State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY Victoria Sarver FOR THE REASONS STATED BELOW:
(Print name of injured employee)

I, **Douglas W. Larson**, declare as follows:
(Print your name)

1. I am licensed in the state of California as a **PSYCHOLOGIST**, license number **PSY9281**
(Type of license)

2. The attached medical record pertains to:

Employee name: **Victoria Sarver**

Address: **666 West 18th Street Apt. 4 Costa Mesa, CA 92627** Phone: **(949) 514-4207**

W.C. Claim number: **550613; 550796**

W. C. Claims administrator: **Ms. Janice Gardner** Phone: **260-482-8668**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

SUBSTANTIAL RISK OF POTENTIAL NEGATIVE REACTION TO PSYCHOLOGICAL INFORMATION.

(1)

4. On **January 11,** 20**19**, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.

6. The employee has designated the following physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, for alternate service of the employee's copy of this record:

Name: **Dr. Mohsin Shah**

Address: **455 Old Newport Blvd. Suite 101 Newport Beach, CA 92663**

Phone: **(949) 933-7012** Fax: _____

Medical license no. (CA, if known): _____

Date of employee designation of this physician or health care provider: _____ (MM/DD/YYYY)

7. For the above reasons, in response to the employee's request of _____ (date MM/DD/YYYY) for a copy of the record, I responded in the following manner: (*Check one below, as appropriate.)*

☐ I declined to allow the employee to personally inspect or receive a copy of the record.

☐ I declined to allow the employee to personally inspect, receive a copy or to be served personally with a copy of the record. However, at the employee's request, I did provide to, or serve a copy of the record on, the physician or health care provider designated by the employee as noted below:

Name: **N/A**

Address: _____

Phone: _____ Fax: _____

Date of Service: _____

Manner of Service: (mail, overnight mail, courier, fax) **Mail**

8. From this time forward, I shall note in the medical file for this employee each time any licensed physician, within the definition of Labor Code 3209.3 or a health care provider as defined in Health and Safety Code § 123105, requests to inspect or copy this record on behalf of the employee.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date signed: February 10, 2019

_____ **DOUGLAS W. LARSON**

(Signature) (Print name)

Address: **34428 Yucaipa Boulevard, Suite e355, Yucaipa, CA 92399** Phone: **(909) 798-8999**

File record of requests for copies of the attached record made subsequent to the declaration date above:

Date	Person	License type and License number

State of California

DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

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

Case Name: **Victoria Sarver** *(employee name)* v **Lighthouse Coastal Community Church** *(claims administrator name, or if none employer)*

Claim No.: **550613; 550796**

EAMS or WCAB Case No. (*if any*): ADJ11096006, ADJ11096005, ADJ11248785

I, **Douglas W. Larson** *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: **34428 Yucaipa Boulevard, Suite e355, Yucaipa, CA 92399**
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

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

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	**02/10/19**	Ms. Janice Gardner Brotherhood Mutual Insurance Fort Wayne PO Box 2228 Fort Wayne, IN 46801
A	**02/10/19**	Ms. Natalia Foley Law Offices of Natalia Foley, Esq. 8306 Wilshire Blvd, #115 Beverly Hills, CA 90211
A	**02/10/19**	Mr. Mike Mazurek, Esq. Famiglietti & Vople 1748 Katella Ave, #209 Orange, CA 92867
A	**02/10/19**	Dr. Mohsin Shah 455 Old Newport Blvd. Suite 101 Newport Beach, CA 92663

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: July 21st, 2015

(signature of declarant)

Douglas W. Larson

(print name)

QME Form 122
Rev. February 2009

Douglas W. Larson, Ph.D.
Licensed Psychologist PSY9281
(855) 375-2776 FAX (909) 363-8822

Billing and Correspondence:
34428 Yucaipa Boulevard, Suite e355
Yucaipa, CA 92399

February 10, 2019

Ms. Natalia Foley, Esq.
Law Offices of Natalia Foley, Esq.
8306 Wilshire Blvd, #115
Beverly Hills, CA 90211

Mr. Mike Mazurek, Esq.
Famiglietti & Vople
1748 Katella Ave, #209
Orange, CA 92867

RE:	Victoria Sarver vs Lighthouse Coastal Community Church
WCAB/EAMS No.	ADJ11096006, ADJ11096005, ADJ11248785
CLAIM #:	550613; 550796
DOB:	11/01/1966
OCCUPATION:	Janitor
SSN:	xxx-xx-3970
DATE OF INJURY:	CT: 09/01/13-09/01/17; 08/30/17; CT 09/15/13-09/15/17

The following psychological evaluation report contains confidential and privileged information. Some information contained in this report may be misunderstood and distorted by the applicant and/or the applicant's friends or family members which may result in significant psychological distress to those individuals. This report and all of its contents are meant for the use of qualified professionals only, and those professionals involved with the medical legal workers' compensation case. Persons breaching the confidential nature of this report assume the risks and liabilities involved.

COMPREHENSIVE PSYCHOLOGICAL MEDICAL LEGAL EVALUATION

Dear Ms. Foley and Mr. Mazurek

Thank you for the referral of Victoria Sarver to my office for an evaluation. I am available and willing to prepare supplemental reports as needed for this case. The following is a complete report of the psychological evaluation of which was conducted by myself at my Santa Ana, California office located at 201 E MacArthur Blvd, Santa Ana, CA 92707. On January 11, 2019, Ms. Sarver arrived in my office promptly for the appointment. The evaluation's procedures were

mostly completed on that day, with a follow up phone call on 2/9/19. Prior to beginning my evaluation of Ms. Sarver, I communicated that I am a psychologist and that the examination was scheduled for a full day. I indicated that I would submit my report of the evaluation to the attorneys and claims examiner involved in this case and that this information would otherwise be confidential. The applicant expressed understanding of the nature of our meeting and proceeded with the evaluation's procedures. The following report contains my opinions and conclusions regarding all relevant issues involved in this case. This report is in compliance with Labor Code sections 139.2, 139.3, 3208.3, 4628, 5307.1 and 5307.6 as well as Regulations 38, 9726 and 9795 of the workers' compensation laws of the State of California.

Extraordinary circumstances were involved with this evaluation which included: This psychiatric evaluation required an extraordinary complex, detailed developmental, family, social, and psychiatric/psychological history. This level of information is necessary, in order to adequately and credibly address essential issues. Psychiatric/psychological protocols are required, in order to address the issue of permanent work function capacity. These include the evaluation, assessment and analysis of multiple, complex work functions. This psychiatric/psychological evaluation necessitates assessment for the presence or absence of exaggeration due to psychiatric disorder or malingering. This process required complex analysis, in order to determine essential issues, such as compensability of the alleged injury. Review and analysis of the approximately 1,000 pages of records. Considering and addressing issues of apportionment in this case. Considering and addressing issues of medical causation in this case. Report preparation includes conceptualization, formulation of all relevant data, dictation, editing of report, relevant research, and review of final report.

Billed time in hours was as follows:

Face to Face Interview:	3.0
Review of Records	7.0
Psychological Testing, Face to Face:	5.0
Psychological Test Scoring:	1.0
Necessary Research	2.0
Report Preparation:	13.0
TOTAL:	31.0 Hours

PROCEDURES & TESTS ADMINISTERED:

Face to Face History/Examination.
Psychological Testing:
- Rey 15 Item Memory Test - 2 (Rey).
- Test of Memory Malingering (TOMM).
- Minnesota Multiphasic Personality Inventory - 2nd Edition (MMPI-2).
- Beck Anxiety Inventory (BAI).
- Beck Depression Inventory (BDI).

Hamilton Rating Scales of Depression (Hamilton).
Epworth Sleepiness Scale (Epworth).
Wechsler Adult Intelligence Scale – 4th Edition (WAIS-IV).
Wide Range Assessment of Memory & Learning – 2nd Edition (WRAML-2).
Wide Range Achievement Test -- 4th Edition (WRAT-4)
Woodcock-Johnson III Test of Achievement (WJ-III).
Bender Gestalt Visual Motor Integration Test -- 2nd Edition (Bender 2).
Trail Making Test (Trails).
Review of Records.
Necessary Research.
Report Preparation.

IDENTIFYING INFORMATION:

Ms. Sarver is a 52-year-old female. Her date of birth is reported as 11/01/1966.

SUMMARY AND INTEGRATION:

Industrial causation with greater than 50% medical probability is indicated at this time for her mental health problems, although with additional requested information my opinions may change. My reasoning is as follows:

Since the events are in part due to those in a superior position to her there is a scenario where the Rolda defense might be asserted, and at that point, Rolda procedures would need to be followed. Given an onset of April 2016, a Benson analysis at this time indicates 40% to the cumulative trauma of her back issues, 40% due to the cumulative trauma surrounding sexual harassment and its sequelae, and the remaining 20% due to her marital problems. The specific injury of 8/30/2017 and the car accident in June 2017 may be permanent aggravating factors or temporary exacerbating factors depending on additional information including additional records and evaluations, treatment, and a subsequent re-evaluation.

In brief, Ms. Sarver was employed as a janitor by her beloved church in September 2008 and was fired in September 2017, and during that time was sexually harassed by a senior pastor, but delayed reporting it only after her older daughter noted similar behavior, and Ms. Sarver feared for the safety of her younger daughter. After she reported the incident initially she was treated well but over time felt that she was considered a problem leading to write ups, reduction in hours, humiliating treatment, and ultimate termination.

An important facet of this case is that Ms. Sarver has learning problems, was retained one year in school, and has notable memory problems detailed in the body of the report which may be related to an auto accident in June 2017, three months before she was fired. For example, her deposition testimony contains many instances of confusion and memory problems. Her

nonAME/QME neurologist opined she had a post-concussive syndrome with PTSD and no apportionment to other factors, but it also appears he did not have access to all the information available to me. In addition, I could not find a clear exposition as to the details of her accident, and Ms. Sarver's memory problems. As such, anAME/QME evaluation from a neurologist or neuropsychologist is recommended (e.g., Larrabee, 2012; Masel & DeWitt, 2014). Ms. Sarver indicated she kept a calendar of events which has not been submitted in evidence, which may be useful in the future.

Beside the sexual harassment, Ms. Sarver worked as janitor, and for many years had to load and unload chairs from a broken dolly, which led to nonMMI industrial back pain per the orthopedic AME/QME in this case, and associated anxiety and depression which has waxed and waned. Because of her complaints about worrying and then having an upset stomach, as well as reporting an ulcer, an AME/PQME in internal medicine is also recommended.

Despite her emotional issues and physical issues she was able to work at her job until she was fired, and filed her claim after she was fired.

She has struggled off and on with depression and anxiety for many years, first noted in the records provided on 7/23/2010 when she went to an emergency room, and she was unemployed. However, no formal diagnoses were provided at that time. Ms. Sarver indicated that she had counseling for a DUI in the past, which was helpful. She also sought counseling from a free clinic. She also struggled with drug and alcohol use until she found her church, where turned her life around. She went through a period of stress when she was divorcing her second husband, but he has not become a significant source of support for her.

In April 2016 while she was hospitalized for a hysterectomy she was given the following diagnoses at Hoag Hospital: anxiety disorder, unspecified; major depressive disorder, single episode. This diagnosis was not explained in any detail, but the diagnosis did follow her report of the sexual harassment.

Ms. Sarver ultimately was fired from her position and apparently there was no clear written statement of why she was fired. Ms. Sarver did recall she had been given three letters of write-ups by another church worker named Jeannie, which Ms. Sarver felt were for fairly petty items. As such, personnel records could be useful.

Ms. Sarver would probably benefit from psychotherapy and a medication review. Therefore, at this point, she would not be considered to have reached Maximum Medical Improvement (MMI). Apportionment is similarly deferred.

At this time, Ms. Sarver has moderate symptoms of memory, depression and anxiety such that her current GAF (see Appendix A) would be 60. Although she has made progress in recovering, she still has significant symptoms. As such, she is recommended for the standard Cognitive

Behavioral Therapy following ACOEM Guidelines (Appendix B) detailed in the body of the report.

No Temporary Total Disability (TTD) or Temporary Partial Disability (TPD) is indicated as a result of her mental health symptoms. Any problems in performing her job would appear to be due to physical pain and is deferred to the appropriate specialty.

A reevaluation is suggested after Ms. Sarver has completed recommended treatment and has been declared Permanent and Stationary by any other specialties involved in this case.

REVIEW OF RECORDS:

11/26/2018: State of California Division of Workers' Compensation – Medical Unit QME Appointment Notification Form naming Douglas Larson, Ph.D. as QME.

01/03/2019: Famiglietti & Volpe, Defendant Cover Letter

Start of Review:

07/23/2010: Patient Information Form

Admitting Reason: Ear pain, throat pain. Patient is insured through private pay secondary; she is unemployed. Admitting DX: acute pharyngitis. Discharge DX: Acute pharyngitis.

07/23/2010: Hoag Hospital Emergency Physician Record, author not noted

She presented with moderate chills, sore throat and fever that started two days ago.

ROS was positive for fainting, dizziness, confusion and anxiety. No prior surgeries were noted. She was currently on no meds.

Psychiatric portion of the exam documented that she was AOx3 with normal mood and affect.

She was diagnosed with pharyngitis, exudative and prescribed Azithromycin and Medrol.

No mental health concerns are documented in this reporting.

- DX Signed by Mr. Gilboy was provided for the meds.
- Patient discharge Instruction Summary documents an RX for Azithromycin and Medrol Dosepak – No MH concerns noted.

- Patient Stated Home Medication List – nothing noted
- ED Fall, Abuse and Suicide Risk Assessment – all marked negative or "no".
- Medication Administration Record – ED
- Conditions for Admission

10/25/2011: Hoag Hospital, Patient Information

Admitting reason: Flu. She was Private Pay Secondary; unemployed. Admitting DX: Vomiting Alone. Discharge DX: Psychogenic respiratory disorder; anxiety state NOS; dehydration; vomiting alone; diarrhea; anemia NOS and Depressive disorder NEC.

10/25/2011: Hoag Hospital ED Triage Note, Veronica Sezanov, R.N.

She presented with vomiting and headache. She reported the inability to keep anything down and was around a recent family member who had bronchitis. Her cough was almost resolved. She also complained of SOB and depression.

Past medical history was significant for anemia, syncope and depression. Social history documented that she has a prior history of ETOH and drug abuse.

On exam, she was alert and mildly anxious. Mood and affect were WNL.

She was diagnosed with vomiting/diarrhea, dehydration, anxiety and hyperventilation.

Her condition improved and she was discharge dome with Zofran. Education materials and counseling were provided.

- RX for Zofran was included, signed by David Meyers, M.D.
- ED Disposition Note documents complaints of vomiting and HA. She was discharged once her symptoms were controlled. She was resting, denied pain, denied nausea, VSS and NAD.
- ED Focused Assessment Flowsheet Information does note that at 20:10: she did not meet SI criteria; Abuse Assessment was also WNL. She was noted to be AOx4 with no deficits noted.
- ED Vital Signs Flowsheet Information ledger was included – No MH issues.

