

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Case No. 2013-001814

South Carolina Second Injury Fund,.....Appellant,

v.

Griffco of Wampee, Inc., Employer, and
Commerce & Industry Insurance Company, Carrier,..... Respondents.

In re:

Patricia Fore, Employee, Claimant,

v.

Griffco of Wampee, Inc., Employer, and AIG Domestic Claims, Carrier, Defendants, Respondents

RECORD ON APPEAL

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ATTORNEY FOR APPELLANT

ATTORNEYS FOR RESPONDENTS

INDEX

Commerce & Industry Insurance Company v. South Carolina Second Injury Fund

1. Single Commissioner Decision and Order (October 7, 2009).....	1
2. Single Commissioner Decision and Order (January 18, 2012)	16
3. Single Commissioner Decision and Order (December 19, 2012).....	32
4. Appellate Panel Decision & Order (July 15, 2013)	42
5. Appellate Panel Hearing Transcript (April 16, 2013).....	50
6. Notice of Possible Second Injury Fund Claim (March 10, 2011).....	61
7. Letter from Phillip L. Johnson to Wayne Koon (June 20, 2011).....	62
8. Carrier's Form 54 (October 26, 2011).....	63
9. Second Injury Fund's Form 55 (November 10, 2011).....	64
10. Carrier's Form 58 (February 21, 2012)	65
11. Notice of Witnesses and Written Medical Reports To Be Introduced as Direct Evidence on Behalf of Defendant (February 21, 2012).....	66
12. Medical Records of Dr. Mark A. Wolgin (December 27, 2001-February 10, 2011)	68
13. Medical Records from Loris Healthcare System (February 4, 2006; November 30, 2007; February 24, 2008).....	92
14. Medical Records from Phoebe Putney Memorial Hospital (November 17, 2008- May 21, 2010).....	101
15. Medical Records from Doctors Care (May 1, 2009).....	127
16. Medical Records from Strand Regional Specialty Associates (May 8, 2008)	128
17. Medical Records from OrthoImaging (September 19, 2008-February 25, 2010)	133
18. Medical Records of Leonard Jones, BS (May 19, 2010)	138

19. Medical Records of Julie M. Scott, P.T. (September 30, 2008; September 1, 2010; September 27, 2010)	141
20. Medical Records from Southwestern Home Care & Medical Services (May 24, 2010-June 1, 2010).....	154
21. Letter from Thad Griffin (August 16, 2010)	167
22. Letter to Second Injury Fund (October 2, 2009).....	168

STATE OF SOUTH CAROLINA) BEFORE THE SOUTH CAROLINA
COUNTY OF HORRY) WORKERS' COMPENSATION COMMISSION
)

Patricia Fore,) WCC FILE NO. 0810152
)

Claimant,)
)

-vs-)

DECISION AND ORDER

Griffco of Wampee, Inc.,)
)

Employer,)
)

and)
)

Commerce and Industry Insurance)
Company,)

Carrier,)
)

Defendants.)
)

HEARING:

Held in Conway, South Carolina on August 12, 2009.

APPEARANCES:

Claimant represented by Stephen B. Samuels, Esquire, of Samuels Law Firm, LLC. Employer & Carrier represented by James Lichty, Esquire, of McAngus Goudelock & Courie, LLC.

PURPOSE OF THE HEARING:

To determine issues raised on the Forms 50 and 51.

DECISION AND ORDER:

by Andrea P. Roche, Commissioner.

APA SUBMISSIONS

CLAIMANT'S SUBMISSIONS

APA	MEDICAL PROVIDER	DATES	PAGES
1.	Orthopaedic Associates	12/27/01-4/17/09	1-17
2.	Loris Healthcare System	2/24/08	18-22
3.	Strand Regional Specialty Associates	2/24/08-5/8/08	23-33
4.	Phoebe Putney Memorial Hospital	11/17/08-12/5/08	34-37
5.	Midlands Orthopaedics	7/7/09	38-39

DEFENDANTS' SUBMISSIONS

APA	MEDICAL PROVIDER	DATES	PAGES
1.	Loris Healthcare System	2/24/08	1-6
2.	Doctors Care	5/01/08	7
3.	Strand Regional Specialty Associates	5/8/08	8-9
4.	Orthopaedic Associates	9/16/08-4/17/09	10-17
5.	Phoebe Putney Memorial Hospital	11/17/08-12/5/08	18-21
6.	Midlands Orthopaedics	7/7/09	22-24

STIPULATIONS

The parties stipulate to the following matters:

1. The Commission has jurisdiction to hear the matters presented;
2. Jurisdiction is proper in Horry County;
3. The parties had notice of the hearing scheduled for August 12, 2009. All parties were represented by Counsel;
4. This matter came before the Commission on a Form 50 filed by the Claimant.

5. The Commission's file, Commissioner's notes, and the Administrative Procedures Act submissions are a part of the record.
6. Claimant has an average weekly wage of \$449.36 resulting in a compensation rate of \$299.59.
7. Defendants admit Claimant sustained a compensable injury by accident to her right hip on February 21, 2008 which was timely reported. Defendants deny Claimant's allegation that she injured her back in the admitted accident.

STATEMENT OF THE CASE

Claimant filed a Form 50 seeking a finding of compensability for an injury by accident which occurred on August 21, 2008 when she bumped into a meat saw while carrying 50-60 pounds of meat. Claimant alleges she injured her back, right hip and right leg. She seeks temporary total disability compensation from August 31, 2008 and continuing on a running award. She further seeks payment for past causally related medical treatment along with continuing medical treatment, specifically including surgery to her back.

Defendants admit Claimant gave timely notice of her injury by accident on August 21, 2008. Defendants admit a minor injury to Claimant's right hip, but deny any other body parts were injured or affected. Defendants contend Claimant's current disability is not a result of her injury, which they contend resolved with no long term affects. Defendants further contend that even if Claimant is partially disabled, she is not entitled to any temporary compensation as she abandoned her job and is able to work based on her representations to the Employment Security Commission.

At the hearing, Defendants moved to leave the record open to take the *de bene esse* depositions of Randall Oxford and Dr. James O'Leary.

Oxford is a meat cutter employed by the Employer at the time of the accident. He witnessed the accident. Defendants contend his testimony is relevant to the facts and circumstances surrounding the accident. Claimant objects to the record being left open on the grounds that: (1) there is no showing Oxford was subpoenaed to the hearing as required by Reg. 67-615 (2)(a); (2) Oxford's discovery deposition had been noticed by the Claimant for August 4, 2009 and subsequently cancelled without objection by the Defendants; (3) Randall Oxford had not been listed as a witness by Defendants; and (4) there is no showing Oxford was unavailable to appear at the hearing.

Testimony of a witness not under subpoena is may be allowed at the Commissioner's discretion upon the moving party showing a reasonable basis for failure to subpoena the witness. Defendants have shown no basis for failing to subpoena Oxford. He was not listed as a witness; Defendants did not object to the cancellation of his deposition; and there has been no showing that he is an indispensable witness, particularly since this is an admitted injury by accident. I find Oxford's testimony is not crucial to any defense in the case; Defendants suffer no prejudice; and Defendants have failed to show due diligence in procuring his testimony. The motion to leave the record open to depose Randall Oxford is denied.

Dr. O'Leary was retained by Defendants to perform an Independent Medical Evaluation on Claimant. His report is dated July 7, 2009 – twenty-four days before Defendants Form 58 and APA submissions were submitted. Defendants apparently noticed Dr. O'Leary's deposition for September 25, 2009 without confirming with Claimant's attorney.

Dr. O'Leary was not subpoenaed to the hearing. No motion for postponement was made 10 days prior to the hearing as required by Regulation 67-613 B (2). I do not find the deposition of an

expert whose report is included in both party's APA submissions meets the requirements for additional evidence set forth in the regulation. See Reg. 67-613 C (1). I find Dr. O'Leary's testimony is not crucial to any defense in the case, particularly since this is Defendants' retained expert. Defendants have failed to show due diligence in procuring his testimony. The motion to leave the record open to depose Dr. O'Leary is denied.

EVIDENCE OF THE CASE

Testimony:

Claimant, Patricia Fore, testified on her own behalf. She is 44, been married for 20 years, and has two dependant children aged ten and two. She went to high school, got a GED, and got a two-year Associates Degree in Business Management. Fore stated she has worked in restaurants, construction, and as a meat cutter.

