STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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

1. Insurer Name and Address

Broadspire P.O. Box 2840 Clinton, IA 52733 Claim#: 005834-002603-WC-01

2. Employer Name

Westpac Labs, Inc.

3. Address No. and Street	City	Zip Code
10200 Pioneer Blvd., Suite 5000	Santa Fe Springs	90670

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

Medical Courier

5. Patient Name (first Name,	middle initial	, last name)	6. Sex	7. Date of Birth
Martin		Lugo Sr.	M	07/30/1964

8. Address No. and Street	City	Zip Code	9. Phone Number
P.O. Box 12512	Costa Mesa	92627	

10. Occupation (Specific job title)	11. Social Security Number	12. Address No. and Street Where Injury Occurred
Medical Courier	561-71-1451	On route

City Where Injury Occ.	County	13. Date and hour of injury or onset of illness
	L.A.	CT 01/01/2019-04/05/2021

14. Date last worked	15. Date and hour of 1st exam or treatment	16. Have you or your office previously rendered treatment
03/25/2021	06/24/2022	No

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

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

On 7/04/2020, the patient was rear-ended by a drunk driver on Bushard and Ellis, injuring his neck, lower back, and right knee. The second injury occurred on 3/23/2021 when he stopped at his last route; when opening the company vehicle door and getting in the car, he felt a sharp pain in his hip and inner groin pelvic area

18. **SUBJECTIVE COMPLAINTS**

The patient is experiencing pain in his upper, mid, and lower back, left hip, bilateral shoulders, ankle, feet, right elbow, hand, knee, and arm pain, which has caused him to feel very depressed, sleep disturbance, lack of motivation, irritable, low-stress tolerance, anxious, nervousness, fearful, unable to focus or concentrate

19. **Objective Findings**

A. Physical Examination

Clinical Interview, Psych Testing

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

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

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

	Diagnosis		ICD-10
1.	PTSD	ICD-10	309.81 (F43.10)
2.	Chronic Pain	ICD-10	338.4 (G89.4)
3.	Insomnia Disorder	ICD-10	780.52 (G47.00)
4.		ICD-10	
5.		ICD-10	
6.		ICD-10	
7.		ICD-10	
8.		ICD-10	
9.		ICD-10	
10.		ICD-10	
11.		ICD-10	
12.		ICD-10	

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

22. Is there any other current condition that will impede or delay patient's recovery? [ ] If "yes," please explain below:

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

Psychological Evaluation Psychological Testing

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

12 CBT and 12 Biofeedback therapy, 6 BDI, BAI for next 3 months. Ref to Psychiatrist, Orthopedic

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

Date admitted [ ] Estimated length of stay [ ]

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

If "no", date when patient can return to Regular work [ ] Modified work [ ]

Specify restrictions

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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

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

Physician signature Julie Goalwin, PhD   Cal. License Number: PSY14146

Executed at: Los Angeles County   Date *(mm/dd/yyyy)*: 06/24/2022

Physician Name Julie Goalwin, Ph.D., QME, AME   Specialty: Clinical Psychologist

Physician address: 115 Pine Ave, #640,Long Beach 90802   Phone Number (562) 364-8587

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

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

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

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

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

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☒ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Lugo Sr., Martin	
Date of Injury (MM/DD/YYYY): 04/05/2021	Date of Birth (MM/DD/YYYY): 07/30/1964
Claim Number: 005834-002603-WC-01	Employer: Westpac Labs Inc

Requesting Physician Information

Name: Julie Goalwin Ph.D			
Practice Name: Julie Goalwin Ph.D		Contact Name: Nonnie Mata	
Address: 115 W. Pine Ave. Ste. 640		City: Long Beach	State: CA
Zip Code: 908024452	Phone: (562) 364-8587	Fax Number: (562) 364-8588	
Specialty: Psychologist		NPI Number: 1659539526	
E-mail Address: drjuliegoalwin@gmail.com			

Claims Administrator Information

Company Name: Gallagher Bassett		Contact Name: Diane Noble	
Address: PO Box 2840		City: Clinton	State: IA
Zip Code: 527332840	Phone: (800) 370-0594	Fax Number: (615) 778-5135	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Post-traumatic stress disorder, unspecified;Chronic pain syndrome;Insomnia, unspecified	F4310,G894,G4700	12 CBT sessions weekly for the next 3 months	90837	TREATING PTSD ACCORDING TO THE CA MTUS- ODG MENTAL STRESS CHAPTER, THERE WOULD BE A REQUEST FOR INITIAL TRIAL OF 12 CBT SESSIONS OVER THE NEXT THREE MONTHS. MEDICALLY NECESITY AND CLINICAL RATIONALE: WITHOUT SUCH TREATMENT, THE DEPRESSION, ANXIETY, SLEEP PROBLEMS AS WELL AS 90% OF BODY BURNT , STRESS-INTENSIFIED MEDICAL SYMPTOMS AND THE REATED FUNTIONAL IMPAIRMENT COULD WORSEN RATHER THAN IMPROVE AS EXPECTED.
Post-traumatic stress disorder, unspecified;Chronic pain syndrome;Insomnia, unspecified	F4310,G894,G4700	12 Biofeedback sessions 3-4 times a month in the next 3 months	90901	TREATING PTSD ACCORDING TO THE CA MTUS- ODG MENTAL STRESS CHAPTER, THERE WOULD BE A REQUEST FOR INITIAL TRIAL OF 12 CBT SESSIONS OVER THE NEXT THREE MONTHS. MEDICALLY NECESITY AND CLINICAL RATIONALE: WITHOUT SUCH TREATMENT, THE DEPRESSION, ANXIETY, SLEEP PROBLEMS, STRESS-INTENSIFIED MEDICAL SYMPTOMS AND THE REATED FUNTIONAL IMPAIRMENT COULD WORSEN RATHER THAN IMPROVE AS EXPECTED.
Post-traumatic stress disorder, unspecified;Chronic pain syndrome;Insomnia, unspecified	F4310,G894,G4700	PSYCHOLOGICAL TESTING 6 BDI & BAI		Every other week to measure progress or note when there is lack of , or setback

