPATHY, BILATERAL LOWER EXTREMITIES**
7. **PSYCHOLOGICAL CONDITIONS:**
    A. **MAJOR DEPRESSIVE DISORDER**
    B. **GENERALIZED ANXIETY DISORDER**
    C. **INSOMNIA DISORDER**

Disability Status:

Subjective Complaints:

1. Visual difficulty
2. Shortness of breath
3. Urinary frequency
4. Cervical spine pain
5. Thoracic spine pain
6. Lumbar spine pain
7. Left hip pain
8. Left knee pain
9. Left ankle pain
10. Anxiety
11. Depression
12. Difficulty concentrating
13. Difficulty sleeping
14. Difficulty making decisions
15. Forgetfulness
16. Dermatologic complaints

Objective Findings:

1. Weight: 184 lbs.
2. Blood pressure 104/58 mmHg
3. Cervical spine tenderness
4. Decreased lumbar spine range of motion
5. Lumbar spine tenderness

6. Decreased lumbar spine range of motion
7. Left shoulder tenderness
8. Decreased bilateral shoulder range of motion
9. Decreased bilateral hip range of motion
10. Left knee tenderness
11. Decreased bilateral knee range of motion
12. The 10/22/20 pulmonary function test revealed a FVC of 3.36 L (75.1%), a FEV 1 of 2.57 L (83.5%), and a FEF of 2.38 L/s (102.0%)
13. The 10/22/20 12-lead electrocardiogram revealed sinus rhythm, a pulse of 63 bpm, possible inferior infarct, probable old anteroseptal infarct, and an age indeterminate infarct
14. The 10/22/20 audiogram revealed right 500 Hz: 25; 1,000 Hz: 30; 2,000 Hz: 25; and 3,000 Hz: 50, and left 500 Hz: 35; 1,000 Hz: 20; 2,000 Hz: 35; and 3,000 Hz: 20
15. The 10/22/20 random blood sugar was recorded at 233 mg/dL
16. The 9/18/18 MRI of the lumbar spine revealed Grade I anterolisthesis of L4 on L5, a 26.1 x 29.x mm left renal cyst, a 3.5 mm broad based disc protrusion at L4-5 indenting the bilateral exiting nerve roots, and a 3.7 mm focal right paracentral disc protrusion at L5-D1 causing transition of the right L5 nerve root

Permanent Impairment Ratings (Prior to the Date of Injury):

According to the AMA Guidelines 5th Edition, Table 13-5 Clinical Dementia Rating (CDR) on page 320, and Table 13-6 Criteria for Rating Impairment Related to Mental Status on page 320, Mr. Kendrick's traumatic brain injury (TBI) qualifies for a CDR score of 0.5 (Memory (M): 0.5; Orientation (O): 0.5; Judgement and Problem Solving (JPS): 0.5; Community Affairs (CA): 0.5; Home and Hobbies (HH): 0.0; Personal Care (PC): 0.0). This corresponds to a Class I rating, equating to a **13% WPI**.

According to the AMA Guidelines 5th Edition, Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury on page 384, the patient's lumbar spine strain warrants a DRE Class II rating of **5% WPI**.

According to the AMA Guidelines 5th Edition, Table 16-18 Maximum Impairment Values for the Digits, Hand, Wrist, Elbow, and Shoulder Due to Disorders of Specific Joints or Units on page 499, Table 16-19 Joint Impairment from Synovial Hypertrophy on page 500, and Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole Person on page 439, Mr. Kendrick's left shoulder (glenohumeral joint, 60% upper extremity) injury warrants mild classification, corresponding to a 10% joint impairment. The left shoulder impairment is equivalent to a 6% upper extremity impairment (60% x 10% = 6%), which corresponds to a **3% WPI**.

According to the AMA Guidelines 5th Edition, Table 4-1 Classification of Hypertension in Adults and Table 14-2 Criteria for Rating Permanent Impairment Due to Hypertensive Cardiovascular Disease both on page 66, Mr. Kendrick's hypertension qualifies for a Class II rating (Stage I, without hypertensive medications, without evidence of proteinuria), corresponding to a **18% WPI**.

According to the AMA Guidelines 5th Edition, Table 10-8 Criteria for Rating Impairment Due to Diabetes Mellitus on page 231, Mr. Kendrick;s diabetes mellitus type II warrants a moderate Class I rating (Type-II diabetes, without medications, without evidence of microangiopathy), corresponding to a **3% WPI.**

Using the Combined Values Chart (CVC) on page 604, Mr. Kendrick's combined Whole Person Impairments (18**%** + 13% + 5**%** + 3% + 3%) equates to **37% WPI.**

Permanent Impairment Ratings (After the Date of Injury):

According to the AMA Guidelines 5th Edition, Table 13-4 Criteria for Rating Impairment Due to Sleep and Arousal Disorders on page 317, Mr. Kendrick's sleep impairment warrants a low Class I rating, corresponding to a **2% WPI**.

According to the AMA Guidelines 5th Edition, Table 11-1 Monaural Hearing Loss and Impairment on page 247, Table 11-2 Computation of Binaural Hearing Impairment on page 248, and Table 11-3 Relationship of Binaural Hearing Impairment to Impairment of the Whole Person on page 250, Mr. Kendrick's sensorineural hearing loss (right: 130; left; 110) corresponds to a **2% WPI**.