- ED Intake and Output Flowsheet Information – No MH issues noted.
- ED Pediatric Assessment Flowsheet Information – No MH issues noted.
- Medication Reconciliation/Orders, Medication Prescriptions and Medication Administration
- Conditions of Admission

01/26/2012: Hoag Hospital ED Orders

Because of chest pain and abdominal issues, labs were ordered along with an EKG, CT with IV contrast of the abdomen & pelvis as well as a chest x-ray.

06/05/2012: Patient Information Form

Admitting Reason: Lower back pain, nausea/vomiting x2 days. Private pay secondary insurance. She is note to be unemployed. Admitting DX: Nausea alone. Discharge DX: Vomiting alone, ovarian cyst NEC/NOS and Tobacco Use Disorder.

06/05/2012: Hoag Hospital ED Triage Note, Stacey Knight, R.N.

She presented to the ED with low back pain and N&V. She was determined to be in GI category. Her pain was a 7/10. The Physician Record from this visit did not disclose the physician name.

ROS documented a recent weight loss for the past two months; 25 episodes of nausea/vomiting, chest pain for two weeks, stating this is related to stress; last BM was this morning and back pain. She was currently on Vicodin and Valium. She is a smoker but does not drink.

On exam she was alert, oriented x 4 with normal mood and affect.

Labs were drawn and an EKG & Pelvic CT were performed. She was prescribed Zofran and counseling.

Her clinical impression: Vomiting.

She was discharged home with improved condition.

- Routine Lab results were also provided
- ED Position Note: No MH concerns mentioned at time of discharge

- ED Focused Assessment Flowsheet Info: SI was negative; Abuse Assessment was negative; at 20:20: she was noted to be AOx4 with no deficits. No MH concerns are noted.
- ED Vital Signs Flowsheet Information
- Discharge Summary signed by Pascal Juang, M.D. was negative for any MH concerns.
- Physician Orders: No MH concerns noted
- ED Orders: No MH problems mentioned
- ECU Orders
- Medication Orders
- Conditions of Admission and Authorization to Administer Intravenous Contrast Agent.

06/05/2012: Hoag Hospital CT Abdomen Pelvis with Contrast, read by Richard Taketa, M.D.

Impression:

1. Nondistended small bowel loops are seen with isolated air-fluid levels. This can be seen with aerophagia, mild ileus or mild enteritis. No obstruction seen.
2. Incidental 1.2 cm left adnexal cysts
3. Incidental isolated splenic granuloma

06/06/2012: EKG Read by Subbarao Myla, M.D.

Impression:

- No significant change.

12/05/2012: Patient Information Form

Admitting Reason: Possible Abscess. Patient is self-insured and unemployed. Admitting DX: Female genital symptoms, NOS. Discharge DX: Unilateral femoral hernia.

12/05/2012: Hoag Hospital, ED Triage Note, Calvin Ly, R.N., Signed off by Dr. Juang.

She presented with a right pelvic pain/bump that was 7/10.

The Emergency Physician Record documented a past HX of anxiety and back pain as well as a diagnosis of diverticulitis and peptic ulcer in June. She was currently taking Prilosec, Vicodin and Valium. She was noted to be a smoker. ROS was negative for psyche concerns.

Neuro/Psyche exam noted she was oriented x4 with normal motor and sensation. Mood and affect were also marked normal.

DX: Right femoral hernia.

She was discharged home with improved condition.

- ED Focused Assessment Flowsheet Information: 18:42: No SI; Abuse Risk: WNL; she was AOx4
- Vital Signs Flow Sheet
- ED MD Disposition: Discharged home no problems.
- Patient Discharge Instruction: No MH concerns mentioned
- CPOE Discharge Report – No MH issues mentioned
- Medication Administration Record – Discharge

01/23/2014: Michael Shahbazian, M.D. Pain Specialists of Orange County – Pain Management Consultation

CC: LBP for two years, but worse x 10 lbs. Has LDDD and Dr. Khan is requesting L4-5 epidural steroid injections. Dr. Khan noted that her mood was good and she is tolerable with Vicodin 1-2 per day. She cannot tolerate NSAIDs b/c of GI ulcers. She reported occasional mild weakness in the RLE due to pain as well as occasional numbness in the dorsum of right foot. LBP is constant. She wanted the injections.

Mechanism of injury was unknown; low back pain was an 8/10 today. She reported that sleep disturbance due to pain is a problem. Current meds include Flexeril, Valium, and Vicodin.

PMH: Anemia, arthritis, degenerative and ulcer disease. Past SX: hernia. No family history. She smokes; does not drink or use illicit drugs.

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DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

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W.C. Claim number: **550613; 550796**

W. C. Claims administrator: **Ms. Janice Gardner** Phone: **260-482-8668**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

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ROS psyche indicates: No current issues with anxiety; no depression.

On exam, she was noted to be well appearing, well-nourished and in no distress; although a formal MSE was not performed.

Assessment: Chronic LBP; LDDD; and Neuropathy.

Per Dr. Khan, Dr. Shahbazian did recommend LESI series after she completes PT. An RX for Vicodin was given and she was referred back to her PCP. Apparently she also had issues with a urinary leak and was to f/u with Dr. Khan for that as well.

02/04/2014: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She underwent lumbar steroid injection today.

02/24/2014: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She presents with back pain, disc disease and neuropathy and comes in for her second lumbar epidural steroid injections. She reported 40% improvement in her symptoms since the last injection. Mood is good and she is neurologically stable at this time.

03/10/2014: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She had two of her injection and is here for her third and final treatment. She responded well to the first, but not too much for the second. No MH concerns were noted.

05/12/2014: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc Notes

She presented with chronic low back pain with radiation down the RLE due to LDDD. Moderate benefit with LESI x 3. HX of GI Ulcer; avoiding NSAID. No emotional/mental complaints noted.

She was in no distress and A/O x 3. Noted: Intact memory, judgment and insight; normal mood and affect. Speech normal rate and tone.

Assessment: Chronic LBP; LDDD; and neuropathy.

She was to continue Vicodin and use topical deep blue oil over pain prn. No other MH concerns noted.

07/09/2014: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc Notes

Patient getting good benefit with chiro care but can no longer afford to go. Taking Norco with benefit. She would like to schedule her next ESI. ROS Psyche was negative.

On exam, psyche was WNL, A/O x 3; no distress. DX: Chronic LBP, LDDD and Neuropathy.

Plan: Continue Norco, topical deep blue oil over pain and schedule for LESI x 3 after 08/04/14. No MH issues noted.

08/11/2014: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She presents with back and leg pain that improved with LESI in the past. She comes in for another one today. Mood was noted to be good and is neurologically stable

09/16/2014: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She presented for lumbar epidural steroid injection today.

10/07/2014: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She reported no more leg pain after her last two epidural injections. She has a little bit of patch numbness and neuropath in the distal LE and some mild back pain controlled with Norco. Mood is good and she is neurologically stable. Injection was administered.

01/05/2015: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She presents for a single maintenance epidural steroid injection. She reports greater relief with previous injections. Mood is good and she was neurologically stable. She was provided an injection today.

03/02/2015: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc Notes

Last LESI in January was very helpful. He noted that she is going through personal issues at home so more pain but tolerable with Norco. Mood good, NAD and pleasant. No current issues with anxiety or depression are noted.

Objectively, psychiatric exam WNL for memory, judgment, mood and affect as well as speech.

DX: Lumbago; lumbar disc degeneration.

Meds were refilled. He noted again that neuro and mood was stable and she should follow up in two months for another LESI.

04/23/2015: Patient Information Form

Admitting reason: Vaginal bleed 1 month. Noted to be unemployed. Private Pay insurance. Admitting DX: Noninflam dis vagina nec. Discharge DX: Noninflam Dis Vagina Nec; Anxiety State NOS; Anemia NOS; Tobacco Use Disorder; Present history of SPF DGST DS and Peptic Ulcer Disease; Depressive Disorder NEC; intramural leiomyoma; ovarian cyst NEC/NOS; and HX of Drug Allergy NEC.

04/23/2015: Hoag Hospital, ED H&P, completed by Munazza Khan, M.D. Internal Medicine

She presented with complaints of vaginal bleeding for about a month. She reported he has a lot of stress occurring in her life and that she is losing weight.

ROS did not comment on psychological disposition. She was noted to be a smoker but denied alcohol and illicit drug use. Travel history and screen was reviewed and negative. She is currently on Valium and Norco.

On exam she was AO x 4 and in no acute distress. She had normal mood and affect.

Labs were reviewed. Pelvic US was performed with some abnormalities noted. She was given IV Fluids.

Clinical impression: Vaginal bleeding and uterine fibroids.

She was provided counseling and declared clinically stable. She was discharged home with improved symptoms.

- ED Triage Note documented that this was an OB/GYN issue. No mental health concerns noted.

- ED Disposition Note reviewed; no MH concerns mentioned.

- ED Focused Assessment by Katrina Brandt at 8:39: Noted no SI; Abuse risk was WNL. She was noted to be AOX4 with no focal deficits; 09:15: No MH concerns noted; 09:30: No MH concerns noted; 10:05: No MH concerns noted; 10:45: No MH concerns: 11:30: No MH notes; 12:33: Results and POC discussed; no mention of MH issues.

- Patient Discharge Instruction Summary, Brain Grade, M.D. was negative for MH concerns.
- Vital Sign recordings were noted
- Pulse Oximetry-Centralized and Laboratory Results were noted
- Medication Administration Log
- ED Disposition Note: Pain was starting to decrease and she was in no acute distress. No other MH concerns were mentioned.
- Informed Consents and Conditions of Admission

04/23/2015: Hoag Hospital, US of the Pelvic, read by Michael Roossin, M.D.

Impression:

- 1.7 cm uterine leiomyoma; uniocular cyst within each ovary measuring 2.5 cm on the left and 1.7 cm on the right; preliminary findings were sent by secure means to Dr. Grade.

05/05/2015: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She presents for a single LESI for maintenance. She reported good results with injections in the past. Mood is good and she was neurologically stable. Injection was administered.

06/02/2015: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

She had her first injection; thought she was getting her #2 today.

Patient stable on current meds without SE. Psyche ROS was negative.

Psyche exam was WNL; NAD, A/O x 3. DX: Lumbar radiculopathy. Continue Norco. She has a DNFB script. Continue Soma and schedule for LES1 #2.

06/09/2015: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

Today, she was experiencing LBP radiating into RLE with numbness in the right foot.

She was NAD, pleasant but uncomfortable. ROS Psyche: No current issues with anxiety or depression. Health Maintenance: Depression Screen X R11.

04/28/2016: Hoag Hospital History & Physical Note, Roya Rakhshani, M.D.

Patient was referred for surgery for heavy bleeding. This had been ongoing for 3 months.US showed fibroids and normal uterine cavity.

Surgical history documented history of hernia repair and chronic back pain. Socially, she never smoked, drank or used illicit drugs. Under ROS, psychiatric was negative for agitation, anxiety, depression, HI, insomnia, mood swings, or SI.

On exam, she was noted to respond appropriately, and was in no distress. Mood and affect were appropriate to situation.

She was to undergo laparoscopic robotic assisted hysterectomy, bilateral salpingo-oophorectomy, and possible exploratory laparotomy.

04/29/2016-04/30/2016: Patient Information Form

Admitting reason: Menorrhagia; uterine fibroid unresponsive. Same day surgery/private pay. Admitting DX: Other Chronic Pain. Discharge DX: Endometriosis of uterus; leiomyoma of uterus, unspecified; other chronic pain; peritoneal adhesions; pelvic and perineal pain; excessive and frequent menstruation with regular cycle; dorsalgia; anxiety disorder, unspecified; major depressive disorder, single episode; other specified postprocedural states; allergy status to other drug/meds/biol subst. status; and other long term drug therapy.

04/29/2016: Hoag Hospital Operative Report, Roya Rakhshani, M.D.

Preoperative diagnoses: Chronic pelvic pain and menorrhagia, unresponsive to medical treatment; Postoperative diagnosis: Adhesions and probable Adenomyosis.

She underwent laparoscopic robotic-assisted hysterectomy, bilateral salpingo-oophorectomy and lysis of adhesions.

There were no complications. She left the operating room in stable condition with spontaneous respiration.

04/29/2016: Hoag Hospital Adult Patient Profile

Under the Risk/Screens/Assessments section of this report, **she answered "yes" during the abuse screen: Threatened or abused physically, emotionally or sexually by partner/spouse/family member; however, no details are disclosed.** She is a current every day smoker but denied ever using alcohol. Under Values/Beliefs/Spiritual Care, she denied any preferences. No other mental health concerns are noted in this reporting.

On exam, she was in no distress. Psyche exam was normal. DX: Lumbago; lumbar radiculopathy.

A T/L MRI was ordered as well as referral to Dr. Nguyen. They would hold LESI #2 today. Norco was increased. Mood was noted to be stable.

08/06/2015: Elika Kamdar, M.D./Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

She reported a worsening of radicular symptoms. She saw Dr. Nguyen and recommended further LESI. Still waiting for MRI. She is here for refills and asking for LESI authorization. The psychiatric portion of ROS was not reported.

On exam she was NAD. Psyche was negative. DX: Lumbago and lumbar radiculopathy.

Meds were refilled. Authorization for LESI #2 was requested. No MH concerns were addressed.

10/06/2015: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

Chronic low back pain; she would like to schedule for LES #3 at this time. She had the MRI and this was pending review with Dr. Nguyen at the end of the month.

Exam was WNL (no change). DX: Lumbar disc degeneration; lumbar radiculopathy.

Meds were continued. She was to schedule for LESI #3. No MH concerns addressed.

10/06/2015: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She continued with back pain reporting limited success with her epidural steroid injections. They decided to proceed with bilateral lumbar facet blocks. Recent MRI was done, but she has not brought the report to them yet. She will be following up with Dr. Nguyen.

01/04/2016: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

The subjective complaints document that the LBP and leg pains are doing better with meds but under a lot of stress in her life affecting her appetite and weight loss. She states that she saw her PCP for it and nothing is wrong.

NAD, pleasant, mood good. ROS Psyche: No current issues with anxiety and depression. Health Maintenance: Depression Screen X R11.

On exam, psyche portion was WNL. DX: Lumbar disc degeneration; lumbago, and lumbar radiculopathy.

Meds were refilled. Neuro and mood were stable. Consult referring surgeon. She was to f/u in three months.

01/08/2016: Dr. Harold Iseke, D.C. Epworth Sleepiness Scale

Score: 11.

04/05/2016: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

Pain is unchanged. She has yet to f/u with neurosurgeon. Psychiatric ROS was negative. Psyche exam was WNL.

DX: Unchanged from previous reporting.

She was to continue her meds and was pending a second opinion with spine surgery. F/U in three months.

