

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

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

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

Patient:

Lugo		Martin		
Patient last name:		Patient first name:		MI
PO Box 12512	Costa Mesa	CA.	92627	Male
Patient's street address/PO Box	Patient City	State	Zip Code	Sex
Medical Courier	(949) 609-9888	Date of Birth	7/30/1964	
Occupation	Phone Number			

Claims Administrator Date of Injury 1/1/19-4/5/20;3/23/21;

PLEASE PROVIDE

Claims Administrator Name		Claim Number		
Claims Administrator Street Address		Claims Administrator City	State	Zip Code
Phone Number	Fax Number	Westpac Labs Inc		
		Employer Name	Phone Number	

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

Subjective Complaints:

See attached

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

See attached

Diagnosis:

- | | |
|-------------------------------------|---------------------------|
| 1. Cervical disc protrusion | ICD-10 M50.20 |
| 2. Cervical radiculopathy | ICD-10 M54.12 |
| 3. Lumbar musculoligamentous injury | ICD-10 S33.5XXA, S39.012A |
| 4. Lumbar disc protrusion | ICD-10 M51.26 |
| 5. Lumbar radiculitis | ICD-10 R54.16 |
| 6. Shoulder sprain / strain | ICD-10 S43.409A, S46.919A |
| 7. AC Joint sprain / strain | ICD-10 S43.50XA |
| 8. Shoulder sprain / strain | ICD-10 S43.409A, S46.919A |
| 9. Hip sprain / strain | ICD-10 S73.109A |
| 10. Hip sprain / strain | ICD-10 S73.109A |

11. _____
12. _____

ICD-10 _____
ICD-10 _____

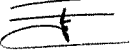
Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g.,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

Follow up 4-6 weeks
Pending MRI left hip.
Follow up Dr. Mays

Work Status: This patient has been instructed to:


- Remain off-work until 6 weeks
- Return to *modified* work on _____ with following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

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

Physician Signature: 
Name: Sepideh Tarameshloopoor, DC Cal. Lic. # DC 32616 Specialty: Chiropractic

Primary Treating Physician: (original signature, do not stamp) Date of exam: 10/13/2021

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 § 139.3.

Physician Signature: 
Executed at: La Palma, CA. Cal. Lic. # DC 16128
Physician Name: Edward Komberg, DC Date (mm/dd/yyyy) 10/13/2021
Physician Address: 7951 Valley View Specialty: Chiropractor
Phone: (714) 994-1131

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

Subjective: (Continued)

He presents today complaining of constant moderate 5-6/10 achy neck pain, stiffness, tingling, and cramping pain when moving to the left side. He presents today with complaint of constant moderate 7-8/10 dull, achy low back pain, stiffness, and tingling. He is complaining of frequent mild 3-4/10 left shoulder pain. The patient, Mr. Lugo, has complaint of frequent moderate 5-6/10 right shoulder pain, numbness, and tingling. He is complaining of constant moderate 6/10 left hip pain. He is complaining of intermittent mild 2-3/10 right hip pain.

Objective: (Continued)

Height: 6'2", Weight: 342 pounds, Temp.: 97.4° F, B.P.:142/81, Pulse: 70 bpm, right-hand dominant. Dermatome sensation is intact and equal bilaterally in both the upper and lower extremities. **Cervical:** The cervical ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the cervical spine. There is +3 tenderness to palpation of the cervical paravertebral muscles bilateral trapezii. There is muscle spasm of the cervical paravertebral muscles and bilateral trapezii. Cervical Compression causes pain. Cervical Distraction causes pain. **Lumbar:** The lumbar ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the lumbar spine. There is +3 tenderness to palpation of the lumbar paravertebral muscles and bilateral SI joints. There is muscle spasm of the lumbar paravertebral muscles and bilateral gluteus. Kemp's causes pain on the left radiation. Seated Straight Leg Raise causes pain on the left radiation. **Left Shoulder:** The left shoulder ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the left shoulder. There is +3 tenderness to palpation of the trapezius, anterior shoulder, and posterior shoulder. There is muscle spasm of the trapezius, anterior shoulder, and posterior shoulder. Speed's causes pain. Apley's Scratch causes pain. **Right Shoulder:** The right shoulder ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the right shoulder. There is +3 tenderness to palpation of the trapezius, anterior shoulder, and posterior shoulder. There is muscle spasm of the trapezius, anterior shoulder, and posterior shoulder. Speed's causes pain. Apley's Scratch causes pain. **Left Hip:** The left hip ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the left hip. There is +3 tenderness to palpation of the anterior hip, posterior hip, and lateral hip. There is muscle spasm of the anterior hip, posterior hip, and lateral hip. Patrick's or FABERE causes pain. **Right Hip:** The right hip ranges of motion are decreased. There is +3 tenderness to palpation of the anterior hip, posterior hip, and lateral hip. There is muscle spasm of the anterior hip, posterior hip, and lateral hip. Patrick's or FABERE causes pain.

**State of California, Division of Worker's Compensation
REQUEST FOR AUTHORIZATION
DCW Form RFA**

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DCW 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, Martin
Date of Injury (MM/DD/YYYY): 1/1/19-4/5/20; 3/23/21; Date of Birth (MM/DD/YYYY): 7/30/1964
Claim Number: Employer: Westpac Labs Inc

Requesting Physician Information
Name: Edward Komberg, DC
Practice Name: Tri-City Health Group Contact Name:
Address: 7951 Valley View City: La Palma State: CA
Zip Code: 90623 Phone: (714) 994-1131 Fax Number: (714) 994-4415
Specialty: Chiropractor NPI Number: 1629278935
E-mail Address:

Claims Administrator Information
Company Name: Contact Name:
Address: City: State:
Zip Code: Phone: Fax Number:
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 (if known)	Other Information (Frequency, Duration quantity, etc..)
Cervical musculoligamentous injury	[S13.8XXA]	Follow up Dr. Mays		
Rule out cervical disc	[M50.20]			
Lumbar musculoligamentous injury	[S33.5XXA, S39.012A]	Follow up		
Lumbar disc protrusion	[M51.26]			4-6 weeks
Hip sprain / strain bilateral	S73.109A			
Shoulder sprain / strain bilateral	S43.409A, S46.919A			
AC Joint sprain / strain bilateral	S43.50XA			

Requesting Physician Signature:  Date: 10-13-2021

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:
Comments: E-mail Address:

**Tri-City Health Group
7951 Valley View
La Palma, CA 90623**

Tel: 714 994-1131

Fax: 714 994-4415

MEDICAL FACSIMILE COVER SHEET

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The following fax contains information pertaining to:

Patient Name:	Martin Lugo
Employer:	Westpac Labs Inc
Insurance:	Per CCR §9780.1 & §9781 please provide carrier information
Claim Number:	Unavailable
Facsimile:	Unknown
Applicant Attorney:	Workers Defenders Law Group
Facsimile:	(310) 626-9632

Date Sent:	Nov 22, 2021	Number of Pages:	5
Description:	Dr Komberg Progress Report (PR-2)&RFA 10/13/2021		

Sent By: Clare

In the event that any of the above information is incorrect, please contact the front office personnel or office manager to provide correct information.

Send Result Report



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**Tri-City Health Group
7951 Valley View
La Palma, CA 90623**

Tel: 714 994-1131

Fax: 714 994-4416

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No.	Date/Time	Destination	Times	Type	Result	Resolution/ECH
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