Fore began working for Employer, Griffco, on August 25, 2005. She started out wrapping meat before being promoted to backup meat cutter.

Fore took a four week leave when her youngest child was born.

Claimant had an accident while working at Griffco on February 21, 2008. She described it:

Me and Daniel was in the meat room. I had two heavy things of meat. I can't remember exactly what we had in them, and we were moving pretty fast and I stepped into the corner of the meat saw and it kind of did an awkward twist and I heard something crunch on the inside. [Tr. p. 9, ll. 13-18].

Claimant hit the meat saw hard. The saw is about three feet long and weighs 2-300 pounds. She felt a pain, but kept working.

Fore was scheduled to work on Sunday. Sunday morning, she called Daniel Hall , the meat market manager, and told him she was going to the emergency room because she had got hurt a

couple of days before. Claimant went to Seacoast Emergency Room. Afterwards, she came by the store and was told she needed to speak to the owner, Thad Griffin. He was not in the store, but she did speak with on the phone about what had happened. Griffin told her he would pay for the emergency room bill. She laid a copy of the work excuse from Seacoast on Griffin's desk. She did not keep a copy.

About a week later, Claimant spoke with Griffin about workers' compensation. She was still out with her injury, but here daughter had gotten sick. She asked for time off to care for her daughter. Griffin told her to take all the time she needed.

Claimant testified she had kept Griffin up to date with her and her daughter's status. She shopped in the store at least once a week. On March 31, 2009, Claimant took her daughter to Charleston Children's Hospital. When she got out of that appointment, she called Griffin to see if she could return back for light duty. Griffin informed her "that I quit my job."

Claimant applied for unemployment. She advised the ESC of her work injury and her work restrictions. For a time she received unemployment benefits, but they were terminated when her doctors refused to sign a release to go back to work.

Claimant moved to Georgia in May 2008 because her husband was transferred. She is currently waiting on surgery. Workers' compensation has not paid for any medical treatment. Mr. Griffin paid for the Seacoast Emergency Room visit.

Claimant described her physical condition. She stays in pain in her back, right hip and right thigh. She takes pain medication. She cannot go back to work as meat cutter right now. She is under restrictions of no lifting over 15 pounds, plus limits on standing, sitting and repetitive work.

On cross-examination, Claimant confirmed she felt a crunch in her back. When she went to

the emergency room, she did not know it was a back injury because the pain was mostly in her hip area and ran down her leg. She thought she might have cracked a bone in her hip.

Claimant testified it was impossible for her to return to work after her daughter became ill and March 31st both because her daughter had been taken out of day care and because she was physically unable to work. Claimant confirmed that she was required to look for work as part of her unemployment compensation application. She applied for numerous jobs where they had light duty work.

Claimant testified she told Doctors Care and Strand Regional Specialty that she felt a crunch in her back and was carrying meat when she hit the saw.

On redirect, Claimant testified that she had never had a prior back problem, had never heard the term "radiculopathy" before this accident, and did not know that back problems could cause pains down her legs. She further confirmed she told the Employment Security Commission about her back injury and work restrictions. She asked Mr. Griffin about going back to work light duty, but was told she did not have a job there. Mr. Griffin never offered her light duty.

Defendants called Brian Thad Griffin. Griffin testified he is the manager at Griffin's IGA.

Griffin testified he knew Claimant claimed an injury on February 21, 2008. He testified the only conversation he had with her was the next Tuesday when she came in to the store. He asked her how her hip was. She replied it was fine; the doctor told her she had some contusions and she had got a shot.

Griffin testified they also discussed Claimant's daughter's illness. Griffin stated Claimant was supposed to call him on March 4th after seeing a specialist in Charleston. He denied Claimant told him she did not think she could work because of her injury. He denied receiving a work slip

from Claimant. He testified his impression was they would discuss her work status on March 4, 2009. Griffin testified he saw Claimant in the store one time after that and waved at her, but never got a chance to talk with her.

Griffin next spoke with Fore on March 31, 2009, "when she called and wanted her job back, wanted to know when she could come back to work." He told her he thought she quit. He testified he did not know that she was coming back to work and hadn't talked with her in a month. He stated, "the impression she gave me the Tuesday prior was that, you know, she would probably have to be out with the child." [Tr. p. 41-42].

On cross-examination, Griffin testified he was certain Fore had an accident while working for his company. He admitted he did not file her claim under workers compensation, but did pay for the emergency room.

Griffin admitted speaking with Fore about her daughter's illness one week after the accident. He told her she could take all the time she needed and would be under FMLA. He did not give her the FMLA paperwork to fill out. He denied ever speaking to her in the next month, but admitted he "had people in the store telling me how she was . . ." [Tr. p. 46, ll. 2-3].

Griffin confirmed Claimant had taken off 4 weeks for the birth of her child and that he gave her job back to her when she returned.

Griffin testified Claimant called him on March 31, 2008, asking to come back to work. He told he thought she had quit to take care of her child. He confirmed she never told him directly that she had quit. Griffin admitted there was no documentation of whether Claimant quit or was fired.

Griffin testified meat cutter is a very heavy job requiring carrying 50 pounds of meat on a regular basis. He acknowledged the band saw weighs close to several hundred pounds and would

take a good lick to move.

Griffin admitted Claimant could not work as a meat cutter within her doctor's restrictions and that he never offered her any work since the last time she worked for him.

On redirect, Griffin testified Claimant never sought him out to speak to him about the status of her daughter. On recross, he admitted Claimant did advise one or two people in the store of her daughter's status, and that word got back to him.

Medical and Expert Records:

February 24, 2008: Dr. Meacher at the Seacoast Medical Center noted, "43-year old white female . . . describing pain in her lateral hip and right thigh with a 'Charley horse type muscle pain' radiating to her lower leg today. Patient recalls turning and accidentally hitting the lateral aspect of her right hip against a table saw February 21, 2008.

In the patient information sheet for Strand Regional Specialty Associates on May 8, 2008, Claimant wrote "continuous pain in joint (hip) and it will run down leg." [Claimant's APA p. 28]. The doctor's assessment on that visit was "Traumatic right trochanteric bursitis with *possible mild sciatica*." [Claimant's APA p. 30(emphasis added)].

Dr. Moree's reports show, "Dr. Moree feels that Ms. Fore has a right L4-L5 sciatic radiculopathy due to previous work-related trauma." [Claimant's p. 36].

Dr. Wolgin stated "Clearly, in my opinion her condition is due to her back and very often there is an overlap between hip and back, such as with the shoulder and back." [Claimant's APA p. 16]. Dr. Wolgin opined, "With regard to causation, my opinion is that to a reasonable degree of medical certainty that his patient's condition developed from her workplace exposure based on her

history to me. [Claimant's APA p. 16]

Dr. O'Leary opined: "It is my opinion that the patient's complaints of back and hip pain are directly related to her injury in February of 2008." [Defendants' APA p. 23].

FINDINGS OF FACT

Based on the testimony, exhibits and APA submissions, I find the greater weight of the evidence supports the following findings of fact:

1. Based on the medical records and testimony, I find Claimant injured her back in the February 21, 2008 accident when she bumped into a meat saw while carrying approximately 60 pounds of meat. I find the injury manifested itself as hip symptoms to start with.

2. Claimant's symptoms have been consistent throughout her course of treatment. In the emergency room evaluation on February 24, 2008, she described "pain in her lateral hip and thigh with a 'Charley horse type muscle pain' radiating to her lower leg . . ." [Claimant's APA p. 21]. In the patient information sheet for Strand Regional Specialty Associates on May 8, 2008, she wrote "continuous pain in joint (hip) and it will run down leg." [Claimant's APA p. 28]. The doctor's assessment on that visit was "Traumatic right trochanteric bursitis with *possible mild sciatica*." [Claimant's APA p. 30(emphasis added)]. Dr. Wolgin stated "Clearly, in my opinion her condition is due to her back and very often there is an overlap between hip and back, such as with the shoulder and back." [Claimant's APA p. 16].

3. The finding of a back injury with radiculopathy into the right leg is supported by the opinions of Claimant's doctors. Dr. Moree's reports show, "Dr. Moree feels that Ms. Fore has a right L4-L5 sciatic radiculopathy due to previous work-related trauma." [Claimant's p. 36]. Dr. Wolgin opined, "With regard to causation, my opinion is that to a reasonable degree of medical

certainty that his patient's condition developed from her workplace exposure based on her history to me. [Claimant's APA p. 16]. Dr. O'Leary opined, "It is my opinion that the patient's complaints of back and hip pain are directly related to her injury in February of 2008." [Claimant's APA p. 39].