03/22/16-04/27/16: Surgical Nursing Documentation – Progress Notes, author not identified.

These handwritten notes were not legible due to poor handwriting. Based on process of elimination, these appear to be handwritten OB/Gyn records from Dr. Rakhshani.

04/27/2016: Physician Pre-surgical Orders, Roya Rakhshani, M.D.

Preoperative EKG, chest x-rays and CBC were ordered.

04/27/2016: Hoag Hospital Chest X-rays, read by Mark Chen, M.D.

Impression:

- No evidence of acute cardiopulmonary disease.

04/27/2016: EKG, interpreted by Brian Cheanie, M.D.

Impression:

- No significant change when compared to ECG of 06/05/12.

- Patient Discharge Instructions – No MH issues noted.
- Admission Records – No MH concerns identified.
- Personal Property Disclosure
- OP History Questionnaire, reviewed but no mental health concerns noted
- An Immediate Postop Note was reviewed and no mental health concerns were noted.
- Orders placed for Zofran.
- Routine Blood Work was included
- Orders for Pathology reading: No MH concerns noted.
- Surgical Pathology Report was also included for this date; no MH concerns documented.
- Pre/Post Procedural Flowsheet was reviewed in its entirety; no mental health concerns are noted.
- Pre Procedure Patient Self-Assessment Sleep Apnea Screen was performed: No MH Concerns documented.
- Written Surgery Instructions: No MH concerns noted.
- **Anesthesia Preop/Intraop Records do note under ROS that she has a history of anxiety and depression;** however, no details are provided. On exam, she was noted to be awake, alert and aware however, no formal MSE was performed.
- Perioperative Preop/Holding Records was reviewed in its entirety and noted she was alert and oriented. **Under Patient Education section of this reporting, she was asked if she has ever been threatened or abused physically, emotionally or sexually and she responded "No". This is not consistent with the Adult Patient Profile noted above. No other forms of abuse were indicated.**
- Perioperative Medication Administration Record was also reviewed.
- Intraoperative Patient Record: No MH concerns noted.

- Perioperative PACU Record: No MH concerns mentioned.
- PACU Discharge: No MH concerns mentioned.
- Anesthesia Post-Operative Evaluation: Stable, awake and Alert; no concerns involving MH.
- Patient History Questionnaire completed by Ms. Sarver was completed. She did report the following issues: chronic pain treatment; back/neck pain; anemia and bleeding disorders as well as numbness in her feet. She denied drinking or using illicit drugs but does smoke. There was no MH concerns noted on this form.
- **04/29/16: Hoag Memorial Hospital Adult Plan of Care:** This began at 11:25 without any MH issues; reassessed at 18:11 no MH issues; 21:38 POC and guidelines reviewed; **5:14, she was provided an Ativan x 1 for anxiety no other details provided; 11:25: Coping was observed and stated to be acceptance**; 12:00: No MH addressed; 14:00: No issues noted; 16:00: no problems; 18:00: no concerns noted; 18:11: No MH concerns noted; 20:00: POC discussed. Coping/Independence: Calming techniques promoted; care explained to patient/family 20:06: OA x 4, behavior was appropriate to situation; 21:38: No MH concerns.
- **04/30/16: Hoag Memorial Hospital Adult Plan of Care:** 14:00: No MH concerns noted: 09:00: AOx4 follows commands, speech spontaneous, well placed, logical, purposeful motor response and behavior was appropriate to situation. **Under "Coping": she was observed to be accepting, combative but cooperative; verbalized emotional state was acceptance. She was provided choices, care explained, relaxation techniques reviewed, promoted safe supported environment and questions were answered;** 10:15: No MH issues noted.
- Intake/Output ledger for both dates
- Vital Sign recordings for both dates
- Medication Orders, signed by Reviewing Nurse
- **Medication Administration Logs: This confirmed the administration of Lorazepam injection (Ativan) prescribed for Anxiety. She was noted to be calm & cooperative shortly after receiving the medication**
- Chest X-rays were also included.

- Conditions of Admission signed by Ms. Sarver, as well as Informed Consent & Consent for Surgery or Procedure

- Various health insurance authorizations

04/30/2016: Hoag Hospital Discharge Note- Nursing

No MH concerns were addressed in this document. She was discharged 04/30 at 10:40.

- CPOE Discharge Report was provided and reviewed. There were no MH issues mentioned.

07/05/2016: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

LBP; she had a laparoscopic hysterectomy last month due to fibroids. She was waiting for 2nd opinion with neurosurgeon. She would like to schedule her next series of LESI. Meds helped to manage pain.

Psyche was not addressed under ROS. Psyche exam was WNL (unchanged from previous reporting).

DX: Lumbar disc degeneration; lumbar radiculopathy.

Meds were refilled. She was to be scheduled for her next series of 3 LESI.

11/30/2016: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

Continued orthopedic complaints noted. She was also noted to be NAD, pleasant and good mood. She was here for a repeat LESI because it worked well in the past.

ROS Psyche was negative. PMH included Anemia, degenerative arthritis and PUD. Exam was performed and psyche portion was unchanged and negative.

DX: Chronic pain syndrome; Lumbar disc degeneration; lumbago and lumbar radiculopathy.

Meds were refilled and adjusted. It was noted that her neuro and mood were stable. She was administered LESI #1 today.

11/30/2016: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She underwent lumbar steroid injection today.

03/08/2017: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

She had LES #1 and needs LESI #2.

ROS did not note psyche. PMH Anemia; degenerative arthritis; duodenal ulcer disease. Brief exam showed psyche portion was WNL.

Assessment: Lumbar radiculopathy.

Her meds were continued and adjusted. LESI #2 would be scheduled. Referral to spine surgery was indicated to explore other options.

03/20/2017: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She underwent lumbar steroid injection today.

04/10/2017: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She presented for an injection due to back pain and radiculopathy, left greater than right. This is her 3rd and final injection of this series. She reported mild weakness and paresthesias of the LLE and is waiting to see her surgeon.

She comes in for meds management and injection #3.

06/15/2017: Newport Mesa Medical Group, Munazza Khan, M.D.

This report documents that she states she had a car accident and is having issues with speech-SR. Subj: MVA, c/o dizziness, neck and bilateral knee pain.

Exam: AAOx3, NAD, normal level of consciousness. Musculoskeletal and neurological exam was performed. No formal MSE was noted.

Assessment: Anxiety, back pain and weight loss 4 knee & right elbow pain.

She was referred for chest x-rays, a CT of the head and was to continue with present treatment. She was to D/C Xanax and prescribed Valium 2 mg. q.h.s. follow up in two weeks.

06/23/2017: Referral Authorization

Physical therapy as requested by Dr. Khan was approved.

07/10/2017: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

She was following for LBP. Reported she was recently in a MVA and feels that her pain was worse. She is pending MRI. Pain otherwise the same. Meds continue to provide relief with no SE.

ROS Psyche was negative. Psychiatric portion of the exam was WNL. DX: Lumbar radiculopathy.

Meds were refilled and adjusted. F/U with neurosurgeon. Repeat ESI in future if pain becomes worse/returns.

09/06/2017: M. Mohsin Shah, M.D. Psychiatry & Neurology, Initial Neurosurgical Evaluation.

- *Please note that the DOB does not match the applicant of records and is noted to be 08/07/1981.*

DOI: 06/07/2017. No history was reported in regard to social, family and relevant medical history.

MSE documented that she is AOx3 and vitals were stable. Essential tremors were noted at rest. Her appearance was anxious and distant. Concentration was able to perform limited serial 7's and could spell WORLD forward and backward. Her affect/mood is sad and jittery. Neuro and orthopedic exam were also performed.

DX: 1. Postconcussional syndrome; 2. Posttraumatic stress disorder; 3. Depression; 4. Cervical myospasm; 5. Sprain of ligaments of lumbar spine; 6. Low back pain.

Causation was noted to be related to the 06/07/17 accident. Apportionment was not indicated.

Dr. Shah recommended ongoing conservative treatment for the head, neck and back; transcranial magnetic stimulation; psychology/psychiatry evaluation and treatment for psychodynamic therapy; referral to an orthopedic surgeon and f/u in one month.

10/02/2017: Newport Neurosurgery Specialist, M. Mohsin Shah, M.D. Neurological Exam.

- *Please note that the DOB does not match the applicant of records and is noted to be 08/07/1981.*

The handwritten symptoms, findings and diagnoses appear to be consistent with the 10/04/17 reporting.

10/04/2017: M. Mohsin Shah, M.D. Psychiatry & Neurology, Initial Neurosurgical Evaluation.

- *Please note the report appears to be incorrectly titled and V. Sarver's DOB is documented as 08/07/1981 which is not consistent with the Application for Adjudication of Claim noting a DOB: 11/01/1966.*

DOI listed is 06/07/17. Instead of an HPI, it documents an interim history in that Victoria is tearful and learned about a niece who recently died in the Las Vegas shooting. She has been very anxious and nervous with difficulty in focus, concentration, short-term memory and judgment. She feels almost paralyzed to do anything due to the recent grief on top of recent car wash [sic]. She frequently feels jittery and flashbacks. She has not been able to work hence she was fired.

On exam she was AOx3. MSE noted she was anxious with sad mood/affect. Thought processes were coherent. A neurological and orthopedic exam were also performed.

DX: 1. Concussion; 2. Postconcussional syndrome; 3. Severe Depression and 4. Post- traumatic Stress Disorder.

Dr. Shah recommended transcranial magnetic stimulation and Paxil 20 mg (#30) one tab p.o. q.h.s. F/u 3 months. He noted that she suffered a severe head concussion as a result of her recent incident that is based on historical, clinical and imaging criteria. Expected periods of convalescence where she may find it difficult to resume normal activities and work, resulting insignificant loss of productivity.

He discusses that she may experience other sequelae of head injury including, but not limited to persistent fatigue, malaise, short term memory impairments, difficulty with focus and concentration, irritability, anxiety, depression, poor sleep, suicidal thoughts, dizziness, gait imbalance, sensitivity to light and sound and seizures. Although most symptoms improve with time and possible medical intervention, symptoms may recur and subsequently require further medical and/or psychiatric attention.

He further noted that the predominant symptoms of the concussion include tension headaches and an element of anxiety. Her natural course appear to be improving. He recommended ongoing activities as tolerated.

When considering her ability to work, he recommended that she abstain from heavy objects greater than 20 lbs. when she is more symptomatic. However, once she feels better, he didn't believe that these restrictions would be need.

10/19/2017: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

LBP and leg pains. Pain is fluctuating but continues to be stable on meds. In reference to the recent MVA, she told his MA that her attorney sent her to another Pain Management specialist, but reported not getting Opioids from him. CURES was check and there was no violation.

She was noted to be NAD, pleasant and good mood. ROS Psyche was negative.

Exam was performed; psyche portion was WNL. DX: Lumbar disc degeneration; lumbago; lumbar radiculopathy and lumbar spinal stenosis.

He suggested LESI series; meds were refilled. Continue HEP. Referred to PT. F/U with PCP and other doctors. Should see back surgeon. F/U 3 months.

11/14/2017: WCAB Application for Adjudication of Claim.

DOI: 08/30/17. Description indicates that she was forced to go on her knees in the middle of the parish crowd and wash the floor so everyone would laugh at her in order to discriminate, diminish and sexually harass. That caused applicant severe stress, sleep, depression, mental anguish, resulting in flashbacks.

A handwritten note also documents "Deprivation". She was employed as a Janitor; however, the employer was not listed on this form. Form was completed by Natalia Foley, her attorney.

11/14/2017: DWC-1 Form.

Only the employee section is completed. DOI: 08/30/17. She worked for Lighthouse Coastal Community Church in Costa Mesa. She described the incident as, "applicant was forced to go on her knees in the middle of the parish crowd and wash the floor so everyone would laugh at her to discriminate, diminish and sexually harass applicant, causing severe stress, sleep, depression, mental anguish and resulting in flashbacks".

11/14/2017: WCAB Application for Adjudication of Claim.

DOI: CT 09/01/13-09/01/17. She claimed injury to the head, upper extremities, back, hernia and lower extremities. The description documents stress and strain, repetitive work, lifting heavy items, constant bending, kneeling, washing, causing headache, pain in neck, shoulders, arms, wrist, lower back and lower extremities. Employer wasn't listed. Form completed by Natalia Foley, Applicant Attorney.

11/14/2017: DWC-1 Form.

Only the employee section is completed. DOI: CT 09/01/13-09/01/17. She worked for Lighthouse Coastal Community Church. She claimed stress and strain, repetitive work, lifting heavy items, constant bending, kneeling, washing, causing headache, pain in the neck, shoulders, arms, wrist, lower back and lower extremities.

11/17/2017: Patient Health Questionnaire (PHQ-9) completed by V. Sarver

In the last two weeks, she answered "not at all" to the following: Little interest or pleasure in doing things; feeling down, depressed or hopeless; moving or speaking so slowly that other people have noticed; or the opposite; thoughts that she would be better off dead or hurt herself in some way.

She answered "several days" to trouble falling or staying asleep or sleeping too much; feeling tired or having little energy, feeling bad about a herself or that she is a failure or have let herself or family down; and trouble concentrating on things, such as reading the newspaper or watching T.V. and more than half the days, she has had a poor appetite or overeating. She scored 6.

When asked how difficult any of the problems checked made it for to work, take care of things at home or get along with other people and she noted it was extremely difficult.

- A Neuronetics Motor Threshold Determination Worksheet was also performed at this visit.

- Patient Consent for NeuroStar TMS Therapy was signed.

11/29/2017: Brotherhood Mutual Notice Regarding Delay of Workers Compensation Benefits

Referencing the CT 09/01/13-09/01/17.

11/29/2017: Brotherhood Mutual Notice Regarding Delay of Workers Compensation Benefits

This letter references the 08/30/17 DOI.

12/18/2017: Patient Health Questionnaire (PHQ-9) completed by V. Sarver

In the last 2 weeks, she answered "several days" to thoughts that she would be better off dead or hurt herself in some way.

She answered "More than half the days" to little interest or pleasure in doing things.

She answered "Nearly every day" to feeling down, depressed or hopeless; trouble falling or staying asleep; feeling tired or having little energy; poor appetite; feeling bad about or self – or that she is a failure or have let herself or family down; trouble concentrating on things, such as reading the newspaper or watching T.V.; and moving or speaking so slowly that other people could have noticed? or the opposite – being so fidgety or restless that she has been moving around a lot more than usual. She scored: 21.

01/11/2018: Harold Iseke Chiropractic Professional Corp – PTP's Initial Evaluation and Report

This report lists the DOI: 08/30/17; CT 09/01/13-09/01/17. Employer was Lighthouse Coastal Community Church where she worked as a janitor. Her Job History and Job description was provided noting she had been employed since 2009.

HPI indicated that she gradually developed pain in the head, arms, low back, abdomen and feet due to repetitive nature of her job. Further discussed is her abdominal hernia that was noted around 2013.

