

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) Change in treatment plan Release From Care
- Change in work status Need for referral or consultation Response to request for information
- Change in patient's condition Need for surgery or hospitalization Request for authorization
- Other: _____

Patient

Seeram Patient last name: Sandra Patient first name: _____ MI

2692 cabrillo ave Patient Street Address/PO Box Torrance Patient City CA State 90501 Zip Code Female Sex

branch manager Occupation [1] 310-561-2036 Phone Number _____ Date of Birth 11/19/1968

Date of Injury Ct: 11/16/2018
- 05/02/2019

Claims Administrator

Broadspire Claims Administrator Name: 189103909 Claim number:

P.O. Box 14645 Claims Administrator Street Address/ Lexington Claims Administrator City KY State 40512 Zip Code

[1] 916-850-8200 Phone Number _____ Fax Number JP Morgan Chase Bank Employer Name _____ Phone Number

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

Continued symptoms of both anxiety and depression.

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

Continued objective functional improvement documented on progress note.

1. Major Depressive Disorder, Single Episode	ICD-10	F32.9
2. Generalized Anxiety Disorder	ICD-10	F41.1
3. Psychological Factors Affecting Medical Condition (stress-intensified headache, neck/shoulder/low back tension/pain, nausea, chest pain, shortness of breath, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high blood pressure)	ICD-10	F54
4.	ICD-10	
5.	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?

Psychiatric medication (90792)
CBT Psychotherapy (90834)
All as needed and all as requested by RFA in effect according to guidelines.

Work Status: This patient has been instructed to:

- Remain off-work _____ . **Requires a medical leave of absence from 10-07-19 to 01-07-20.**
- See P&S evaluation of _____.
- Return to *modified* work on _____ with the following limitations or restrictions. (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

Ms. Seeram was found to be temporarily totally disabled on a combined physical and psychological basis.

- Return to full duty on _____ with no limitations or restrictions.

Primary Treating Physician: *(original signature, do not stamp)*

Physician signature: _____

Executed at: Van Nuys, CA

Physician Name: Thomas Curtis M.D.

Physician address: 14531 Hamlin Street, Van Nuys, CA 91411

Date of exam 10-07-19
(Last Treatment)

Cal. License. Number : A23197

Date: 11-25-19

Specialty: Psychiatry

Phone Number: (818)780-4409

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.

RE: Sandra Seeram vs. JP Morgan Chase Bank

WCAB#: ADJ12217216

(PROOF OF SERVICE BY MAIL - 1013a, 2015.5 C.C.P.)

I am a resident of/employed in the aforesaid county, State of California; I am over the age of eighteen years and not a party to the within action; my business/residence address is: 14531 Hamlin Street, Van Nuys, CA 91411.

On 11-25-19, I served the foregoing

Attending Physician's Report

Applicant Attorney:
Natalia Foley, Esq.
5753 E Santa Ana Cyn Rd Ste. G#616
Anaheim, CA 92807

Insurance Carrier
Broadspire
P.O. Box 14645
Lexington, KY 40512

On the interested parties in this action by placing the true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Van Nuys, California, addressed as follows:

I certify (or declare), under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

11-25-19

Date

Signature of Declarant

IRENA E. HAMAMDJIAN

Full name of Declarant