4. Claimant suffered compensable injuries to her back and right hip. Her back injury affects her right leg.

5. Claimant is not at MMI and additional medical treatment will tend to lessen her period of disability. Her treating physician, Dr. Wolgin, recommends surgery. She is awaiting authorization for surgery by Dr. Wolgin. [Claimant's APA p. 16-17]. Claimant testified she wants to proceed with spine surgery. Dr. O'Leary opined she is not at maximum medical improvement and did not feel she can return to work at this point. Although noting she was a high-risk candidate for surgery, he stated he would "defer to the spine surgeon with regards to surgical intervention." [Claimant's APA p. 39].

6. As this is a denied claim and Defendants have not designated a treating physician, I find good cause for the Commission to designate the treating physician. Claimant lives in Georgia and has been under the care of Drs. Mason, Moree and Wolgin at Orthopaedic Associates in Albany, Georgia. I therefore find it appropriate that these doctors be designated the authorized treating physicians. Defendants shall pay for and authorize without delay all causally-related treatment ordered or prescribed by these doctors.

7. Claimant is entitled to temporary total disability compensation from March 31, 2008 and continuing on a running award until further Order of the Commission. I find Claimant has been disabled from that date and no suitable employment was offered by the Employer. Claimant specifically inquired as to whether the Employer had work available within her restrictions.

8. I do not find Claimant's application for and receipt of unemployment benefits bars her from receiving workers' compensation benefits. At no point did Claimant advise the Employment Security Commission that she was able to work full, unrestricted duty. She informed the Employment Security Commission of her work-related injury from the outset. The Employment Security Commission found she was ineligible to receive benefits until she presented evidence that her "health condition is such that you are able to work." [Defendants' APA p.18].

CONCLUSIONS OF LAW

1. Claimant sustained an injury by accident arising out of and in the course of her employment on February 21, 2008 within the meaning of S.C. Code Ann. § 42-1-160 (2007).

2. Disability is defined as "Incapacity because of injury which the employee was receiving at the time of injury in the same or any other employment." Reg. 67-502. Employer offered no suitable employment within her capacity to Claimant. As she was still disabled due to her injury, she is entitled to temporary compensation until she reaches MMI. § 42-9-10; 42-9-190.

3. Medical treatment is to be provided so long as it tends to lessen the period of disability. § 42-15-60; Dodge v. Brucoli, Clark, and Layman, Inc., 518 S.E.2d 593 (S.C. 1999); Dykes v. Daniel Constr. Co., 202 S.E.2d 646 (S.C. 1974).

4. The employer's representative shall provide and pay for medical care while a claimant is receiving or entitled to receive temporary compensation benefits. Reg. 67-509. Medical, surgical, hospital and other treatment which will tend to lessen the period of disability within the judgment of the Commission shall be provided by the employer. In case of a controversy arising between employer and employee, the Commission may order such further medical, surgical, hospital or other treatment as may in the discretion of the Commission be necessary. S.C. Code Ann. § 42-15-60.

When the Employer refuses to provide medical treatment, the Commission has authority to designate the treating physician.

5. The Workers' Compensation Act "requires employers to pay temporary total disability to an employee who has 'been out of work due to a reported work related injury' for eight days." Martin v. Rapid Plumbing, 369 S.C. 278, 631 S.E.2d 547 (Ct.App.2006), *quoting* S.C. Code § 42-9-260(A) (Supp. 2006). When the injured worker is under work restrictions, the employer must either offer suitable employment within the injured worker's capacity or pay temporary total disability compensation. *See* S.C. Code § 42-9-190 (2005); Last v. MSI Const. Co., Inc., 305 S.C. 349, 409 S.E.2d 334 (1991))(fact that incarcerated claimant remained unemployable for reasons other than his injury was not dispositive of his right to temporary compensation; rather, the issue was whether the injury had resulted in some loss of his earning capacity). *See also* Grayson v. Carter Rhoad Furniture, 317 S.C. 306, 454 S.E.2d 320 (1996)(temporary compensation improperly suspended because claimant not at MMI and still under restrictions by the doctor, thus no evidence period of temporary total disability ever ended); Hines v. Hendricks Canning Co., 263 S.C. 399, 211 S.E.2d 220 (1975)(allowing an employee temporary total benefits and rejecting the carrier's argument that the claimant's loss of earning capacity was caused by his full-time attendance at school rather than his work-related injury). *Cf.* Orr v. Elastomeric Products, 323 S.C. 342, 474 S.E.2d 448 (Ct. App. 1996)(claimant's inability to work was still due to her injury and not to her pregnancy and that the prolongation, caused by the pregnancy, of the period of temporary disability did not alter that overriding fact).

6. "While [a] claimant's application for and acceptance of unemployment compensation may be considered by the commission as evidence in deciding whether disability continued, and may

be conclusive against the award of total disability benefits for the period of time during which unemployment compensation was drawn, it [would be] error to conclude that such conduct raised an estoppel in bar of any relief to which claimant would otherwise be entitled as an injured employee.” Harvey v. Art Metal, Inc., 247 S.C. 443, 147 S.E.2d 697 (1966). “[T]here is no real inconsistency between the claimant's entitlement to unemployment compensation for loss of wages through the termination of a job which he could and did perform in his partially disabled condition, and his entitlement to some workmen's compensation benefits.” Id.

“It would, therefore, not be appropriate or equitable to allow the Defendant (carrier) to derive a windfall benefit by taking credit against any sums received from other sources or to permit the carrier not to make payments which are admittedly due under the Workmen's Compensation laws of the State, merely because of money received by the worker from other sources during the same period of time.” McLeod v. South Carolina Ins. Co., 272 S.C. 254, 251 S.E.2d 193 (1979).

AWARD

IT IS THEREFORE ORDERED that Defendants shall pay for past causally-related medical treatment;

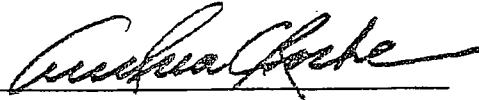
IT IS FURTHER ORDERED that Defendants shall authorize without delay all causally-related medical, surgical and other treatment prescribed by a qualified surgeon selected by Defendants within reasonably close geographical proximity to Claimant;

IT IS FURTHER ORDERED that Defendants shall pay temporary total disability to Claimant in the amount of \$299.59 commencing on March 31, 2008 and continuing until further order of the Commission;

IT IS FURTHER ORDERED that permanency is premature;

IT IS FURTHER ORDERED that no hearing costs are assessed.

AND IT IS SO ORDERED.



Andrea P. Roche, Commissioner
S.C. Workers' Compensation Commission

Dated: October 7, 2009

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

SBS
JL

This 13th day of October, 2009.

By Barbara Chesebrough
Administrative Assistant to the Commissioner

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S.C. WORKERS' COMP. COM.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO.: 0810152

PATRICIA FORE,

Employee,

Claimant,

vs.

GRIFFCO OF WAMPEE, INC.,

Employer,

AND

COMMERCE & INDUSTRY INSURANCE
COMPANY c/o CHARTIS CLAIMS, INC.,

Carrier,

Defendants.

DECISION AND ORDER

DATE OF HEARING:

Hearing held in Horry County, S.C. on September 27, 2011.

APPEARANCES:

Claimant appeared and represented by Stephen B. Samuels, Esquire of Samuels Law Firm of Columbia, South Carolina.

Defendants represented by James H. Lichty, Esquire of McAngus Goudelock & Courie, L.L.C. of Columbia, South Carolina.

PURPOSE OF THE HEARING: To determine all issues as set forth in Forms 50 and 51.

COMMISSIONER:

Commissioner G. Bryan Lyndon

FILED:

January 18, 2012

STIPULATIONS

1. Venue was proper in Myrtle Beach, South Carolina.
2. At the time of the alleged injury, Claimant earned an average weekly wage of \$449.36 with a corresponding compensation rate of \$299.59.
3. Notice of hearing was timely and properly served upon all parties of interest.
4. The South Carolina Workers' Compensation Commission has jurisdiction of this claim.
5. The Commission File becomes part of the record with the exception of self-serving declarations and unstipulated medical reports.