Treatment with Dr. Khan as well as Dr. Shahbazian is noted. Also documented is the treatment with Dr. Nguyen in 2014. She reported that Dr. Nguyen placed her off work in 2014 and she returned to work at regular duties with the same employer. (Date not specified). She continued to experience pain and discomfort in her arms, low back and feet with associated headaches.

She also continued to experience stress, anxiety and depression. She still takes meds that afford temporary relief. In September of 2017 she was terminated. Details not provided.

She is not working currently and is not receiving benefits.

She is taking pain and anxiety meds. She reports that her social life has been severely affected. She has difficulty sleeping due to stress, anxiety and depression caused by her current medical condition.

Social history notes that she is divorced and has two children ages 23 and 12. She smokes cigarettes and occasionally drinks alcohol. She denied any HX of medical conditions. She is currently taking Valium, Paxil and Norco. She denied any previous industrial injuries or auto accident. She had a hysterectomy in 2016.

Under ROS, she reported a history of unexpected weight loss and fatigue. She reported history of intermittent headaches and dizziness. Has anxiety, depression and occasional panic attacks. She denies any suicidal attempts.

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY Victoria Sarver **FOR THE REASONS STATED BELOW:**
(Print name of injured employee)

I, **Douglas W. Larson**, declare as follows:
(Print your name)

1. I am licensed in the state of California as a **PSYCHOLOGIST**, license number **PSY9281**
(Type of license)

2. The attached medical record pertains to:

Employee name: **Victoria Sarver**

Address: **666 West 18th Street Apt. 4 Costa Mesa, CA 92627** Phone: **(949) 514-4207**

W.C. Claim number: **550613; 550796**

W. C. Claims administrator: **Ms. Janice Gardner** Phone: **260-482-8668**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

SUBSTANTIAL RISK OF POTENTIAL NEGATIVE REACTION TO PSYCHOLOGICAL INFORMATION.

4. On **January 11,** 20**19**, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.

She can perform her ADLs, but some with difficulty: Taking a bath, getting dress, combing hair, going to the toilet, sit, stand, recline, walk normally, climb stairs, lift and drive a vehicle. She has some difficulty riding on land forms of transportation. Sexual function and flying were not applicable. She is unable to sleep restfully or sleep normal at night due to her injuries. She is currently not working.

Subjectively, she reported issues regarding her thoracic spine, lumbar spine, right elbow, right forearm, right hand, right knee and left knee. She also reported head pain that is over the right temporal region, sharp and throbbing and exacerbated by stress and anxiety. She complained of sleep loss due to pain and fatigue. She states that due to the prolonged financial hardship, she is feeling like condition will never improve and is causing anxiety, stress, depression and irritability.

Exam was performed without MSE. DX: Sprain of ligaments of thoracic spine; pain in thoracic spine; sprain of ligaments of lumbar spine; low back pain; pain in right elbow, right hand, right knee, right ankle, unspecified abdominal pain, sleep disorder, anxiety disorder, major depressive disorder, single episode, acute stress reaction, irritability and anger, chronic pain due to trauma, myalgia and myositis.

She was referred for MRIs of the lumbar spine, left elbow and right and left knees. She received one chiropractic treatment today. Medical records were requested. Ortho and hernia specialist were also noted.

Patient was placed on TTD.

As far as causation, Dr. Iseke felt that her current symptomatology is a result of the specific work related injuries that occurred on 08/30/17; CT 09/01/13-09/01/17, during her employment for Lighthouse Coastal Community Church as a janitor.

- A DWC Form RFA was submitted for MRI, orthopedic consultation, hernia specialist consultation, acupuncture and chiropractic treatment.

- A Handwritten History Check Off Form was included and consistent with the above reporting.

01/11/2018: Harold Iseke, D.C. Treatment SOAP Note

Chiropractic treatment and instruction on exercise was provided. No MH concerns were noted.

01/19/2018: Deposition of Victoria Sarver, Volume I.

The deposition, Volume I, began on pages 5-14 of the transcript and covered the basic rules and guidelines to be followed when providing sworn testimony while under oath and indicated that the patient had filed a claim for a specific injury occurring on 08/30/2017. The depo related that Ms. Sarver alleged she was forced on her knees, in front of others, and was told to scrub floors in order that the onlookers might discriminate, diminish and sexually harass her. As a result of this incident, the claim cited that the Plaintiff suffered severe stress, depression mental anguish and loss of sleep.

The second injury was listed as a CT claim that lasted the duration of employment with Light house, beginning on 09/01/2008 and continuing until 09/01/2017.

Further clarification cited that during that time period, the deponent experienced stress, strain, repetitive work, lifting heavy items and movements including constant bending, kneeling, washing and lifting that allegedly caused headaches, pains in the neck, shoulders, arms, wrists, lower back and lower extremities.

Also included in the initial questioning period was the prescription for Valium that was often taken in order to help the claimant sleep.

After discussing the current treatments for pain that had been administered over the last three years, pages 20-32 depicted that the psych claim had been filed and that prior to her claim, the patient had spent some time in jail for a DUI and had been the victim of a burglary.

Further testimony related that she had also been in a volatile relationship with her child's father who would hit her, some 20 years prior.

In addition to being injured in an auto accident and subsequently filing a claim, the transcript reported that the patient, at some earlier time, had been officially diagnosed with depression.

Further clarification conducted on pages 38-41 indicated that Ms. Sarver had engaged in drug and alcohol, as well as psychological counseling for mental distress and partying too much.

With respect to the incidents involved in the current claim, pages 42-75 showed that the mental injuries had begun in approximately 2014 and had involved a pastor at her church. The first incident was described as occurring after the patient had moved some chairs in the sanctuary when the pastor came in and kissed her with an open mouth. She recalled being upset and immediately leaving the premises, however did not report it to anybody and stated that the following day, she told him to forget it.

She further stated that during her divorce, the pastor would make inappropriate comments and hug or touch her in an awkward way, which made her feel uncomfortable and unsafe.

Additional statements cited that the pastor had continued his behavior and when the applicant found out that her daughter was also experiencing some of the same things, she had reported all the harassment to the head pastor. Upon reporting the first incident and continuous comments, the patient was offered mentoring by the head pastor and was switched to working nights, when the defendant was not in the office.

Also included during this line of questioning was the reasons behind the decision for reporting the inappropriate behavior and showed that the patient had become concerned that the pastor had talked or acted in the same ways to her youngest daughter and that all the incidents that had occurred in 2015 with exception of the last incident, which was stated as occurring in 01/2016.

The incident consisted of the pastor asking if the two of them could date, since she was now divorced.

Included in cross-examination was testimony on pages 80-88 that reflected change in treatment by the other ladies in the office, once the situation was reported.

Ms. Sarver indicated that after a while the other office personnel began to belittle and ostracize her. She also recalled that her hours were cut and that she was no longer allowed to volunteer or bring help when she needed assistance in lifting heavy items. The record also showed that in the last year of employment she had been disciplined at least four times; she felt unfairly, and her hours had been cut back to 12 hours per week.

Page 90 stipulated to a Volume II and the deposition concluded on page 91.

01/23/2018: Harold Iseke, D.C. Treatment SOAP Note

Manual acupuncture and infrared therapy was administered. No MH concerns were noted.

01/25/2018: Harold Iseke, D.C. Treatment SOAP Note

Chiropractic treatment and instruction on exercise was provided. No MH concerns were noted.

01/30/2018: Harold Iseke, D.C. Treatment SOAP Note

Manual acupuncture and infrared therapy was administered. No MH concerns were noted.

02/16/2018: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

Orthopedic pain is addressed; her right foot feels like knives are going into the foot. Last infection was 3/2017. She denied sleep disturbance due to pain.

ROS Psyche is negative. Exam performed; psyche portion was WNL. DX: Unchanged.

Norco was refilled and she was scheduled for LESI at the right L5-S1. RTC 3 months.

02/26/2018: Harold Iseke, D.C. PTP PR-2

Her physical complaints are revisited and she was also provided a Patient Self-Assessment check off list.

Of note, Mood is addressed from a scale of 1-10, (10 being extremely bad), she rated herself as a 9. She reported a 10 in regard to being anxious or worried over the past week due to pain; an 8 over being depressed; a 10 over being irritable and a 10 about general anxious/worried about performing activities because it might make her symptoms worse. ADLs are consistent with prior reporting. She did complain of continued sleep loss due to pain and fatigue as well as anxiety, stress and depression due to prolonged pain and financial hardship.

No MSE was performed. DX was unchanged from previous reporting but included headache, sleep disorder, anxiety disorder, major depressive disorder, acute stress reaction and irritability and anger.

- A DWC Form RFA was submitted for MRI, orthopedic consultation, hernia specialist consultation, acupuncture and chiropractic treatment.
- Handwritten Re-Evaluation Check Off Form was also provided consistent with the above reporting; this included the ADL Questionnaire to which she continued to report difficulty with her mental health concerns.
- A Patient Self-Assessment Check Off Form was also completed

02/27/2018: Harold Iseke, D.C. Treatment SOAP Note

Manual acupuncture and infrared therapy was administered. No MH concerns were noted.

03/06/2018: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She underwent lumbar steroid injection today.

03/14/2018: Mohsin Shah, M.D. Initial Neurosurgical Evaluation

- *Again, report is incorrectly labeled as "Initial" and the DOB of Ms. Sarver on the identifying info documents 08/07/1981*

She returned for re-exam. Exam showed she was awake, alert and oriented to person, place and time. Vitals were stable.

MSE: She is anxious; concentration is erratic; speech pattern is pressure. Her affect/mood was jittery. Judgment/Insight WNL. Thought process/reality was coherent. Neuro exam also noted.

DX: 1. Concussion; 2. Postconcussional syndrome; 3. Severe depression; 4. Posttraumatic stress disorder.

She was recommended to continue transcranial magnetic stimulation.

- A Neurological Exam Check Off Form was also provided and this was consistent with the above reporting.

03/23/2018: WCAB Application for Adjudication of Claim.

DOI: CT: 09/15/13-09/15/17. She claimed injury to the brain and nervous system. Description: Stress, depression, anxiety, PTSD due to sexual harassment by the priest, harassing behavior and hostile work environments and retaliation by the church administration for complaint against the priest. Employer is not listed. Form completed by attorney, Natalia Foley.

03/23/2018: DWC-1 Form.

Only the employee section is completed. DOI: 09/15/13-09/15/17. Employer was Lighthouse Coast Community Church. She described stress, depression, anxiety, PTSD due to sexual harassment by the priest, harassing behavior and hostile work environments by the church administration.

03/27/2018: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

Mild improvement reported after last injection. She is stable on meds and comes in today for her 2nd LESI.

05/11/2018: Deposition of Victoria Sarver, Volume II.

The deposition, Volume II, began on pages 99- of the transcript and covered what had occurred, with reference to work, since the last deposition. Initial information related the basic rules and

guidelines that should be followed when providing sworn testimony while under oath, the prescription of pain medication for issues resulting from a lower back injury and indicated that the patient had been treating for depression and anxiety stemming from a divorce and issues at work.

Further clarification attempted to give dates for the prescriptions and whether or not they were due to work-related injuries or those suffered in an auto accident.

After listing the various body parts that had been injured, pages 133-139 reflected that the patient believed her psych issues were partly caused by the church, home life and the Las Vegas shooting, where her daughter's friend's girlfriend was shot.

An incident dated 08/30/2017 was then testified to on pages 146-174 and showed that on that date, the Plaintiff had been performing her regular duties and cleaning the church offices when she was told to clean a particular office floor immediately, by another individual. She further recalled that she was told to stop what she was doing immediately and to clean up some drywall that was on the floor.

Due to her back issues, Ms. Sarver had to get on her knees in order to clean the drywall and surrounding areas on the floor. She also recalled that the other individuals in the office had appeared to be laughing at the petitioner as she worked and as a result, she had become embarrassed.

Following pages indicated that the patient was not told how to clean, or to get down on her knees and clean and in fact, the claimant had cleaned with wipes while on her knees on prior occasions.

Other specifics were related in relation to where individuals were during the cleaning incident. but pages 214-225 then identified information relating to the term discriminate. The patient stated that the laughing and floor cleaning was the office's attempt to discriminate or make fun of her and made her feel harassed.

Testimony further cited that the patient had begun treating for depression and stress after the automobile accident.

Transcript pages 229-237 indicated that a neurological diagnosis was given and cited post-concussion syndrome, concussion, severe depression, posttraumatic stress disorder and anxiety. Symptoms had included a foggy state of mind, but had really only been noticed after the auto accident had occurred.

Additional issues that had resulted from the head trauma and stress was memory loss that manifested itself in the form of forgetting various every day events as well as anxiety, depression, embarrassment and a feeling of fear.

In reference to the cleaning event, the patient recalled feeling embarrassed, belittled and diminished and stated that even though she often experienced discrimination while at work, that event had been extraordinarily difficult.

Later questions and answers related information about the treatments administered for the physical pains felt by the Plaintiff and then later relieved the court reporter of duty under the code.

Page 248 stipulated to a Volume III and the proceeding was concluded on page 250.

05/22/2018: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

Mild improvement noted with LESI #2, and she is here for #3. Stable on Norco. NAD, pleasant and mood good. ROS Psyche, no current anxiety or depression.

Exam showed she was AOx3; intact memory, judgement and insight; normal mood and affect. Speech normal rate and tone.

DX: Orthopedic, unchanged.

Norco was refilled. She was referred to PT and was to continue HEP. F/U 3 months.

05/22/2018: Spinal CARE Surgicenter, Michael Shahbazian, M.D. Procedure Note

She underwent lumbar steroid injection today.

07/14/2018: Payam Moazzaz, M.D. Orthopaedic Surgeon, Panel Qualified Medical Evaluation.

DOI: 09/01/13 listed on first page. HPI documents she worked at Lighthouse Community Church as a janitor. It goes on to state that on 12/20/13 (Different DOI), she was lifting a vacuum and injured her lower back and right groin. Injury she was reported and she was sent to the doctor. She was diagnosed with hernia and ultimately had surgery for hernia repair on 12/25/13. She required two surgeries due to the complications.

She also described a CT from 09/01/13-09/01/17 for the same employer. She developed orthopedic problems due to repetitive janitorial work. She was not offered treatment. She continued working until June of 2017 at which point she was terminated and has not worked since that time.

- *Please note the inconsistencies of the dates are transcribed verbatim from Dr. Moazzaz' report.*

He goes on to document her treatment so far. Presenting complaints are listed and all relate to her orthopedic symptoms. These do affect her ADLs, which includes difficulty with all of them.

He documented that she was employed for 10 years for the church. She worked full time.

PMH documented two hernia surgeries and a hysterectomy. Also noted was a rear-end MVA that caused injury to her neck and upper back, but she could not recall the details. Dr. Moazzaz noted that she was divorced. He reviewed an extensive amount of medical records.