...esting Physician Signature: [signature]	Date: 07/11/2022

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)"

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

State of California, Division of Workers' Compensation

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☒ New Request ☐ Resubmission – Change in Material Facts

☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health

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Date of Injury (MM/DD/YYYY): 04/05/2021		Date of Birth (MM/DD/YYYY): 07/30/1964	
Claim Number: 005834-002603-WC-01		Employer: Westpac Labs Inc	
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Practice Name: Julie Goalwin Ph.D		Contact Name: Nonnie Mata	
Address: 115 W. Pine Ave. Ste. 640		City: Long Beach	State: CA
Zip Code: 908024452	Phone: (562) 364-8587	Fax Number: (562) 364-8588	
Specialty: Psychologist		NPI Number: 1659539526	
E-mail Address: drjuliegoalwin@gmail.com			
Claims Administrator Information			
Company Name: Gallagher Bassett		Contact Name: Diane Noble	
Address: PO Box 2840		City: Clinton	State: IA
Zip Code: 527332840	Phone: (800) 370-0594	Fax Number: (615) 778-5135	
E-mail Address:			
Requested Treatment (see instructions for guidance; attached additional pages if necessary)			
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[illegible]gnosis [illegible]equired)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Post-traumatic stress disorder, unspecified;Chronic pain syndrome;Insomnia, unspecified	F4310,G894,G4700	Referral to a Psychiatrist for PTSD	Consultation & treatment as necessary	TREATING PTSD ACCORDING TO THE CA MTUS- ODG MENTAL STRESS CHAPTER, THERE WOULD BE A REQUEST FOR INITIAL TRIAL OF 12 CBT SESSIONS OVER THE NEXT THREE MONTHS. MEDICALLY NECESITY AND CLINICAL RATIONALE: WITHOUT SUCH TREATMENT, THE DEPRESSION, ANXIETY, SLEEP PROBLEMS AS WELL AS 90% OF BODY BURNT , STRESS-INTENSIFIED MEDICAL SYMPTOMS AND THE REATED FUNTIONAL IMPAIRMENT COULD WORSEN RATHER THAN IMPROVE AS EXPECTED.

Requesting Physician Signature: [signature] | Date: 07/11/2022

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)"

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

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[X] New Request   [ ] Resubmission – Change in Material Facts
[ ] Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
[ ] Check box if request is a written confirmation of a prior oral request.

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Zip Code: 908024452   Phone: (562) 364-8587   Fax Number: (562) 364-8588
Specialty: Psychologist   NPI Number: 1659539526
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Zip Code: 527332840   Phone: (800) 370-0594   Fax Number: (615) 778-5135
E-mail Address:

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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Post-traumatic stress disorder, unspecified;Chronic pain syndrome;Insomnia, unspecified	F4310,G894,G4700	Referral to Orthopedic	Consultation & treatment as necessary	Pt is experiencing severe upper, mid and lower back pain.Left hip, bilateral shoulders, ankle, both feet, right elbow, hand, knee and arm pain .An Orthopedic will assist him on Medication that is needed for his pain and proper treatment

...ing Physician Signature: [signature]	Date: 07/11/2022

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)"

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

daisyBill RFA#547515

DWC Form RFA (Effective 2/2014)

PROOF OF SERVICE BY MAIL

Re: Martin Lugo
Claim No. 005834-002603-WC-01
DOI: CT: 01/01/2019-04/05/2021
WCAB No. ADJ14468138

I am a resident of/employed in the aforesaid county, State of California; I am over the age of eighteen years and not a party to the within action; my business/residence address is:
115 Pine Ave. #640, Long Beach, CA 90802.

I served the following documents:

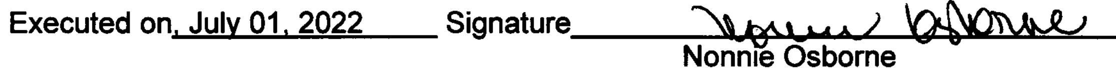
Dr's First Report on 6/24/2022

On the interested parties in this action by placing the true copy of each document in a separate envelope addressed to each addressee, respectively, as follows.

Gallagher Bassett
P.O. Box 2840
Clinton, IA 52733

Workers Defenders Law Group
751 S. Weir Canyon, Suite 157-455
Anaheim, CA 92808

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



Executed on, July 01, 2022 Signature
Nonnie Osborne