APA SUBMISSIONS

Pursuant to the South Carolina Administrative Procedures Act and Regulations of the South Carolina Workers' Compensation Commission, the following records and documents were submitted into evidence.

The Claimant submitted the following exhibits:

1. Loris Healthcare — Seacoast Medical Center, dated 02/24/2008, consisting of 5 pages. (APA 1)
2. Orthopaedic Associates f/k/a Albany Bone & Joint Clinic, dated 09/16/2008 to 02/14/2011, consisting of 73 pages. (APA 2)
3. Strand Regional Specialty Associates, dated 05/08/2008, consisting of 9 pages. (APA 3)
4. Phoebe Putney Memorial Hospital, dated 11/17/2008 to 12/05/2008, consisting of 4 pages. (APA 4)
5. Midlands Orthopaedics, dated 07/07/2009, consisting of 2 pages. (APA 5)

The Defendants submitted the following exhibits:

1. Correspondence from S.C. Attorney General's Office, dated 07/20/2011, consisting of 4 pages. (Exhibit 1) *Page one is omitted as per Claimant's objection.*
2. *Omitted as per Claimant's objection.*
3. Surveillance Video, consisting of 2 discs. (Exhibit 3)
4. Surveillance photograph of Claimant's vehicle, consisting of 1 page. (Exhibit 4)
5. Training Certification of Georgia Assoc. of Professional Bondsmen, dated 08/26/2010, consisting of 1 page. (Exhibit 5)
6. Documentation supporting Claimant's employment with ASAP Towing, consisting of 5 pages. (Exhibit 6)
7. Claimant's Facebook Profile, dated 09/19/2011, consisting of 2 pages. (Exhibit 7)

STATEMENT OF THE CASE

This matter arises to determine the issues raised in the parties' Forms 50 and 51. Claimant alleges that she sustained an injury to the back which resulted in a fusion surgery and a recommendation for additional surgery which she currently declines. A previous order states the Claimant suffered injury to her back and hip that affects her right leg. She alleges that she is entitled to permanent and total disability utilizing two body parts under §42-9-10 or based on greater than fifty percent disability to the back under §42-9-30. She sought lifetime medical treatment and an award paid in lump sum with James v. Anne's language. She admits that she worked for a period of time, but denies that she can continue working. Claimant points to a vocational evaluation and page 77 of the APA's as evidence that she can no longer work.

The Defendants allege that Claimant can work and may continue to be working as evidenced by video surveillance, testimony, and other evidence. Defendants' admit that

Claimant has been rated at 36 percent to the back, but point out that is based on the AMA Guides 6th Edition and the fact she had surgery. They allege that Claimant can work regardless of any reports and argue that the actual impairment should not actually exceed the rating. Defendants request a credit for overpayment of benefits and object to lump sum payment if Claimant were to be found totally disabled. Defendants requested a finding on credibility due to numerous inconsistencies. Finally, Defendants allege Claimant is only entitled to compensation under §42-9-30 and that *Singleton* would apply because she has no ratable impairment other than the back.

Claimant objected to the inclusion of a letter from the Attorney General's office in Defendants' Exhibit 1. This objection was granted and page one was removed from the record.

Claimant objected to the inclusion of a letter from Garry Smith in Defendants' Exhibit 1 into evidence based on allegations that it constituted improper ex parte communication, hearsay, and threat of criminal prosecution. The Claimant additionally argued that the entire Workers' Compensation Commission should recuse themselves from hearing this claim. The Defendants countered that it is not a threat, but simply evidence that a fraud investigation is ongoing. Furthermore, neither the Defendants' Attorney, the Employer, or Carrier was engaged in the communication; it was between the Attorney General's Office, the Workers' Compensation Commission, and the complainant. The Claimant's objections were denied.

Claimant objected to the inclusion of Defendants' Exhibit 2 which is a surveillance report. The objection was granted and Exhibit 2 was removed from the record.

Claimant objected to Defendants' Exhibit 3 which is surveillance footage of the Claimant as being unduly prejudicial. The objection was denied and the surveillance footage was made a part of the record.

EVIDENCE OF THE CASE

Testimony of the Claimant

Claimant is a 46 year old married woman with two minor children. (Tr. at 16-17). She has an associates degree in business management and has experience working in restaurants, construction, meat cutting, and as a bail bondsman. (Tr. at 17). Claimant worked as a meat cutter at the time of her injury and does not believe she can return to this employment field. (Tr. at 18).

Claimant testified she treated with Dr. Wolgin, who performed fusion surgery at L4-5 and L5-S1. She stated that surgery resolved her sciatic pain but that bending coming off the floor remains difficult. (Tr. at 19). She testified that her surgery resulted in a non-union and prospects of a second surgery's success were only 50/50. She declined the additional surgery and stated that she was placed on "extreme light duty." (Tr. at 20-21). Claimant stated that her pain is about 6/10 and can worsen with activity. (Tr. at 39).

Claimant testified that she worked for Steve McGowan at ABC Bail Bonding during the summer of 2010 and worked 20 or more hours per week. (Tr. at 21-22). Claimant testified regarding a calendar that purported to list hours and dates she worked for ABC. Defendants objected to the inclusion of the calendar based on the fact it had not been produced until the Hearing and contained no evidence of pay and did not reference Claimant's name anywhere in the document. The objection was denied. (Tr. at 24). The calendar contains numerous notations, appointments, and work schedules.

Claimant testified that as of November 30, 2010, Claimant's pain was aggravated by the several months of work and noted that she requested additional medications from Dr. Wolgin, which were denied. (Tr. at 26). Claimant stopped working for ABC on January 21, 2011. (Tr. at 28). Claimant was placed at MMI on February 14, 2011.

Claimant testified that she was approached by a competitor, A1 Bail Bonding, about changing her license to its business, place advertising on her truck, and using her name for marketing purposes. (Tr. at 29-30). She alleged that she completed one bond in February 2011 to change the license but did no other work and received no payment. (Tr. at 29-30). According to her testimony, the Claimant entered bonds and advertised for A1 Bail Bonding without compensation. Claimant testified she began doing more bonds in July, August, and September 2011 and was reported by her former employer. (Tr. at 31, 34, 35). Claimant indicated that she arranged for Mary Weaver to work at A1 so that she would not have to get up at all hours of the night. (Tr. at 34-35). Claimant testified regarding an entry on her Facebook page indicating she was "Self Employed and Loving It!" as a bondsman and "bond you out of jail if you need me call me." (Exhibit 7). Claimant testified she took a stalking order out against her former employer because she was aware he was investigating the work she was doing for her competitor. (Tr. at 39-41). On cross-examination, she admitted that the order prohibited her from contacting Mr. McGowan as well. (Tr. at 61).

Claimant testified on cross-examination that she performed the same work for A1 Bail Bonding *for free* as the work she did for pay at ABC Bail Bonding. (Tr. at 49). Claimant was asked why she didn't admit she was working for A1 Bail Bonding when her deposition was taken in August 2011. (Tr. at 49-50; Deposition at 7). She testified that, although she had performed numerous bonds between February and September 2011, she did not consider it work. (Tr. at 50). Claimant admitted that her response at her deposition to whether she was working was "no" and at the Hearing her answer was "yes." (Tr. at 53). Claimant denied that she had time cards when she worked for Steve McGowan at ABC. (Tr. at 53).

Claimant testified that she also worked for ASAP Towing, Steve McGowan's other business. (Tr. at 54). Claimant worked there with her husband and denied that she would affix her husband's name to work she performed. (Tr. at 54).

She also testified at her deposition that she had no further education or certification since the date of injury. However, she admitted at the Hearing that she received certification as a bail bondsman in August 2010. (Tr. at 50). Claimant also admitted that she received a diploma in accounting in 2010 that she did not previously report. (Tr. at 51). Claimant admitted that her response at her deposition to whether she received additional certification or education was "no" and at the Hearing her answer was "yes." (Tr. at 53).

Surveillance footage of Claimant was referenced and Claimant admitted that she could work as long as there was not repetitive bending and twisting involved. (Tr. at 55). Claimant would not confirm or deny that she could repetitively bend based on footage of her bending to pick up items from the bottom shelf at Walmart. (Tr. at 56). She admitted she could pick up light things. (Tr. at 56-57). The Claimant testified she worked twenty hours a week for ABC during September 2010. (Tr. at 57). The September 30, 2010, medical report of Dr. Wolgin states "she is able to continue with her work which is three hours per day three days a week." (APA at 61). Moreover, the vocational report of Glenn Adams states the Claimant reported working an average of twelve hours a week, which is also less than her testimony would suggest. (Tr. at 59, APA at 98).