Exam was performed. He noted that she was well-groomed, in no distress. She displayed appropriate emotional affect. Orthopedic exam ensued as well.

His diagnostic impression: 1. Lumbar sprain/strain with radiculitis; 2. History of chronic low back pain; 3. Possible recurrent hernia; 4. Bilateral hand paresthesias, r/o bilateral hand carpal tunnel syndrome; Bilateral knee arthralgia, r/o bilateral knee internal derangement.

Dr. Moazzaz goes on to discuss the discrepancy in DOI for the hernia; however, he defers the hernia and needed surgery to a general surgery specialist as this was outside of his expertise.

He then goes on to discuss a second distinct MVA that occurred sometime in June of 2017. She told him she injured her neck and upper back; however, the medical records provided documentation of complaints of injury the knees as well. Records also confirm that she had back pain from the MVA.

He discusses the third incident, which is the CT claim involving her hands, lower back and bilateral knees. He felt that it was reasonable to assume that these were sustained at work given her length of employment and the description of the accident; however, apportionment of the knees would need to be considered in relation to the MVA. He also noted that apportionment for the lumbar spine would need to be considered given a history of chronic low back pain noted in 2012.

It appears that multiple diagnostic studies and pertinent medical reports were not provided to the QME in correlation with the patient's history. The doctor felt that further diagnostic testing was indicated and did not believe that she was P&S.

He noted her subjective complaints from an orthopedic perspective as well as repeated her ADL problems. He also noted her exam findings again. He indicated that she could return to work with restrictions. These were as follows: She can carry and lift up to 20 lbs. occasionally, 10 lbs. frequently; she may stand or walk for 6 hours in an eight-hour day and may sit 8 hours in an 8

hour day with normal breaks. She cannot perform climbing, kneeling, stooping, crawling or crouching. Overhead activity may be done on an occasional basis. Use of the hands for fine or gross manipulative movements may be done on a frequent basis. She doesn't require use of an ambulatory device.

He believed that her symptoms were caused by a combination of the CT industrial injury from 09/01/13-09/01/17, the specific injury of 11/2012 and the MVA of 06/07/17. He preferred to address apportionment once the patient was released to a P&S status.

He recommended an EMG/NCV of the bilateral upper extremities as well as an MRI of the lumbar spine and bilateral knees. He deferred his opinion on impairment once she reaches P&S.

- **Payam Mazzaz, M.D. Orthopedic Surgery Examinee QME Questionnaire** was also included and correlated with the above QME report. This did note that the pain does awaken her from sleep unless she takes medication to sleep. She also indicated under ADLs, that "It is affecting everything that I do. I can't do normal stuff that I used to do, mentally and physically."

08/01/2018: Deposition of Victoria Sarver, Volume III.

The deposition, Volume III, commenced on pages 258-283 of the transcript and covered information regarding the basic rules and guidelines to be followed when providing sworn testimony while under oath, current sources of income and various special occasions that had taken place since the last deposition.

Also related during the initial questioning period were the circumstances surrounding the applicant developing a hernia after vacuuming.

Surgeries were later performed and pages 284-297 indicated that psychiatric problems, resulting from her position at the church, included an increased emotional stated, a fear of leaving the house and while at the church, had experienced anxiety, nervousness and fearful/uncomfortable.

Psychiatric treatment had first been administered approximately 3 years prior to the current deposition, but reported that approximately 24 years prior, she had participated in a drug counseling program after using cocaine.

Further testimony reflected that problems with the harassing pastor had commenced sometime in 2012 and those instances had caused the Plaintiff anxiety and psychological stress.

According to physician's records, the patient had been diagnosed with a tobacco use disorder, depressive disorder, anemia, ovarian cyst and had undergone a hysterectomy for years of hemorrhaging.

Cross-examination was then conducted on pages 297-304 and depicted information regarding her current symptoms.

Ms. Sarver indicated that her anxiety often was associated with a crawling like sensation over the skin and a feeling of fear. She further said that she also now experienced emotional suffering in the form of loneliness, sadness and jealousy at being separated from her church family. She also stated that she felt mentally abused and betrayed and that her trust in the pastor was greatly damaged by all the abuse and for a period of time had put a strain on her faith.

Statements given on page 304-312 indicated that her feeling of stress, related to her divorce, were less than her stresses that stemmed from those experienced at the church.

The decision to report the harassment was then addressed and the patient expressed a fear that she would not be believed, due to her emotions resulting from her pending divorce.

The record then indicated that the spiritual counseling administered by the head pastor's mom had yielded some relief, but by then, members of the staff knew and subsequently treated her different and would often make her feel rejected.

As a result, she recalled her sleep being affected and she had become depressed and often suffered from panic attacks.

Further examination, on pages 313-327 cited information regarding written reports citing items left out when the patient had been cleaning. It then switched to include information regarding sexual intercourse. The deponent claimed that she had not engaged in such acts due to her not feeling good about herself and that she was currently not dating anyone.

Notes were also given that stated an attempt to garnish wages for back taxes, which angered the Plaintiff.

Page 328 relieved the court reporter of duty under the code and the proceeding was subsequently concluded.

08/22/2018: Michael Shahbazian, M.D. Pain Specialists of OC – H&P, Progress/Proc

She presented with L/S pain that was a 6/10 today.

ROS Psyche was negative. Exam was WNL (Unchanged from previous reporting).

DX listed orthopedic issues only.

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY Victoria Sarver FOR THE REASONS STATED BELOW:
(Print name of injured employee)

I, **Douglas W. Larson**, declare as follows:
(Print your name)

1. I am licensed in the state of California as a **PSYCHOLOGIST**, license number **PSY9281**
(Type of license)

2. The attached medical record pertains to:

Employee name: **Victoria Sarver**

Address: **666 West 18th Street Apt. 4 Costa Mesa, CA 92627** Phone: **(949) 514-4207**

W.C. Claim number: **550613; 550796**

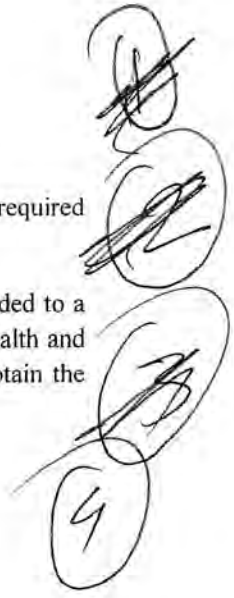
W. C. Claims administrator: **Ms. Janice Gardner** Phone: **260-482-8668**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

SUBSTANTIAL RISK OF POTENTIAL NEGATIVE REACTION TO PSYCHOLOGICAL INFORMATION.

4. On **January 11,** 20**19**, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.



She was scheduled for LESI at L4-S1 series starting after 9/03. Norco was refilled and she was to continue HEP. May take Aleve. RTC 3-4 months.

11/28/2018: Kevin Jung, D.C. Primary Treating Physician PR-2.

Subjectively, the patient complained of head problems. This was described as frequent occipital and frontal sharp and throbbing headache with dizziness, nausea, and light sensitivity exacerbated by stress.

Dr. Jung also listed orthopedic issues of thoracic spine, lumbar spine, right elbow, right forearm, right hand, right knee, left knee, right ankle and abdominal pain radiating to the right groin.

A Patient Self-Assessment Form was completed by Ms. Sarver. She responded: Pain average is 7/10. Pain interferes with sleep 8. Pain interferes with social activities 10; pain interferes with travel by car for more than an hour 9; general daily activities 10; limited activities to prevent pain from getting worse 10; interferes with relationships with family/partner/significant other 10; interferes with ability to do jobs at home 9; interferes with ability to keep up hygiene 7; ability to wrist or type 3; dress 5; engage in sexual activity 10; interferes with concentration 10. In reference to Mood: Overall mood 8; over past week how anxious or worried: 10; Over past week, how depressed: 7; over past week how irritable: 7; in general, how anxious/worried about performing activities because they make your symptoms worse – 10. Also noted were ADLs.

She expressed difficulty with taking a bath, brushing her teeth, getting dressed going to the toilet, writing, typing, speaking; standing; sitting, reclining, walking, climbing stairs, hearing, seeing, grasping, differentiating between what she touches, lifting, driving and sleeping.

ROS: Under the sleep and psyche portion, she did complain of loss of sleep due to pain and fatigue. She also stated that due to prolonged financial hardship, she feels like her condition will never improve and is causing anxiety, stress, depression, irritability and nervousness.

No MSE was performed. DX: Headache, pain in thoracic spine; spinal enthesopathy, thoracic religion; low back pain; spinal enthesopathy, lumbar region; pain in right elbow, pain in right hand, pain in right knee, pain in the left knee; unspecified abdominal pain, sleep disorder, unspecified, anxiety disorder, unspecified; major depressive disorder, single episode, unspecified; acute stress reaction; irritability and anger; nervousness, chronic pain due to trauma; myalgia and myositis, unspecified.

12/03/2018: Precision Occupational Medical Group, EMG/NCV of the Upper Extremities, read by Diana Munoz, D.O.

Impression:

- Abnormal study: Bilateral median nerve entrapment at the wrist affecting the sensory fibers. Findings consistent with carpal tunnel.

- **Questionnaire (PMR Exam)** was also completed by the patient. This indicated that from lifting chairs and heavy tables back and forth; from the faith "cofa" to the big church doing all the things that janitor stuff every day. She denied previous symptoms. She also described her janitorial duties. She went to the doctor because she couldn't handle the pain. She noted she was taking medication for back pain, nerves (Valium) and Stress Pacsle (assuming [Paxil]). Under ROS, she did answer "yes" to having memory loss/difficulty concentrating; depression, anxiety, headaches, sleep disturbances/insomnia; and weight loss. Social history documented that she is single; she smokes and drinks on holidays. Symptoms are constant. No other mental health concerns are noted.

12/05/2018: Mega Imaging, MRI of the Left Knee, read by Penelope Block, M.D.

Impression:

1. Longitudinal horizontal oblique tearing of the anterior horn and body of the lateral meniscus, violating the superior meniscal surface at the anterior horn, and inferior meniscal surface at the lateral meniscal body, with superimposed low-grade inner margin tearing

2. Low-grade longitudinal intrasubstance tearing of the distal patellar tendon at the tibial tuberosity insertion, extending craniocaudally over a distance of approximately 1.1 cm, on a background of tendinosis

3. Ossific fragment within the distal patellar tendon at the tibial tuberosity insertion, extending craniocaudally approximately 1.2 cm, with mild bone marrow edema within the ossific fragment, suggestive of adult Osgood-Schlatter's disease

4. Tricompartmental chondromalacia, most pronounced within the patellofemoral compartment, characterized by moderate-grade articular cartilage fissuring on a background of low-grade articular cartilage loss

5. Very small joint effusion and popliteal cyst

6. Mild edema of the suprapatellar fat pad, nonspecified, possibly representing quadriceps/suprapatellar fat pad impingement

Additional Records Reviewed but not Summarized:

- Duplicate reports, Billing Forms, Advocacy Letter to the PQME, Dr. Moazzaz, Patient Information Sheet from Orange County Pain Specialist regarding PI auto case; PHQ-9 Implementation Plan, a PI Bill from Dr. Shah totaling $3200.00. Patient Ledger from Pain Specialist of OC was provided.

- Description of "Employee's Job Duties for Eric Wyamon, noted as the Head Pastor was included. This is not summarized as it is not the applicant who is being examined.

- Med-Legal Correspondence from Natalia Foley, Esquire

This concludes my review of medical records available at this time.

HISTORY OF PRESENT ILLNESS:

Regarding sexual harassment issues, the line of negative events involved a previous pastor (Pastor Leigh) French kissing her on the mouth, which appeared to be a culmination of several attempts from him to be overly friendly throughout the years. Ms. Sarver had somewhat valued Pastor Leigh's interactions before that, because he would counsel her.

When the incident first occurred, Ms. Sarver tried to dismiss it and move on, because she valued keeping her job. It was only when her daughter also reported similar questionable behavior by the pastor when she (the daughter) was a child that Ms. Sarver became more concerned and decided to report it to the authorities at her church, chiefly Pastor Eric.

After Ms. Sarver made the report to Eric (the other pastor was in his 70's and has retired to Arizona), that she started to note a chill in the air in terms of her relations with other church staff, members, that she was not being treated well and her hours were being cut more and more.

Also, as part of the negative interactions, she reported being almost literally forced to clean a floor in the presence of other witnesses despite her protestation that the cleaning would not be necessary. She ultimately did comply with the request by a contract worker named "Hassim" to do the cleaning and afterwards felt she was being laughed at by the other people when she left the room.

The pastor who inappropriately kissed Ms. Sarver was known as Pastor Leigh and was in his 70's at the time. She indicated after Pastor Leigh kissed her she left the church, got in her car and went straight home. She indicated that at the time it happened he did smell like alcohol.

Ms. Sarver indicated at times in the past when she went for counseling that the pastor would ask her to sit on her lap and give hugs. She indicated the day he kissed her, which was shocking; it put some of his other behavior in perspective.

Ms. Sarver indicated that Pastor Leigh wanted to talk to her the next morning, but she did not want to talk about it and just tried to let it go.

Ms. Sarver indicated she ultimately decided to talk about it after her older daughter Lindsey had left the church, and following a church event they a conversation with that Pastor Leigh had been inappropriate with Lindsey when she was in high school. Ms. Sarver indicated this conversation was in the context that Lindsey would often come and help her do her cleaning because of her bad back. Ms. Sarver indicated at one point Pastor Leigh patted Lindsey on the butt and at times Pastor Leigh would ask her to sit on her lap and give her candy. Ms. Sarver recalled when she came home from the initial incident with Pastor Leigh that Lindsey was around, but they never really talked about it until about a year later. Ms. Sarver also indicated that at times her memory was off, and had kept a calendar of events which as of this writing had not been submitted for my review.

Ms. Sarver indicated that after Lindsey disclosed what had happened with the pastor she decided to go to Eric. She also indicated she was concerned no one was going to believe her. She indicated she recalled her stomach being in knots over the situation. After she reported the evaluation she was relieved that Eric seemed to believe her. However, over time it seemed they (church staff member) were not as friendly to her. Ms. Sarver recalled they would be in the conference room when they were having a meeting and they would completely ignore her.

Regarding the other negative interpersonal incidents, as noted in records reviewed, one of the people Ms. Sarver had significant difficulties with was a man known as "Hassim." Hassim was married to one of the church staff members and was contracted to do some repairs at the church, and was working on drywall when this incident happened. Ms. Sarver recalled on the day of the incident with Hassim she had already been busy trying to do many errands for many different people in the office. She indicated she pushed by Hassim to try and clean up a pile of drywall while he was working in the room. Ms. Sarver indicated she was planning to pick up the drywall when she finished one of her other errands, but he insisted she stop immediately and pick up the materials on the floor. She indicated recalling telling Hassim that she would do it when she was done, but he responded "no" and that she needed to do it immediately.