According to the Schedule for Rating Permanent Disabilities, under the labor provisions of the Labor Code of the State of California (2005), Section-1c Converting the GAF Score to a Whole Person Impairment on page 16, Mr. Kendrick's GAF score of 55 corresponds to a **23% WPI**.

According to the AMA Guidelines 5th Edition, Table 15-3 Criteria for Rating Impairment Due to Lumbar Spine Injury on page 384, the patient's lumbar spine strain warrants a DRE Class III rating of **9% WPI**.

According to the AMA Guidelines 5th Edition, Table 13-16 Criteria for Rating Impairment of One Upper Extremity on page 338, Mr. Kendrick's left-sided upper extremity disability from cerebrovascular accident (non-dominant) qualifies for a moderate Class II rating (can use the effected extremity, difficulty with grasping and holding, has difficulty of digital dexterity), equating to a **9% WPI**.

According to the AMA Guidelines 5th Edition, Table 17-33 Impairment Estimates for Certain Lower Extremity Impairments on page 546, Mr. Kendrick's left knee impairment is most consistent with moderate Cruciate or Collateral Ligament Laxity, corresponding to a **7% WPI.**

According to the AMA Guidelines 5th Edition, Table 13-15 Criteria for Rating Impairment Due to Station and Gait Disorders on page 336, Mr. Kendrick's lower extremity hemiparesis from cerebrovascular accident warrants a Class I rating, corresponding to a **7% WPI**.

According to the AMA Guidelines 5th Edition, Table 4-1 Classification of Hypertension in Adults and Table 14-2 Criteria for Rating Permanent Impairment Due to Hypertensive Cardiovascular Disease both on page 66, Mr. Kendrick's hypertension qualifies for a Class II rating (Stage I, without hypertensive medications, without evidence of proteinuria), corresponding to a **25% WPI**.

According to the AMA Guidelines 5th Edition, Table 10-8 Criteria for Rating Impairment Due to Diabetes Mellitus on page 231, Mr. Kendrick;s diabetes mellitus type II warrants a moderate Class II rating (Type-II diabetes, uncontrolled with diet, without evidence of microangiopathy), corresponding to a **7% WPI.**

Using the Combined Values Chart (CVC) on page 604, Mr. Kendrick's combined Whole Person Impairments (25**%** + 23% + 9**%** + 9% + 9% + 7% + 7% + 7% + 2% 2%) equates to **63% WPI.**

Work Restrictions:

For Mr. Kendrick's insomnia, he should be restricted from working the graveyard shift, limited use of driving, any work that requires complete awareness and concentration (operation of heavy machinery), or work where his safety and the safety of others depends on Mr. Kendrick.

For Mr. Kendrick's hearing loss, he should be precluded from work requiring detection of sound, work that requires distinguishing between different sounds, and any work where the safety of others is dependent on the patient's ability to detect sounds such as an alarm, siren, or alerting system. A brief discussion should be provided for Mr. Kendrick's co-workers about his hearing impairment, and any information about how they best communicate and learn new information, consider the use of adaptive technology to overcome any barriers associated with hearing, and consider adaptations to workstations in the event his physical impairment limit his effectiveness.

For Mr. Kendrick's complaints of lumbar spine pain, he should be precluded from work involving heavy lifting, repetitive pushing, pulling, or stooping.

For Mr. Kendrick's upper extremity disability, he should be precluded from continuous use of the hands and wrists, repetitive fine motor manipulations of the hands, frequent pushing and pulling of the hands and wrists (greater than 10

pounds), and activities that require flexion, extension, and twisting of the hands and wrists.

For Mr. Kendrick's left knee disability, he should be precluded from work on girders, climbing ladders, rooftops, or unprotected heights, work on platforms greater than 5 feet, and work near dangerous moving machinery.

Attestation:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I further declare under penalty of perjury that I personally performed the evaluation of the patient and that I personally performed the cognitive services necessary to produce this report at the above address, and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

The laboratory tests, if taken, were performed by Sinai Lab or MetroLab, Inc., Encino, CA. X-rays, if taken, were administered by Jose Navarro, licensed x-ray technician #RHP 80136, and read by me. The chiropractic care and physical therapy treatments are provided under the direction of Scott Mintz, D.C.

I obtained the history, performed the physical examination and dictated this entire report, with the assistance of Ryan Shoji, clinical research associate.

I further 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.

Based on Labor Code Statute 4628, a fee of $64.50 per page for a total of 17 pages has been added to cover reasonable costs of the clerical expense necessary to produce this report.

Disclaimer:

The examination of this claimant was performed by Dr. Koruon Daldalyan MD. It should be noted; however, that aside from the physical examination, the editing of this report and the reviews deemed necessary and appropriate to identify and determine relevant medical issues including diagnosis, causation and treatment recommendations have been performed by me in consultation with Dr. Koruon Daldalyan MD.

Should you have any questions or concerns regarding the evaluation or treatment provided to this claimant or this report, please feel free to contact me.

Sincerely,

Marvin Pietruszka, M.D., M.Sc., F.C.A.P.
Clinical Associate Professor of Pathology
University of Southern California
Keck School of Medicine
QME 008609
MP/rs

Koruon Daldalyan, M.D.
Board Certified, Internal Medicine