Claimant requested to call Tony Lee Owens. Defendants' objection to this testimony was granted and the testimony was taken as Proffered Testimony outside of the presence of the Commission and is not part of the record. (Tr. at 67).

Testimony of Steve McGowan

Steve McGowan was called by the Defendants. Mr. McGowan is the owner of ABC Bail Bonds and employed Claimant for about six months. (Tr. at 70). He hired Claimant as a result of the recommendation of her husband, an employee in his towing company. (Tr. at 72). She initially just worked on computers, but wanted to work more and more hours. (Tr. at 74). She went to Atlanta to receive her certification as a bail bondsman soon after in late-August 2010. (Tr. at 74). He stated that Claimant left his employment because she wanted more money. (Tr. at 78). He also indicated that he paid her under the table and under her husband's name because she requested it that way. (Tr. at 78). She began working about 10 hours a week but eventually began working 30-35 hours per week, and sometimes over 40 if she worked on a weekend. (Tr. at 79). Of note, documented work of as much as 29 hours per week was reflected in Claimant's personal calendar, but was not reflected in her deposition testimony or medical records. Mr. McGowan indicated he has observed Claimant working for A-1 Bail Bonds and has surveillance footage of her performing duties at the jailhouse bonding an individual from jail. (Tr. at 80-81).

On cross-examination, Mr. McGowan agreed that he knew Claimant had back pain and stiffness "every now and then." (Tr. at 83).

Medical Evidence

Claimant first presented to Loris Healthcare on February 24, 2008 complaining of right leg and hip pain from bumping her right hip against a table saw three days earlier. (APA 1 at 1, 4).

Claimant next presented to Strand Regional Specialty Associates on May 8, 2005. She was diagnosed with traumatic right trochanteric bursitis with possible mild sciatica. (APA 3 at

83). Claimant received an injection and was recommended to engage in physical therapy. (APA 3 at 84).

Claimant next treated with Dr. Wolgin and Orthopaedic Associates in Albany, Georgia. She first presented on September 16, 2008, complaining of persistent right hip pain with radiation all the way down the leg. (APA 2 at 6). MRI testing revealed mild degenerative and facet changes in the lower lumbar spine with an L4-5 small right neural foraminal disc protrusion. (APA 2 at 8). MRI testing of the right hip was normal. (APA 2 at 10). Based on the mild findings, Claimant was referred to physical therapy. (APA 2 at 11). After several weeks of physical therapy ending in October 2008, Claimant reported little relief. (APA 2 at 20, 21). She received brief pain management treatment in November and December 2008 with Dr. Lamar Moree. (APA 4 at 88-91).

At Claimant's next appointment on April 17, 2009, Dr. Wolgin opined that Claimant's injury was due to her back and not her hip. (APA 2 at 21). Based on her continued complaints and low benefit through therapy and injections, Dr. Wolgin recommended consideration of a one or two level fusion surgery. (APA 2 at 22). Dr. O'Leary provided a second opinion on July 7, 2009 and recommended injection therapy rather than surgery, but deferred to Dr. Wolgin. (APA 5 at 92-93). Claimant returned on February 2, 2010 complaining of the same low back and right leg pain. Due to the gap between treatment, Dr. Wolgin ordered additional MRI imaging to assess any changes. (APA 2 at 23).

Claimant's MRI's came back showing a possible tiny protrusion at L4-5 with mild facet arthropathy and no nerve root compression; L5-S1 showed mild changes as well. (APA 2 at 25). Claimant returned to Dr. Wolgin to discuss the tests and decided to move forward with surgery. (APA 2 at 26). A peer review was conducted on these findings and Dr. Wolgin suggested a

psychosocial evaluation and a provocative discography. (APA 2 at 29; APA 6 at 94-95). Additional testing was not performed prior to surgery. (APA 2 generally).

Claimant underwent an L4-5, L5-S1 transforaminal lumbar interbody fusion on May 19, 2010. (APA 2 at 38-40). As of May 25, 2010, Claimant continued to complain of pain at an 8/10 level, but noted some improvement of leg complaints by May 27, 2010. (APA 2 at 42, 44). Claimant returned complaining of increased pain on June 22, 2010 and was given an injection. (APA 2 at 47). Dr. Wolgin anticipated that she would be written completely out of work for at least another month. (APA 2 at 47).

Claimant's leg pain improved as of July 20, 2010 but she complained that she still could not lay down in a bed and could not swim because of increased pain kicking her legs; she remained written completely out of work. (APA 2 at 53). Claimant was allowed to return to limited sedentary work as of August 27, 2010 and was recommended to begin physical therapy. (APA 2 at 57).

As of October 19, 2010, Claimant had been through a month of physical therapy with little benefit and reported an increase in her hip and back pain due to sleeping in a bed. (APA 2 at 64). Repeat injections completely relieved the hip pain and partially relieved the back. (APA 2 at 64). Seven days later a prescription note from Dr. Wolgin was prepared, writing her back out of work. (APA 2 at 66). On November 23, 2010, Claimant noted slow improvement, increased walking ability, and little to no leg pain or numbness. (APA 2 at 67). According to Dr. Wolgin's notes, sometime prior to December 21, 2010, Claimant began taking care of a 3-year old and began engaging in frequent bending, lifting, and twisting. (APA 2 at 70).

A CT scan on February 9, 2011 showed no evidence of hardware failure but did show evidence of non-union in places. (APA 2 at 72-76). As of February 14, 2011, Claimant stated

that she felt about the same in the right buttocks area, but did report relief of her prior leg complaints; she did not wish to undergo additional surgery. (APA 2 at 76). Claimant was released from care with a 36 percent impairment rating using the AMA Guides, 5th Edition. (APA 2 at 76, 78). Claimant reported that she continued to care for a toddler full time. (APA 2 at 76).

Claimant's Attorney referred her to Glen Adams for a vocational assessment on September 12, 2011. She reported that she worked for ABC Bail Bonding during January 2011 but only worked 12 hours a week. (APA 7 at 96-106). She reported that Dr. Wolgin supported a trial return to work in January, however, there are no records reflecting this and he continued to place her completely out of work at that time. Claimant was found to be totally disabled; however, she did not disclose any additional employment other than minor, part-time work during January 2011.

FINDINGS OF FACT

Based upon the testimony and exhibits submitted, the undersigned Commissioner makes the following findings of fact:

1. Claimant injured back in an admitted work-related accident on February 24, 2008. The injury affects the left hip/leg (See Order of October 13, 2009.)
2. Defendant to pay all causally related authorized medicals.
3. Claimant had a two level fusion which was not successful. There is a non-union and Claimant is a candidate for another surgery; at present she chooses not to have the surgery.

4. Claimant testified that she attempted to work within her restrictions. Claimant stated she worked about 20 hours per week for \$8.00 per hour. Claimant worked until January 2011 and stated she was unable to work anymore.
5. Claimant was placed at MMI on February 14, 2011, given a 36% impairment rating with restrictions of "unable to return to work" (APA 2 at 76).
6. Claimant stated she helped Tony at A1 Bail Bonding for about a month with bonding and according to Exhibit #1 worked a limited amount of time. She got another person to help because she physically was unable to meet the demands of the job.
7. Claimant stated she had earned money in spite of denying this in her deposition. She further stated that in order to keep her mind occupied she participated in social media.
8. Claimant admitted she was helping Tony but denied that she received any pay. This was for the same job she did prior for which she did receive pay. Claimant stated that she said she was not working in her deposition in May 2011, because she did not consider what she was doing work.
9. A surveillance photograph from September 2011 shows Claimant's vehicle with an advertisement on the back window promoting A-1 Bail Bonds with a 24 hour contact number. (Exhibit 4).
10. As of September 19, 2011, Claimant's Facebook profile showed that her employer was "Self Employed and Loving It!" as a Professional Bondsman in Leesburg, Georgia. It states, "bond you out of jail if you need me call me." (Exhibit 7).
11. Claimant stated she had received no certifications in her depositions but she did in fact have training as a bondsman. (Exhibit 5).