Ms. Sarver indicated she tried to explain to him that it was not a matter of just cleaning up the one little area, but would have to clean up the whole floor because of the drywall. She indicated that Hassim did not accept her explanation and she was ordered to do it immediately, and in her perception he was quite serious.

Ms. Sarver recalled trying to explain that if she were to clean the floor, and they were still working in it that they would still be leaving footprints, and she would have to clean the floor again. She indicated, however, she ultimately just did it. She indicated she was instructed to go under the desks to finish cleaning the floor.

Ms. Sarver indicated during this period she was told by a staff member named Jeannie to go in another room. She recalls looking back as she was going into the other office, and it looked as though the staff members were talking and looking at her, and smirking, and giggling.

Ms. Sarver indicated she had symptoms that seemed to be something like a stroke, that it was like electricity going through her body. She indicated this occurred in the office. She indicated she also had problems crying and forgetting words. She did not want anyone to think she was weird, and she was embarrassed, and ashamed.

Ms. Sarver recalled that on that day Jeannie took her home and that she could not walk or ride a bike, because of the pain from being on her hands and knees.

Ms. Sarver indicated she was fired about a month after that incident.

Ms. Sarver indicated on the day she was fired she came in and was excited, because she just bought a new car. She indicated she started showing the car to Pastor Eric, who told her that he wanted to talk to her in the office. Ms. Sarver indicated she had been late in arriving to the office, because of the car.

Ms. Sarver indicated she did not call, in part, because she wanted to surprise Pastor Eric and show him what she got. Ms. Sarver indicated her paycheck was waiting for her and that was probably around 9:30. Her normal start time was between 8:00-8:30.

Ms. Sarver was angry because Jeannie knew what she was doing and how she handled the situation did not seem right.

Ms. Sarver indicated in the past they had cut her hours after the day that Hassim told her to get on her knees and to get the material cleaned up from the floor. She indicated on that same day she could hear another woman, Robyn, who worked at the church, on the phone talking with new cleaning people. However, Ms. Sarver indicated she did not put two and two together until later.

Ms. Sarver recalled she had three write-ups before being fired. She indicated one for leaving cleaning supplies out such as paper towels. She indicated she did not recall what the second or third write-up was for, but indicated they were all "so stupid."

Ms. Sarver recalled Pastor Leigh had been forced out and it appeared that he conveniently retired, and then went to another state.

Ms. Sarver indicated during this time when she was working she would go in at nights to do her work as a cleaner, because they were doing a lot of construction and she did not want to be in people's way. She also did not want to be around the elders, because in part she was becoming self-conscious because Jeannie had mentioned her clothes.

Ms. Sarver indicated during the summer she might wear a tank top, but indicated she never dressed in "Shorty shorts," which made it feel unfair that Jeannie would comment to her on the phone about her dress attire.

Regarding physical injuries, Ms. Sarver indicates the main reason she is not working is because of her physical problems as opposed to mental problems. Her job involved setting up rooms for events, which would involve loading and unloading chairs from a broken dolly, which over time apparently led to back pain. Ms. Sarver indicated that after moving the chairs, at one point, she was on the floor with ice packs. Details of her condition are deferred to the appropriate specialty.

MENTAL HEALTH SYMPTOMS:

Regarding depressed mood: When asked if she was depressed, Ms. Sarver indicated she did not know if she was depressed, but indicated she cannot get enough energy to do anything. She indicated she did not want to get out of bed at times, but she did because she had to get her daughter to school.

She indicated at the time when her depression or feelings were the worst was when she talked to somebody at the SOS free clinic. She indicated at that time she may have gone about a month and she had also been given medications. She described it as a difficult time, because she had been holding it all in and she recalls going in February to see the lady at the SOS clinic.

Ms. Sarver also indicated at that time she had talked to a friend, Jaime, who had talked about Pastor Leigh taking another woman to get her "boobs done."

Currently, Ms. Sarver indicates she is mentally doing better but has a long way to go. She indicates she feels like she is about halfway better.

Ms. Sarver indicates there are times she will cry. She indicates she will cry by herself, but tries not to cry in front of other people.

Ms. Sarver believes at times she wishes she never would have gone to work for the church. She indicates she feels depressed most days, although once in a while she does not.

Regarding diminished interest or pleasures in activities: Ms. Sarver indicates she struggles with loss of interest in activities. She indicates she has become quite withdrawn and does not

want to go anywhere. She indicated she used to like to go to water parks, but now she does not like to do that. She tries to go to water parks so other people will have some fun.

Ms. Sarver indicates she still has some friends, but has withdrawn from them.

Regarding weight loss and appetite: Ms. Sarver indicates she is 5 feet, 3 inches tall and weighs maybe 104-105 pounds. She indicates she has recently been trying to drink shakes to try and gain weight. She indicates she does not want to eat anymore.

Regarding insomnia/hypersomnia problems: Ms. Sarver said the night before this evaluation she went to bed at 10:30 PM and got up at 6 AM. She reported tossing and turning, and waking 2-3 times and was worrying about coming in for this evaluation. This is a fairly typical pattern for her and that she does not sleep a lot .She recalled listening to a radio station from 9 PM to 10 PM.

Regarding psychomotor agitation/retardation: Ms. Sarver indicates she feels tired and slowed. She has fatigue nearly every day.

Regarding feelings of worthlessness, excessive or inappropriate guilt: Ms. Sarver indicates she feels worthless at times, because she wishes she could do more than she used to.

Regarding reduced ability to think or concentrate: Ms. Sarver indicates she has had memory problems consistent with test results detailed elsewhere.

In terms of her memory, Ms. Sarver indicates she has seen so many doctors she sometimes cannot remember what they said.

Regarding thoughts of death or suicide: Ms. Sarver indicated in the past, once or twice, she may have thought her kids might be better off without her. She indicated she has never had a suicidal attempt.

Regarding anxiety and physical symptoms: Ms. Sarver indicates that at times when she thinks about the difficult interactions she has had with Pastor Leigh she will get knots in her stomach. She indicated probably the first time she had knots in her stomach was when she and Henry were splitting up. She indicated that eventually she had an ulcer and she wonders if maybe she had talked about the issues sooner she would have avoided that. Ms. Sarver indicated at times she has had racing thoughts of being "off the Richter scale." She indicates at times she has had odd sensations of pictures going through her head very, very fast. She also indicated at times she had difficulty sitting still, because of her trying to stay busy.

Regarding anger and frustration: Ms. Sarver also indicates she becomes irritated over little things, and then finds herself apologizing, and then feels guilty about it.

Regarding serious mental health problems: Ms. Sarver indicates she has nightmares and she will have flashbacks about what happened. She indicated she will go over the events in her mind of what happened. She denied hallucinations.

Ms. Sarver she will have triggers when she runs into some of the people from the church, including the landlord she rents from, and when she runs into him she will get triggered. She indicates little things here and there will trigger her memories.

Ms. Sarver indicates she feels bad, because not even one person has called her. She indicates after she was fired she tried to let go and reach out to someone, but no one responded to her. She feels hurt, because she has considered these people to be her friends for many, many years.

PAIN LEVELS:

On the day of this evaluation, Ms. Sarver reported the following pain levels on a scale of 0-10(10 highest):

Head 2
Neck 0
Shoulders 0
Chest 0
Upper and mid back 0
Lower back 2
Hips 0
Legs (tingling) 4
Knees, feet, ankles0

CURRENT/PAST TREATMENT:

In terms of counseling, Ms. Sarver recalled just had the one-time visit at the SOS center. She indicated she spent some time talking to Pastor Leigh.

Ms. Sarver indicated she had seen Dr. Shahbazian, a Pain Specialist, for the last few years.

Ms. Sarver indicates she is currently receiving physical therapy twice a week, although it is hard to get there because she has to drive to Long Beach. She indicated she has had acupuncture one time.

Regarding mental health evaluation, Ms. Sarver indicated she was evaluated by a psychologist in Santa Ana about a year ago.

TRAUMA HISTORY:

Ms. Sarver denied she had ever been sexually or physically abused. She indicated she was often left alone growing up, because her mother was out working. She described herself as a latchkey kid, but she was involved in a lot of sports. She indicated she had spent a lot of time around the beach growing up.

Regarding accidents, Ms. Sarver indicated she was rear-ended when she and Olivia were in the car. She indicated the car was totaled. She indicated she saw the other car coming up on her so it did not hurt as bad. She indicated earlier in the day she has been given some curtain rods by Pastor Eric and as a result of the accident the curtain rods were moving around the car. She indicated one of the curtain rods hit her. She does not recall if she hit her head, but she did remember hitting her elbow. She indicated at the time of the accident she was going down the freeway, and had just got off work, and it was somewhere between 4:30 and 5:00. She indicated her knees were bruised. She indicated she did not go to the hospital at the time. She indicated when she finally went to her doctor he said she would be fine and would be back to normal. She indicated she probably saw the doctor the day after. She indicated she might have noticed some extra problems with concentration, which she described as "chopping off more than I needed at this point." Note that this is a mis-statement of the idiom "biting off more than one can chew."

Ms. Sarver was hit by a car and a bus when she was a child and lost four teeth that were replaced but then died and were taken out.

Regarding battery, Ms. Sarver indicated she had a neighbor who drank a lot and one time pushed her, but there was no arrest.

Regarding domestic violence, Ms. Sarver indicated she had been in fights with Adam, the father of her daughter Lindsey.

Regarding witnessing trauma, Ms. Sarver indicated "One of my best friends who skated with me later got hit by a drunk driver." She indicated she was close to that person.

Ms. Sarver denied any of the following problems: Near death experience, physical abuse, sexual abuse, robbery, death of a child, illness of a child, or military service.
abuse.

SUPPORT SYSTEMS:

She receives emotional support from her daughter Lindsey and her ex-husband Henry.

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY Victoria Sarver FOR THE REASONS STATED BELOW:
(Print name of injured employee)

I, **Douglas W. Larson**, declare as follows:
(Print your name)

1. I am licensed in the state of California as a **PSYCHOLOGIST**, license number **PSY9281**
(Type of license)

2. The attached medical record pertains to:

Employee name: **Victoria Sarver**

Address: **666 West 18th Street Apt. 4 Costa Mesa, CA 92627** Phone: **(949) 514-4207**

W.C. Claim number: **550613; 550796**

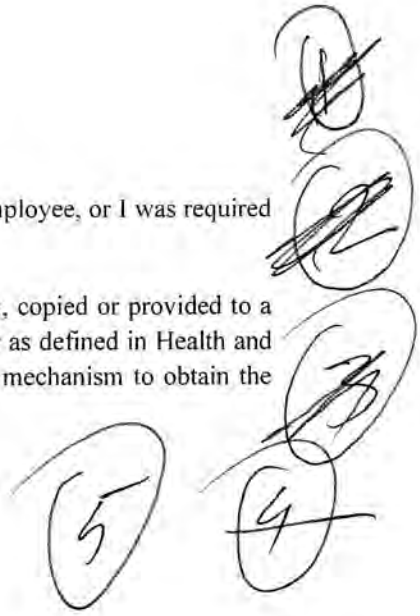
W. C. Claims administrator: **Ms. Janice Gardner** Phone: **260-482-8668**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

SUBSTANTIAL RISK OF POTENTIAL NEGATIVE REACTION TO PSYCHOLOGICAL INFORMATION.

4. On **January 11,** 20**19**, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.



MEDICAL HISTORY:

Ms. Sarver indicated she was generally healthy as a child and was born in a hospital.

Ms. Sarver indicated she broke her leg in fourth grade when she fell off of a Koi pond. She remembers having a cast on and people would sign it. She indicated she could not skate for six weeks and that was frustrating for her.

As noted above she was hit by a car and a bus while riding her bike, and lost 4 teeth.

Ms. Sarver also indicated she broke her fingers when she fell while skating when she was younger. She indicated she had been a big skater and was involved in some competitions including speed skating. She indicated she did roller skating, because she could not afford to do ice skating. She believes she broke two fingers in her right hand.

Ms. Sarver also indicated she broke her elbow when she was about age 26. She indicated she was roller skating at the beach at the time. She indicated they wrapped the elbow so she would not have as much pain.

Ms. Sarver also indicated she slammed her left finger in a door when she was younger.

Ms. Sarver also indicated she broke one of her pinky toes two times. She indicated one was fairly recent and she lost a toenail which was just now growing back in.

Regarding surgeries, Ms. Sarver has had two hernia surgeries around Christmas 2015 two weeks apart. She indicated she had to have the second surgery because the first surgery was not done correctly. She indicated the hernia happened when she tried to pick up a vacuum and move the chair. She did not know exactly that it was a hernia at the time. The hernia situation no longer is a concern and was not part of her claims.

Regarding head injury, Ms. Sarver may have hit her head when falling during skating. She indicated a surf board may have hit her head, but never recalls being knocked out.

Ms. Sarver indicated when she went to see Dr. Shah he put her things on her head to help. She indicated she never really understood what the procedure was and never really discussed the issue with him.

Ms. Sarver indicated her primary physician is Dr. Khan and indicated she has seen him forever.

Ms. Sarver denied any of the following medical problems: Being in a coma, unconsciousness, seizures, TB or neurological problems.

CURRENT MEDICATIONS:

Norco: She had taken 1 at 7 Amon the day of this evaluation, and takes it as needed for severe pain 2-4 per day.

Valium, 2.5, last taken about 2 days prior to this evaluation, about 2-3 times per week, usually when her anxiety is worse.

OTC Tylenol.

FAMILY, SOCIAL, AND ENVIRONMENTAL HISTORY:

PERSONAL AND SOCIAL: Ms. Sarver currently lives with her daughter Olivia in an apartment in Costa Mesa.

Childhood: Ms. Sarver indicated she was born in San Luis Obispo and was raised in Costa Mesa by her mother. She admitted she was kind of a wild child growing up and she did not have a good childhood. She indicated she had to grow up very fast.

Growing up, Ms. Sarver indicated there was no supervision. Ms. Sarver believes her parents divorced before she was born.

Ms. Sarver indicated she lived in New Zealand for 2 years when she was 18 to 19 years old. She indicated she came back to the United States after she found out her dad died. She indicated it felt like it was time to come back to the United States.

Parents: Ms. Sarver's mother, Huia, was from New Zealand and part of the Maori tribe. She indicated her mother was proud of her heritage. She indicated her mother was born there and then came to the United States with her brother's and sister's father. She indicated her mother was known as a "Windmill girl dancer," and there actually a movie about her mother, and at one point she was a little famous. Ms. Sarver indicated her mother was involved in dancing for the troops during WWII. Ms. Sarver indicated when she was around the age of 5 or 6 her mother performed the "Windmill House" dances in England. Ms. Sarver was not aware of her mother education.

Ms. Sarver indicated her mother died 13 years ago and was in her 60's or early 70's. Ms. Sarver indicated she forgot her mother's exact age. She indicated her mother died very quickly after she fell and broke her hip.

Ms. Sarver indicated her mother's occupation after dancing was working known as "The Villa" in a place where she was a counselor for women. She indicated her mother got into that, because she had met a lady who had taken her in under her wing.

Ms. Sarver's father was named James. She indicated she only met him once or twice. She did not his education level or what kind of work he did. She indicated she was in New Zealand when he died.

Siblings: Ms. Sarver has two brothers and one sister.

Ms. Sarver's brother, Lyndon, passed away in his 60's. She indicated they did not have much contact. He was a professional scuba diver for movies. She indicated the last time she saw her brother was probably at a wedding when she was about 17.

Ms. Sarver's brother, Todd, is in his 60's and lives in San Clemente. He recently married for probably the third time. He has three children. He does drywall and runs his own business. She indicates she will occasionally help him with his business. She indicates she is closer to Todd, because he has been around more. He appears to be doing okay.

Ms. Sarver's sister, Maureen, is in her early 60's and lives in Rancho Santa Margarita. She is married to a man named Michael who was a scout for the Phoenix Suns. She indicates she is fairly close her sister, although they are 10 years apart. She indicates if she needed anything her sister would be there for her.

Significant Others: Ms. Sarver indicated she dated a man named Jim from the ages of 15 to 22. She indicated they broke up because he got a girl pregnant and he ended up marrying that girl. Ms. Sarver described him as her first love.

Adam, the father of Lindsey, is three years older than Ms. Sarver and they knew each other from high school from their different crowds of friends. She indicated she went through a period of not seeing him for many years and then they reconnected at a birthday party when she was about 26-years-old. She indicated after Lindsey was born they would get into arguments. She indicated they had a very awkward relationship for many years. She indicated that at the time he was using cocaine, as well as pills. She indicated he had been using drugs significantly for about 10 years. His occupation was as a house painter and he had a little bit of college. She indicated he went to school to learn how to be a mechanic working on yachts, because his parents owned the Newport Anchorage Facility. She indicated he went to prison for 18 months, which was drug-related for weed. She indicated he also went to another prison for a period of time, but she does not know what it was for because she was not involved with him.

Ms. Sarver indicated she was not really aware of his drug use until a sheriff came to her door. She indicated while they were together the cops were called once or twice, because he would have a temper tantrum after getting jealous and "weird" over stupid little things. She indicated she could see a pattern of his behavior escalating. She thinks Lindsey may have witnessed their altercations once or twice. She indicated they currently do not talk to each other.

Ms. Sarver indicated she had been married to Henry who is now 55-years-old. She indicated they are good friends now, but divorced. He has worked as a contractor. She believes he graduated from high school and thinks he might have gone to community college. Ms. Sarver indicated she and Henry broke up, because they argued frequently over Olivia. She indicated that when they were together often he would be working, and Olivia would want his attention, and he would not give it to her. She indicated she met Henry through a friend named Mark while helping somebody paint. She indicated she first saw Henry when she was about 25-years-old and then had no contact for many years after that. She indicated they started going out right after her mother had passed away. She indicated he asked her to go up to a cabin and then they reconnected. She dated Henry for about six months and then they married. She indicated they divorced about three years ago. She noted he has 20 years of sobriety behind him.

Ms. Sarver indicates she is not dating currently and there has been nobody else she has been very serious with.

Children: Ms. Sarver has two daughters.

Ms. Sarver's daughter, Lindsey, is 24-years-old and was born in the United States. She is doing fairly well. She is working for a pharmaceutical company doing reception and working for the owner. Ms. Sarver indicated her daughter has been going back to school. She indicated her daughter was on the water polo team with Newport Harbor High School and they won CIF. She indicated she went to community college for about two years and then decided she wanted to work instead of getting an education. Ms. Sarver indicated she did not know of any drug, alcohol or legal problems, but thinks her daughter probably smokes some marijuana. Ms. Sarver also indicated that at one point her daughter got involved with some people that she did not care for and they were very bad people. She does not have any significant health problems. Her daughter has not dated for two years. Ms. Sarver indicates overall she and her daughter have a good relationship, although the daughter probably does not tell her everything.

Ms. Sarver's daughter, Olivia, is 13-years-old. She is currently in seventh grade. She is doing okay. She described her daughter as trying to find herself. She thinks perhaps her daughter may have ADHD, but has not been diagnosed. She indicated her daughter appears to be going through some issues with hormones. She indicates she has been trying to get her daughter to eat natural foods to help cope with whatever ADHD symptoms that might be going on. She indicates Olivia is way too smart for her own good. She indicates Olivia is getting good grades and now finally getting a social life, as she had been bullied in the past. Ms. Sarver noted that her daughter is blossoming, and becoming very voluptuous, and does seem to have friends. She is playing volleyball and water polo. Her daughter is actually becoming somewhat self-conscious about her breasts, because they are so large.

Ms. Sarver indicated Olivia had been attending the church school since she was very young, but was ultimately transferred to public school after the problems with the pastor. Ms. Sarver indicated she was probably transferred in kindergarten. She indicated she does not have any significant health problems, although she wonders sometimes that she might have some consequences of breathing the chlorine from all her pool activities.

EDUCATION: Ms. Sarver indicated she had some difficulties with learning. She indicated she dropped out of school in the ninth grade and just gave up because of the difficulties. Ms. Sarver indicated she was held back one year in school.

EMPLOYMENT:

Ms. Sarver had some difficulty recalling the time lines of her various jobs.

She indicated when she lived in New Zealand, around the age of 18. While in New Zealand, Ms. Sarver indicated she also worked at a bed and breakfast cleaning. She worked there almost two years.

Ms. Sarver indicated when she came back to the United States she worked at a Sizzler behind the counter. She indicated she worked there about six months and did not recall any problems at that job.

She worked at a place called "El Ranchito" as a hostess. She worked there until they closed down. She indicated she worked at the one on Irvine Blvd.

Ms. Sarver indicated that throughout she did a lot of cleaning jobs and babysat for friends while they would go to work.

Ms. Sarver indicated she worked at TJMAX for about nine months cashiering. She stopped that job because she became pregnant and felt so bad that she could not stand up to be a cashier.

Ms. Sarver worked as a babysitter for three years around the time she was pregnant with Lindsey.

Ms. Sarver also indicated she worked at a place known as "J.T. Marble and Stone." She indicated she worked there for about 3-4 years. She indicated the business had ups and downs, but when that happened, although she would be officially laid off, she would clean the owner's house because they liked her. She indicated they eventually sold the business as the moved to Palm Springs and the new owners from France let everybody go.

Ms. Sarver worked at Togo's for about a year until they closed. She indicated there were no problems.

In her most current job, Ms. Sarver worked for a church doing custodial work, which included cleaning the church and preschool offices, as well as setting up and taking down chairs and tables for special events, which was hard on her back. She indicated there would be a lot of chairs that she would put on the dolly, which was broken and hard to move. She indicated her back started to hurt over the years from moving the chairs.

When asked how she wound up working at the church, Ms. Sarver indicated one day when she was fighting with her mother she took a walk and ended up at the Lighthouse Church as opposed to going to the bar. She indicated this occurred the year before she had Olivia when she was 37 or 38-years-old. She indicated at the time her mother was dying and Ms. Sarver was not in a good place when she walked into the church. She indicated she went to the church a couple times and then did not go back for a year or so. She then went back to attend the church. Ms. Sarver indicated there were a lot of good things at the church and there were a lot of good people. One reason she went to the church was she wanted to show her kids something completely different. She indicated at the time it was a little church.

When asked how she was getting paid at her job at the church, she indicated at the time Olivia was going to preschool. She indicated Henry was not doing a good job paying the bills, and she asked the director at the church if she could work to pay off the preschool bill so she would not get further behind. She indicated Olivia was about 3-years-old when started officially working there. She indicated she worked there while Lindsey was in school for about three hours a day. She indicated she cleaned the church, as well as the offices in the preschool. Ms. Sarver added that at that time there were probably about 200 people in the congregation.

Ms. Sarver indicated when she started working there she would go in at four o'clock in the morning then go back home, and then maybe work some other hours after she dropped Olivia off.

Ms. Sarver indicated that as Olivia got older she was in school longer so Ms. Sarver would work more as well. She indicated she generally worked from 8 am to 2 pm at that time.

Ms. Sarver indicated that after she started making complaints about the pastor who inappropriately approached her it was then that her hours seemed to be continually cut and cut and cut.

Ms. Sarver indicated she really started to have problems working at the church once a woman named "Jeannie" started. She indicated the pastor was married to a woman named "Mary" and Jeannie was a friend of Mary. She indicated Jeannie started working there after she told Pastor Eric about the problems with Pastor Leigh. Ms. Sarver described Jeannie as being critical.

HABITS: Ms. Sarver indicated she might have first had some alcohol when she took sips off party glasses at her mother's place. She indicated the last time she had an alcoholic beverage was within the last few days before this evaluation when she got some eggnog from Trader Joe's. She indicates she does not drink alcohol much. When asked if she went through a period of drinking a lot, she indicated that after her mother died she drank more for a little bit and then when Lindsey was almost two, she went through some times of drinking more.

Ms. Sarver indicated she first tried marijuana around the age of nine with some girlfriends. She indicated in high school she might have used marijuana maybe twice a week in general and on the weekends. She indicated she did not do marijuana for many years, because she became paranoid one time after taking it.

Ms. Sarver she is currently using marijuana oils to help with her pain over the last nine months. She indicated the last time she smoked marijuana was about 15 days ago.

Ms. Sarver indicated she used cocaine around the age of 17. She indicated the last time she used any was over 20 years.

Ms. Sarver indicated no use of heroin or speed; adding that she "did not hang out with those people."

Ms. Sarver indicated she went to AA after she got a DUI.

LEGAL: Ms. Sarver indicated she had been arrested for a DUI and had to go to AA about two years before Lindsey was born. She indicated she was driving at the time after a party. She indicated the drugs that were found were from a family friend. Ms. Sarver indicated she was able to get the DUI removed after attending classes.

Ms. Sarver also indicated she got a DUI on her boyfriend's (Adam) birthday.

Ms. Sarver denied any other workers' compensation claims. There is no history of bankruptcy.

CURRENT LEVEL OF FUNCTIONING/ACTIVITIES OF DAILY LIVING (ADL):

ACTIVITY LEVEL OF FUNCTIONING:

The day before this evaluation, Ms. Sarver indicated her daughter Olivia was sick and vomited in the morning. She said she hung out to take care of her for a while and then she had a doctor's appointment. She indicated she had an MRI for her elbow. She indicated she made soup for Olivia. She indicated she did not watch TV. She indicated she tried to get all the paperwork and all the bills together since it was near the 10th of the month.

Ms. Sarver does not use a brace but thinks she needs to get a back brace.

ACTIVITIES OF DAILY LIVING:

Ms. Sarver indicated because of pain problems she was slower in dressing, bathing and caring for her hair. She has to use long sponges. She has difficulty getting in and out of the bath and can barely wipe her own bottom and indicated it was getting harder.

Regarding preparing meals, Ms. Sarver still does cooking although she gets help from Lindsey.

Regarding housework, Ms. Sarver indicates she tries to sleep on top of the bed so she does not have to change it as much. She indicates she currently sleeps on a blowup bed and it is difficult to get up and down.

Regarding shopping, Ms. Sarver indicated people will help her and she will ask for help to get things that are high.

MENTAL STATUS EXAMINATION:

GENERAL APPEARANCE: Ms. Sarver presented as a pleasant and cooperative woman appearing about her stated age.

At one point, during the evaluation, Ms. Sarver had to get up because of pain from sitting in the chair for an extended period.

She wore a red sweatshirt and blue-jeans. Her hair was in a long ponytail. She wore black glasses, earrings and sandals.

ORIENTATION: She appeared to be of average intelligence based on her best test results. She was oriented in all spheres.

SPEECH: Speech was significantly pressured at times when talking about her problems. She would often pause before answering questions, and restate her thoughts.

THOUGHT PROCESSES: Generally intact. No problems with loosening of associations or significant tangentiality. There was no evidence of a psychotic thought process.

THOUGHT CONTENT: Generally intact. There was no significant poverty of thought. There were no current suicidal, homicidal ideations, auditory or visual hallucinations.

MOOD AND AFFECT: Mood was depressed and anxious. Affect was labile. She cried during the evaluation.

MEMORY: Mildly to moderately impaired. She was able to remember 3 of 3 items immediately, but only 2 of 3 items at 5 minutes. She was able to repeat 6 digits forward but only 3 digits backwards.

CONCENTRATION AND ATTENTION SPAN: Generally intact, although test results also indicate some concerns. She could perform serial 3's up to 30. She could answer the question correctly "if you buy two oranges at 10 cents each how much change would you get back from a dollar?" She could do simple math questions, such as 2+3 and 3x5, and after a pause she could do 9-6. She could spell the words "cat" and "world" forwards and backwards. She was able to say how an orange and apple were both the same "round" and different "color."

FUND OF KNOWLEDGE: Generally intact. She knew the name of the President of the United States. For the capital of United States, she said "Sacramento." When asked what the capital of California was, she corrected herself and then said Washington was the capital of the United States and Sacramento was the capital of California. She said that President Kennedy was shot.

INSIGHT AND JUDGMENT: Fair in that she is aware she has some problems. When asked to interpret the proverb "Don't judge a book by the cover," she responded, "Don't know what's inside of it." When asked what she would do if a small child came up to her in Walmart and said they were lost, she said she would call for the mom.

PSYCHOLOGICAL TESTING:

Ms. Sarver was administered the following tests:

Rey 15 Item Memory Test - 2 (Rey).
Test of Memory Malingering (TOMM).
Minnesota Multiphasic Personality Inventory - 2nd Edition (MMPI-2).
Beck Anxiety Inventory (BAI).
Beck Depression Inventory (BDI).
Hamilton Rating Scales of Depression (Hamilton).
Epworth Sleepiness Scale (Epworth).
Wechsler Adult Intelligence Scale – 4th Edition (WAIS-IV).
Wide Range Assessment of Memory & Learning – 2nd Edition (WRAML-2).
Wide Range Achievement Test -- 4th Edition (WRAT-4)
Woodcock-Johnson III Test of Achievement (WJ-III).
Bender Gestalt Visual Motor Integration Test -- 2nd Edition (Bender 2).
Trail Making Test (Trails).

REY 15 ITEM MEMORY TEST

The Rey 15 Item Memory Test - 2 (Rey) is a common measure of malingering, and for reasons of test security details of procedure are limited.

Correct scores less than 6/15 are highly suspicious.

Results indicate there was no malingering.

TEST OF MEMORY MALINGERING (TOMM)

The TOMM is also a common measure of malingering, and again for reasons of test security details of procedure are limited.

TOMM results indicated no malingering.

MINNESOTA MULTIPHASIC PERSONALITY INVENTORY, 2ND EDITION (MMPI-2).

The MMPI-2 is a self-report true-false questionnaire of symptoms.