12. Claimant stated she could work as long as she did not have to bend over or do lifting.

There was conflicting testimony as to what Claimant said she was working and what reports indicated she could work. The surveillance footage also showed Claimant squatting, bending, and lifting in a manner well-exceeding her self-reported limitations.

13. Claimant indicated to Dr. Wolgin that she took over as the primary caregiver for a toddler and engaged in regular bending, lifting, and twisting. He indicated he was concerned these activities could be exacerbating her symptoms.

14. Claimant stated she recruited a person to work for Tony who was paid. Claimant stated she did the same job but got no pay. She stated she did this because she felt sorry for Tony.

15. A witness for the Defendant, Mr. McGowan stated Claimant is currently working for another company and he took a video of Claimant in the jail house with a file in her hand bailing out someone.

16. Mr. McGowan estimated that Claimant worked for him from August 2010, to January 2011. He knew Claimant's husband and hired Claimant. Witness stated Claimant was good with computers and eventually got a certification for her license to write bail bonds. (Exhibit 5).

17. Witness stated Claimant left because she needed more hours and he paid her \$8.00 per hour up to 30 to 40 hours per week. She averaged about 30 hours.

18. Based on this testimony and the Claimant's, I find Claimant did work for A1 Bail Bonding and provided an inaccurate account to her vocational assessor regarding the length of time she was employed with ABC, the amount she was paid per hour, and the amount of hours she was able to work.

19. The Claimant failed to disclose her second job with A1 Bail Bonding to her vocational assessor and at her deposition. Clearly a vocational assessor uses self-reported earning capacity, low hours, and meager recent work history as evidence to conclude that no viable employment was available.
20. Compensation Rate: \$299.59.
21. After considering all of the evidence I find Claimant has suffered a 40% PPD to the back. I did not find her a credible witness and believe she can work.
22. Defendant to receive credit for all wages paid during the disability period and a credit for temporary total disability benefits paid following maximum medical improvement on February 14, 2011.
23. Claimant to have lifetime replacement of any hardware.

CONCLUSIONS OF LAW

It is concluded under the South Carolina Worker's Compensation Act in Section 42-1-10 S.C. Code of Laws, et. seq., that:

1. Pursuant to § 42-1-40, Claimant had an average weekly wage of \$449.36 and a corresponding compensation rate of \$299.59.
2. Pursuant to § 42-1-130, Claimant was an employee at the time of the alleged work injury.
3. Pursuant to § 42-1-160, Claimant sustained an admitted injury by accident to the back, arising out of and in the course and scope of her employment with the Defendants on February 21, 2008.
4. Pursuant to § 42-9-30, Claimant is entitled to forty percent disability for her injury to the back.

5. Pursuant to § 42-15-60, Claimant achieved maximum medical improvement to the back on February 14, 2010 per the authorized treating physician, Dr. Mark A. Wolgin.
6. Pursuant to § 42-9-210 and *Curiel v. Env. Management Services*, 655 S.E.2d 482 (2007), the date of maximum medical improvement signals the end of entitlement to temporary total benefits), the Defendants are entitled to a credit for overpayment of temporary total benefits from the date of maximum medical improvement, February 14, 2011 and credit for any wages earned while paying benefits during the prior disability period.

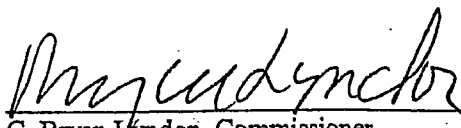
ORDER

IT IS HEREBY ORDERED that the greater weight of evidence supports a finding that Claimant suffered an admitted injury by accident to the back. Claimant's injury resulted in a forty percent (40%) disability to the back.

IT IS HEREBY ORDERED that the greater weight of evidence supports a finding that the Defendants are entitled to credit for overpayment of temporary total benefits from the date of maximum medical improvement, February 14, 2011 at a rate of \$299.59 and credit for any wages earned while paying benefits during the prior disability period.

IT IS HEREBY ORDERED that Defendants shall furnish any prosthetic devices during the life of the Claimant or for so long as such devices are necessary.

AND IT IS SO ORDERED.



G. Bryan Lyndon, Commissioner

South Carolina Workers' Compensation Commission

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

January 18, 2012

By: Tamara Morris, Administrative Assistant to Commissioner Lyndon

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0810152

GRIFFCO OF WAMPEE, INC.,

Employer

AND

COMMERCE & INDUSTRY INSURANCE
COMPANY c/o CHARTIS CLAIMS, INC.,

Carrier,

vs.

SOUTH CAROLINA SECOND INJURY
FUND,

Defendant.

DECISION AND ORDER

DATE OF HEARING:

Hearing held in Horry County, S.C. on April 26, 2012.

APPEARANCES:

Defendant represented by Latonya Edwards, of Dilligard Edwards, LLC, of Columbia, South Carolina.

Employer and Carrier represented by James H. Lichty, Esquire of McAngus Goudelock & Courie, L.L.C. of Columbia, South Carolina.

PURPOSE OF THE HEARING:

To determine all issues as set forth in Forms 54 and 55.

COMMISSIONER:

Commissioner Andrea C. Roche

FILED:

December 19, 2012

STATEMENT OF CASE

This matter was scheduled for hearing on April 26, 2012, to determine the issues raised on Forms 54 and 55. The Defendants seek an Order finding the Second Injury Fund (SIF) responsible for making reimbursement to the Defendants for benefits provided with regard to the underlying workers' compensation claim, to the extent required by S.C. CODE ANN. SEC. 42-9-400. The SIF denies the underlying workers' compensation claim qualifies for reimbursement by the SIF because a.) it does not have proper notice of the claim, b.) the Claimant's pre-existing impairment did not substantially increase the cost of medical treatment, and c.) the claim for reimbursement is barred by operation of S.C. CODE ANN SEC. 42-7-320. No objections were raised as to the respective APA Submissions and Exhibits of the parties prior to the hearing.

STIPULATIONS

1. The South Carolina Workers' Compensation Commission has jurisdiction of this claim.
2. Venue is proper in Myrtle Beach, South Carolina.
3. Notice of hearing was timely and properly served upon all parties of interest.
4. The Commission File becomes part of the record with the exception of self-serving declarations and unstipulated medical reports.

APA SUBMISSIONS

Pursuant to the South Carolina Administrative Procedures Act and the Regulations of the South Carolina Workers' Compensation Commission, the following records were admitted into evidence:

Defendants Submissions:

1. Medical records of Mark A. Wolgin, M.D., Orthopaedic Associates, dated 12/27/01-02/1/11, consisting of 24 pages;

2. Medical records of Loris Healthcare System, dated 02/04/06; 11/30/07; 02/24/08, consisting of 9 pages;
3. Medical records of Phoebe Putney Memorial Hospital, dated 11/17/08-05/21/10, consisting of 25 pages;
4. Medical records of Doctors Care, dated 05/01/09, consisting of 1 page;
5. Medical records of Strand Regional Specialty Associates, dated 05/08/08, consisting of 5 pages;
6. Medical records of OrthoImaging, dated 09/19/08-02/25/10, consisting of 5 pages;
7. Medical Records of Leonard Jones, BS, Clinical Neurodiagnostis, dated 05/19/10, consisting of 3 pages;
8. Medical records of Julie M. Scott, P.T., Ortho Sport Physical Therapy, dated 09/30/08; 09/01/10-09/27/10, consisting of 13 pages;
9. Medical records of Southwestern Home Care & Medical Services, dated 05/24/10-06/01/10, consisting of 13 pages.

- Ex. 1. Letter from Thad Griffin, dated 08/16/10, consisting of 1 page;
- Ex. 2. WCC Order dated January 18, 2012, consisting of 16 pages;
- Ex. 3. Letter to Second Injury Fund, dated 10/02/09, consisting of 1 page;
- Ex. 4. WCC Order dated October 12, 2009, consisting of 15 pages.

EVIDENCE OF CASE

This matter originated as a denied claim for injuries to the Claimant's back, stemming from an alleged accident on February 21, 2009. The Commission conducted a hearing on August 12, 2009, to determine whether the Claimant was entitled to benefits. The Defendants placed the SIF on notice of a potential claim by letter dated October 2, 2009. Exhibit 3. By Order dated October 13, 2009, the Commission found the injury compensable and ordered the Defendants to provide medical and temporary disability benefits. Exhibit 4. The Commission file does not contain a Form 19 documenting payment of the Commission award of October 13, 2009. A Form 40 in the Commission file submitted by the Claimant's attorney suggests the Defendants had not paid the award of compensation as of November 17, 2009.