MMPI-2 profile was invalid due to elevated L scale and F scale, so the clinical scales could not be interpreted.

T-Scores are as follows:

L	F	K	1	2	3	4	5	6	7	8	9	0
66	82	48	105	92	90	71	69	73	84	100	75	51

BECK ANXIETY INVENTORY (BAI)

The BAI is a self-scoring inventory used for measuring the severity of individual anxiety.

The BAI score was 20, indicating moderate anxiety.

BECK DEPRESSION INVENTORY (BDI)

The BDI is a self-scoring inventory of symptoms of depression.

The BDI score was 35, indicating significant depression.

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY Victoria Sarver FOR THE REASONS STATED BELOW:
(Print name of injured employee)

I, **Douglas W. Larson**, declare as follows:
(Print your name)

1. I am licensed in the state of California as a **PSYCHOLOGIST**, license number **PSY9281**
(Type of license)

2. The attached medical record pertains to:

Employee name: **Victoria Sarver**

Address: **666 West 18th Street Apt. 4 Costa Mesa, CA 92627** Phone: **(949) 514-4207**

W.C. Claim number: **550613; 550796**

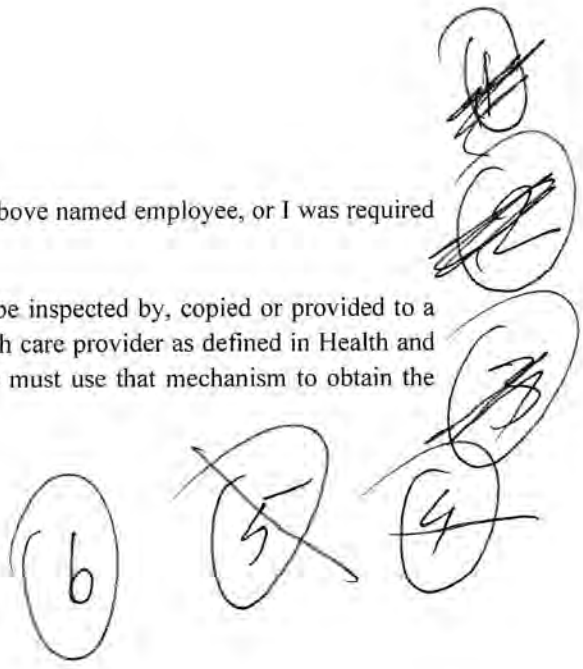
W. C. Claims administrator: **Ms. Janice Gardner** Phone: **260-482-8668**

3. In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

SUBSTANTIAL RISK OF POTENTIAL NEGATIVE REACTION TO PSYCHOLOGICAL INFORMATION.

4. On **January 11,** 20**19**, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.



HAMILTON RATING SCALE OF DEPRESSION (HAMILTON)

The Hamilton is completed by a mental health professional and assesses the patient's functioning on several items.

The Hamilton score was 25, indicating significant depression.

EPWORTH SLEEPINESS SCALE (EPWORTH)

The Epworth Sleepiness is a scale intended to measure daytime sleepiness measured by use of very short questionnaire.

The Epworth score was 6, indicating no sleepiness.

WECHSLER ADULT INTELLIGENCE SCALE – 4th Edition (WAIS-IV).

WAIS-IV

	Intelligence Classification	IQ
Verbal Comprehension	Low Average	81
Perceptual Reasoning	Average	90
Working Memory	Deficient	69
Processing Speed	Deficient	63
Full-Scale	Borderline	74

Factor/Subtest	Scaled
Verbal Comprehens.	
Information	7
Similarities	5
Vocabulary	8
Working Memory	
Arithmetic	4
Digit Span	5

Factor/Subtest	Scaled
Perceptual Reasoning	
Block Design	10
Matrix Reasoning	7
Visual Puzzles	8
Processing Speed	
Digit Symbol	4
Symbol Search	3

Note: Average range for IQ scores is 90-109 and for Scaled scores is 8-12.

IQ scores showed significant scatter from the deficient to average range generally consistent with her history and reflecting some concentration problems.

WRAML-2

Average scaled scores range from 8-12. Average Standard Scores range from 90-109.

Immediate Auditory memory was in the **deficient** range with an adjusted Standard Score of **68**. Delayed Auditory memory was in the **borderline** range with an adjusted Standard Score of **70**.

Visual memory as measured by the Design Memory task was in the **deficient** range with an adjusted Standard Score of **57**.

Working memory as measured by the WAIS-IV Scores was in the deficient range with a Standard Score of 69.

Results overall indicate significant memory problems, consistent with her history of learning problems and difficulties with memory and concentration..

WIDE RANGE ACHIEVEMENT TEST -- 4TH EDITION (WRAT-4)

The claimant was administered the WRAT-4 and the results are as follows:

WRAT-4

INDEX	Index (Standard) Score	Grade Level	Range
Word Reading	71	4.3	Borderline
Spelling	68	3.7	Deficient
Math Computation	69	3.5	Deficient

Note: Average range for standard scores is 90-109.

WRAT 4 results show moderate scatter from the borderline to deficient range, again generally consistent with her history of learning problems and difficulties with memory and concentration.

WOODCOCK-JOHNSON III TEST OF ACHIEVEMENT (WJ-III), PASSAGE COMPREHENSION SUBTEST.

On this subtest, Ms. Sarver completes a reading passage by filling in a missing word.

INDEX	Standard Score	Grade Level	Range
Passage Comprehension	88	4.8	Low Average

Woodcock-Johnson results suggest she will have some difficulty with learning new reading material, consistent with her history of learning disabilities.

BENDER GESTALT II:

Bender

Standard	Percentile	Range
77	6	Borderline

Note: Average range for standard scores is 90-109.

Bender results were in the low average range, generally consistent with her history.

TRAILS A & B:

Trails

Subtest	Seconds	Errors	% ile	Range
Trails A	1 min, 17 sec	0	<1	Impaired
Trails B	N/A	>10	<1	Impaired

Ms. Sarver was accurate, but slow on Trails A and became lost on Trails B. Results are generally consistent with her history.

TEST VALIDITY/MALINGERING:

The Rey and TOMM test scores indicate **no** malingering. Given the invalid MMPI results, greater weight was given to the Mental Status Examination results.

DIAGNOSTIC IMPRESSION:

Based on the results of the face to face interview, Mental Status Examination, applicants reported history and the review of medical records and ancillary documents, and with a reasonable degree of medical certainty, the following diagnostic impressions, in accordance with Diagnostic and Statistical Manual, Fifth Edition (DSM-5) diagnostic criteria, are offered:

Unspecified Depressive Disorder (F32.9)
Unspecified Anxiety Disorder (F41.9)

DISCUSSION OF DIAGNOSES:

Because of the many factors in this case the above diagnoses were indicated. An onset of April 2016 is indicated based on the records available.

IMPAIRMENTS FOLLOWING THE AMA GUIDES:

When considering current social functioning, Ms. Sarver has moderate impairments, because she has withdrawn from friends.

When considering current psychological functioning, Ms. Sarver has moderate impairments, because she of her depression, anxiety, and memory and concentration problems.

When considering current occupational functioning, Ms. Sarver has no impairments, because she could still do her job as a janitor despite her mental health problems.

With regard to concentration and pace, Ms. Sarver has moderate impairments, because of her memory problems.

Lastly, ability to perform activities of daily living, Ms. Sarver has moderate impairments, because she often has no interest in doing activities at home.

RETURN TO WORK STATUS/WORK RESTRICTIONS:

From a psychological point of view, Ms. Sarver was never TTD or TPD and never had work restrictions.

TREATMENT RECOMMENDATIONS:

(Note: References are listed in APPENDIX C.)

Past treatment: Unknown given no records.

Current treatment needs:

There are no applicable ACOEM recommendations for mental health treatment because of this diagnosis, and the breadth length and depth of psychological problems.

However, the ACOEM treatment guidelines for Depression (see Appendix B) can be reasonably modified to account for anxiety, worry, and pain problems

Ms. Sarver would likely benefit from 20 sessions of Cognitive Behavioral Therapy (CBT) over a twelve week period, with a focus on succeeding at work.

Currently, the standard practice for a significant depression and anxiety seen in a mood disorder involves **a medication review/trial**, as well as **12 initial weeks of CBT** (e.g., Burns, 1999).

Cognitive behavior therapy would address issues such as cognitive distortions and findings ways to overcome the effects of stressors.

Standard cognitive behavioral therapy of learning to control negative thoughts, pursue more pleasant social activities and learning some relaxation techniques would be useful.

Problem solving training would be indicated to identify short-term, medium-term, and long-term options. Such options would include professional development, networking, and career exploration.

Stress management courses note the importance of both instrumental and social support (e.g., Foa, Keane, Friedman & Cohen, 2009; Pergola & Smith, 2006).

Pain management techniques following CBT principles (e.g., Turk & Winter, 2006) of relaxation, pacing, and growth could also be incorporated as part of the 12-20 CBT sessions

PROGNOSIS:

Fair with recommended treatment.

CAUSATION:

Causation at this time, for her mental health problems, is currently deemed to be with greater than 50% medical probability due to the negative industrial events she underwent. Since the events are in part due to the reported actions of those in a superior position to her, there is a scenario where the Rolda defense might be asserted, and at that point, Rolda procedures would be expected to be followed.

DISABILITY STATUS:

The California definitions of temporary total disability and temporary partial disability (http://www.dir.ca.gov/dwc/wcglossary.htm) are:

Temporary disability (TD or TTD): Payments you get if you lose wages because your injury prevents you from doing your usual job while recovering.

Temporary partial disability (TPD) benefits: Payments you get if you can do some work while recovering, but you earn less than before the injury.

Temporary total disability (TTD) benefits: Payments you get if you cannot work at all while recovering.

Based on information provided from Ms. Sarver's report of history, the clinical interview, psychological testing, and medical records, the following conclusions seemed most reasonable, from a psychological perspective:

Ms. Sarver was never **Temporarily Totally Disabled (TTD)** or **Temporarily Partially Disabled (TPD)** from a psychological point of view.

Discussion of physical disability is deferred to the appropriate specialty.

PERMANENT AND STATIONARY/MAXIMUM MEDICAL IMPROVEMENT STATUS:

At the time of this examination, Ms. Sarver had **not** reached **Maximum Medical Improvement**, because she may benefit from the course of treatment recommended.

PERMANENT DISABILITY STATUS / IMPAIRMENT RATING:

As there is not yet MMI or permanent and stationary status, there is not yet permanent disability. However, Ms. Sarver would be given a current GAF of 60.

VOCATIONAL REHABILITATION:

Deferred until MMI is reached.

APPORTIONMENT DISCUSSION:

Formal apportionment is deferred until MMI is reached, and as discussed in the body of the report there are several areas to be addressed.

BILLING & COMPLEXITY FACTORS:

ML103: RV = 75 COMPLEX COMPREHENSIVE M-L EVALUATION, involving at least three of the following:

ML104: RV = 5 COMPREHENSIVE MEDICALLEGAL EVALUATION INVOLVING EXTRAORDINARY CIRCUMSTANCES, involving at least four of the following:

XX . Two or more hours face to face time with IW
XX . Two or more hours record review
XX . Two or more hours necessary medical research
XX . Four or more hours of any above 3 in Combination
XX . Six or more hours of first 3 complexity Factors
XX . Addressing issue of medical causation
XX . Addressing issue of apportionment
XX . Psychiatric or psychological evaluation
Total Complexity Factors: 8

9795(d):– -94 EVALUATION AND MEDICAL TESTIMONY BY AGREED PANEL QME 1.25x ML CODE RATE

Billed time in hours was as follows:

Face to Face Interview:	3.0
Review of Records	7.0
Psychological Testing, Face to Face:	5.0
Psychological Test Scoring:	1.0
Necessary Research	2.0
Report Preparation:	13.0
TOTAL:	31.0 Hours

Thank you for the opportunity to participate in this interesting case. I am available and willing to prepare supplemental reports as needed for this case. Please call my office if you have questions or concerns about Ms. Sarver or my report of this evaluation.

DECLARATIONS

The psychological testing and clinical interview were conducted by myself, Dr. Douglas W. Larson, on January 11, 2019 in my Santa Ana, California office.

I hereby 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 I have indicated I have 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 to be true. I also declare under penalty of perjury that I performed all professional services involved with this evaluation. Any clerical preparation involved with this report was conducted by Cyd Kintzer, Mykel Larson and Cheryl Andrews.

I hereby 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 and the preparation of this report.

I declare under penalty of perjury, under the laws of the State of California, the above is true and correct to the best of my knowledge.

Sincerely,

Douglas W. Larson, Ph.D.
Licensed Psychologist PSY 9281, Expires: 6/30/2019
NPI# 1801011580

Executed on February 10, 2019 in the County of San Bernardino, California.

APPENDIX A

GAF RATINGS

Code:

91 – 100: Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81 – 90: Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 – 80: If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61 – 70: Some mild symptoms (e.g., depressed mood and mild insomnia) **OR** some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51 – 60: Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR** moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41 – 50: Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR** any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

31 – 40: Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) **OR** major impairment in several areas, such as work or school, family relations, judgment thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).

21 – 30: Behavior is considerably influenced by delusions or hallucinations **OR** serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR** inability to function in almost all areas (e.g., stays in bed all day; no job, home or friends).

11 – 20: Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) **OR** occasionally fails to maintain minimal personal hygiene (e.g., smears feces) **OR** gross impairment in communication (e.g., largely incoherent or mute).

1 – 10: Persistent danger of severely hurting self or others (e.g., recurrent violence) **OR** persistent inability to maintain minimal personal hygiene **OR** serious suicidal act with clear expectation of death.

0: Inadequate information.

APPENDIX B

ACOEM TREATMENT GUIDELINES FOR DEPRESSION

Note: Abstracted from:

http://www.acoem.org/DepressionInWorkingPopulation.aspx

Pharmacological and Psychotherapeutic Treatment Options: The goal of treatment is remission, not only to eliminate the suffering associated with depressive symptoms, but also to return patients to full function and prevent further depressive episodes. Although there is a limited role for initial pharmacological treatment by non-psychiatrist providers with training and experience (e.g., occupational physicians), definitive management, particularly with combination pharmacotherapy is best managed by psychiatrists experienced in workplace issues. Empirically validated, time-limited (e.g., 12 to 20 sessions) psychotherapies such as cognitive behavioral and interpersonal therapy have demonstrated effectiveness in treating depressive illness and may be appropriate either alone or combined with pharmacotherapy.

APPENDIX C

REFERENCES

ACOEM. ACOEM treatment guidelines for depression. Online resource: http://www.acoem.org/DepressionInWorkingPopulation.aspx

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Masel, B. E., & DeWitt, D. S. (2014). Disease: Long-term consequences of traumatic brain injury. In, Levin, H. S., Shum, D. H. K., & Chan, R. C. K., *Understanding traumatic brain injury: Current research and future directions.* New York, Oxford. (Kindle edition)

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