The medical records show the Claimant first sought treatment from Mark A. Wolgin, M.D., on September 16, 2008. APA p.21. At that appointment, Dr. Wolgin documented the Claimant's medical history, which is "significant for diabetes mellitus." Id. After a course of

conservative treatment, the Claimant elected to undergo surgery. APA p.15. The Claimant received a two-level fusion on May 19, 2010. APA p.38. She also continued follow up treatment with Dr. Wolgin. A CT scan on February 9, 2011, showed no evidence of hardware failure but did show evidence of a non-union in places. Exhibit 2, p.10. As of February 14, 2011, the Claimant stated she did not wish to undergo additional surgery. Exhibit 2, pp. 10-11. Dr. Wolgin released the Claimant from treatment with 36% impairment. Exhibit 2, p.11.

By Order dated January 18, 2012, Commissioner Lyndon found as fact "Claimant has a two-level fusion which was not successful. There is a non-union and Claimant is a candidate for another surgery; at present she chooses not to have the surgery." Id. Commissioner Lyndon further found as fact "Claimant has suffered 40% PPD to the back" and "Claimant to have lifetime replacement of hardware." Exhibit 2, p.14.

Dr. Wolgin completed a statement on February 21, 2011, and provided his opinion, within a reasonable degree of medical certainty:

1. The Claimant most likely had diabetes prior to the injury of February 24, 2008 [sic].
2. The Claimant's pre-existing diabetes most probably caused her to lose more time from work that she would have had from the injury alone.
3. The Claimant's pre-existing diabetes most probably resulted in a higher percentage of permanent impairment that she would have had from the injury alone.
4. The Claimant's medical costs related to this injury most probably were not substantially increased due to the existence of diabetes. APA p.1.

Dr. Wolgin went on to state:

"I can't say how much each of these factors affected/ prevented the healing of her fusion, but

Diabetes

Obesity/ Overweight

Smoking

“all contributed to the nonunion. The patient is a candidate for revision surgery but is not interested. We have discussed weight loss and smoking cessation on multiple visits.” APA p.2.

Additional evidence submitted at the time of the hearing includes a statement from Thad Griffin, the Employer’s president, indicating he was aware from general conversation with the Claimant that she suffered from diabetes prior to her injury.

FINDINGS OF FACT

Having reviewed and considered the positions of the parties and the evidence of the case, the undersigned hereby enters the following findings of fact:

Notice

1. That Defendants placed the Commission and the SIF on notice of a potential claim, in writing, on October 2, 2009.
2. That an Order of the Commission dated October 13, 2009, determined the Claimant suffered a compensable injury to her back on February 21, 2008, and ordered the Defendants to provide compensation.
3. That a Form 40 filed by the Claimant’s attorney suggests the Defendants had not paid any compensation to the Claimant as of November 17, 2009.
4. That Defendants placed the SIF on notice of a potential claim before payment of the first seventy-eight weeks of compensation.

Substantially Greater Compensation or Medical Payments due to Aggravation

5. That Claimant had diabetes prior to her injury.
6. That the Employer had knowledge of the Claimant's diabetes prior to her injury.
7. That Claimant's pre-existing diabetes is a permanent physical impairment.
8. That Claimant's prior permanent physical impairment has not resulted in medical payments that are substantially greater and caused by aggravation of the pre-existing impairment than that which would have resulted from the subsequent injury alone.
9. That the SIF is not obligated to provide reimbursement for medical payments at this time.
10. That Claimant's diabetes contributed to the non-union of her two-level fusion.
11. That Claimant is a candidate for revision surgery due to non-union of her two-level lumbar fusion but is not interested in surgery.
12. That if the Claimant needs revision surgery, the diabetes will have played a role in that, but that's just speculation at this point.
13. That, should the Defendants provide the Claimant revision surgery, a new hearing may be necessary to determine whether that cost is reimbursable by the SIF.
14. That the Claimant suffered 40% partial permanent disability to her back as a result of her injury, as determined by Order of the Commission dated January 18, 2012. This award is currently under appeal to the Full Commission and could change.
15. That the Claimant's prior permanent physical impairment resulted in compensation that is substantially greater and is caused by aggravation of the pre-existing impairment than that which would have resulted from the subsequent injury alone.

16. That the SIF is obligated to provide reimbursement for all compensation benefit payments payable subsequent to those payable for the first seventy-eight weeks following the injury.

Application of S.C. CODE ANN SEC. 42-7-320

17. That Defendants timely submitted a Form 58 and APA Submissions to the Commission on February 21, 2012.
18. That the SIF indicated it would object to any APA Submissions not submitted prior to June 30, 2011, yet failed to raise any objections at the hearing, suggesting it does not deny the evidence contained in the Defendants' APA submissions was submitted to the SIF prior to June 30, 2011.
19. That the SIF did not present an argument to suggest the evidence contained in the Defendants' APA Submissions was not submitted to the SIF prior to June 30, 2011.

CONCLUSIONS OF LAW

Having reviewed and considered the positions of the parties and the evidence of the case, the undersigned hereby enters the following conclusions of law:

1. S.C. CODE ANN. SEC. 42-9-400 governs reimbursement from Second Injury Fund where disability is substantially greater or caused by aggravation of pre-existing employment.
2. S.C. CODE ANN. SEC. 42-9-400(a) establishes the SIF must reimburse an employer or carrier when a Claimant with a permanent physical impairment suffers a subsequent injury leading to substantially greater compensation or medical payments than would have resulted from the injury alone due to the aggravation of the permanent physical impairment. Since the evidence shows compensation payments are substantially greater

due to the prior permanent physical impairment, the SIF shall reimburse the carrier for all compensation payments made to date. The evidence does not establish substantially greater medical payments however, and the SIF is not obligated to reimburse the Defendants for medical payments.

3. S.C. CODE ANN. SEC. 42-9-400(a)(1) establishes the SIF is only responsible for reimbursing compensation benefits payments subsequent to those payable for the first seventy-eight weeks following the injury.
4. S.C. CODE ANN. SEC. 42-9-400(d)(2) establishes a presumption that diabetes is permanent and constitutes a hindrance or obstacle to employment, provided the employer establishes prior knowledge of the permanent impairment. Since the employer established knowledge of the Claimant's diabetes, the condition is permanent and constitutes a hindrance or obstacle to employment.
5. S.C. CODE ANN. SEC. 42-9-400(f) establishes the employer or carrier must notify the Commission and the SIF of a possible claim no later than after the payment of seventy-eight weeks of compensation. Since the Defendants provided notice of a potential claim to both before it provided any compensation to the Claimant, the Defendants provided timely notice of its claim for reimbursement.
6. S.C. CODE ANN. SEC. 42-7-320 establishes a schedule for the termination of the SIF.
7. S.C. CODE ANN. SEC. 42-7-320 establishes the SIF shall not accept a claim for reimbursement after December 31, 2011. This statute pertains to whether the SIF can accept a claim after December 31, 2011 and does not prohibit the Commission from awarding reimbursement of a claim after December 31, 2011.

8. S.C. CODE ANN. SEC. 42-7-320(2) establishes a bar to reimbursement in the event an employer or carrier does not submit all required information for consideration of accepting a claim to the SIF by June 30, 2011. This is an affirmative defense as it relates to the SIF. The SIF did not present any evidence to establish the Defendants failed to submit required information to the SIF prior to June 30, 2011. Moreover, the evidence suggests the SIF agrees the Defendants submitted all required information to the SIF prior to June 30, 2011. Accordingly, the Defendants are not barred from seeking reimbursement by operation of SEC. 42-7-320(2).

ORDER

Having entered the above Findings of Fact and Conclusion of Law, the undersigned Commissioner hereby orders,

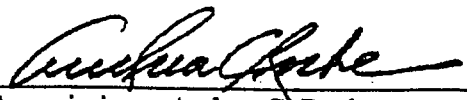
That Defendants are not barred from seeking reimbursement from the SIF,

That SIF shall reimburse the Defendants for all compensation benefits payable subsequent to those payable for the first seventy-eight weeks following the injury,

That SIF shall not reimburse the Defendants for medical payments at this time,

That the question of whether future medical payments are reimbursable by the SIF is premature and to be determined as future medical payments are provided.

AND IT IS SO ORDERED!



Commissioner Andrea C. Roche

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

December 19, 2012

By: Barbara Cheeseboro, Administrative Assistant to Commissioner Roche

APPELLATE PANEL DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0810152

PATRICIA FORE

EMPLOYEE,
CLAIMANT/APPELLANT

VS.

GRIFFCO OF WAMPEE, INC.

EMPLOYER,

AND

AIG DOMESTIC CLAIMS,

CARRIER,
DEFENDANTS/RESPONDENTS

Appellate Panel Review held in Columbia, South
Carolina, on April 16, 2013, per notices timely
And properly served upon all parties of interest.

Appellate Panel Decision and Order Filed:

7-15-13

APPEARANCES: Claimant/Appellant represented by Latonya Dilligard Edwards,
Esquire/SCSIF, of Dilligard Edwards, LLC of Columbia, South
Carolina.

Defendants/Respondents represented by James H. Lichty,
Esquire of McAngus Goudelock & Courie, LLC of Columbia,
South Carolina.

STATEMENT OF CASE

This matter was heard before Commissioner Andrea Roche on April 26, 2012, in Myrtle Beach, South Carolina. On December 19, 2012, she issued the following Order:

That Defendants are not barred from seeking reimbursement from the SIF,

That SIF shall reimburse the Defendants for all compensation benefits payable subsequent to those payable for the first seventy-eight weeks following the injury,

That SIF shall not reimburse the Defendants for medical payments at this time,

That the question of whether future medical payments are reimbursable by the SIF is premature and to be determined as future medical payments are provided.

By Form 30, Appellate submitted the following exceptions to the Single Commissioner's Findings of Fact and Conclusions of Law:

1. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 4) that Carrier placed the Fund on notice of a potential claim before payment of the first seventy-eight (78) weeks of compensation, when such finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
2. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 12) that if the Claimant needs revision surgery, the diabetes will have played a role in that, the error being an award of reimbursement cannot be based on speculation?
3. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 13) that should Carrier provide the Claimant's revision surgery, a new hearing may be necessary to determine whether that cost is reimbursable by the Fund, the error being that any subsequent reimbursement hearing violates the statutory reimbursement scheme?
4. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 15) that Claimant's prior permanent physical impairment resulted in compensation that is substantially greater and is caused by aggravation of the pre-existing impairment that would have resulted from the subsequent injury alone, when such finding is against the preponderance of the reliable, probative, and substantial evidence in the record?
5. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 7) that S.C. Code Ann. Sec. 42-7-320 pertains to whether the Fund can accept a claim after December 31, 2011 and does not prohibit the Commission from awarding reimbursement of a claim after December 31, 2011, when such conclusion is against the greater weight of the reliable, probative and substantial evidence in the record?

6. Did the Hearing Commissioner err in failing to find that the medical evidence in the record rebutted the presumption that Claimant's pre-existing diabetes was permanent and a hindrance per S.C. Code Sec. 42-9-400?

STANDARD OF REVIEW

In appellate review, the Panel shall, pursuant to S.C. CODE ANN. §42-17-50 review the Award, weigh the evidence as presented at the initial hearing and, if good grounds be shown therefor, make its own Findings of Fact and Conclusions of Law. The final determination of witness credibility and the weight to be accorded evidence in workers' compensation cases is reserved to the Full Commission. Etheridge v. Monsanto Co., 349 S.C. 451, 562 S.E.2d 679 (S.C.App 2002). After careful review in the instant case, the Commission affirms, with amendment, the Single Commissioner's Order of December 19, 2012, and issues the following Findings of Fact and Conclusions of Law and Final Order as the final determinations of the Commission.

FINDINGS OF FACT

Based upon the testimony and exhibits submitted, the Appellate Panel of the South Carolina Workers' Compensation Commission makes the following findings of fact:

Notice

1. That Defendants placed the Commission and the SIF on notice of a potential claim, in writing, on October 2, 2009.
2. That an Order of the Commission dated October 13, 2009, determined the Claimant suffered a compensable injury to her back on February 24, 2008, and ordered the Defendants to provide compensation.

3. That a Form 40 filed by the Claimant's attorney suggests the Defendants had not paid any compensation to the Claimant as of November 17, 2009.
4. That Defendants placed the SIF on notice of a potential claim before payment of the first seventy-eight weeks of compensation.

Substantially Greater Compensation or Medical Payments due to Aggravation

5. That Claimant had diabetes prior to her injury.
6. That the Employer had knowledge of the Claimant's diabetes prior to her injury.
7. That Claimant's pre-existing diabetes is a permanent physical impairment.
8. That Claimant's prior permanent physical impairment has not resulted in medical payments that are substantially greater and caused by aggravation of the pre-existing impairment than that which would have resulted from the subsequent injury alone.
9. That the SIF is not obligated to provide reimbursement for medical payments at this time.
10. That Claimant's diabetes contributed to the non-union of her two-level fusion.
11. That Claimant is a candidate for revision surgery due to non-union of her two-level lumbar fusion but is not interested in surgery.
12. That if the Claimant needs revision surgery, the diabetes will have played a role in that, but that is just speculation at this point.
13. That should the Defendants provide the Claimant revision surgery, a new hearing may be necessary to determine whether that cost is reimbursable by the SIF.
14. That the Claimant suffered 40% partial permanent disability to her back as a result of her injury, as determined by the Appellate Panel Decision and Order dated August 27, 2012. This award is currently under appeal to the South Carolina Court of Appeals and could change.

15. That the Claimant's prior permanent physical impairment resulted in compensation that is substantially greater and is caused by aggravation of the pre-existing impairment that that which would have resulted from the subsequent injury alone.

16. That the SIF is obligated to provide reimbursement for all compensation benefit payments payable subsequent to those payable for the first seventy-eight weeks following the injury.

Application of S.C. CODE ANN SEC. 42-7-320

17. That Defendants timely submitted a Form 58 and APA Submissions to the Commission on February 21, 2012.

18. That the SIF indicated it would object to any APA Submissions not submitted prior to June 30, 2011, yet failed to raise any objections at the hearing, suggesting it does not deny the evidence contained in the Defendants' APA submissions was submitted to the SIF prior to June 30, 2011.

19. That the SIF did not present an argument to suggest the evidence contained in the Defendants' APA Submissions was not submitted to the SIF prior to June 30, 2011.

Amendments to Order of Single Commissioner

20. That the single Commissioner's is hereby amended so that the date of accident referenced on page three and on page five shall read February 24, 2008.

CONCLUSIONS OF LAW

It is concluded under the South Carolina Worker's Compensation Act in Section 42-1-10 S.C. Code of Laws, et. seq., that:

1. S.C. CODE ANN. SEC. 42-9-400 governs reimbursement from Second Injury Fund where disability is substantially greater or caused by aggravation of pre-existing employment.

2. S.C. CODE ANN. SEC. 42-9-400(a) establishes the SIF must reimburse an employer or carrier when a Claimant with a permanent physical impairment suffers a subsequent injury leading to substantially greater compensation or medical payments than would have resulted from the injury alone due to the aggravation of the permanent physical impairment. Since the evidence shows compensation payments are substantially greater due to the prior permanent physical impairment, the SIF shall reimburse the carrier for all compensation payments made to date. The evidence does not establish substantially greater medical payments however, and the SIF is not obligated to reimburse the Defendants for medical payments.
3. S.C. CODE ANN. SEC. 42-9-400(a)(1) establishes the SIF is only responsible for reimbursing compensation benefits payments subsequent to those payable for the first seventy-eight weeks following the injury.
4. S.C. CODE ANN. SEC. 42-9-400(d)(2) establishes a presumption that diabetes is permanent and constitutes a hindrance or obstacle to employment, provided the employer establishes prior knowledge of the permanent impairment. Since the employer established knowledge of the Claimant's diabetes, the condition is permanent and constitutes a hindrance or obstacle to employment.
5. S.C. CODE ANN. SEC. 42-9-400(f) establishes the employer or carrier must notify the Commission and the SIF of a possible claim no later than after the payment of seventy-eight weeks of compensation. Since the Defendants provided notice of a potential claim to both before it provided any compensation to the Claimant, the Defendants provided timely notice of its claim for reimbursement.
6. S.C. CODE ANN. SEC. 42-7-320 establishes a schedule for the termination of the SIF.

7. S.C. CODE ANN. SEC. 42-7-320 establishes the SIF shall not accept a claim for reimbursement after December 31, 2011. This statute pertains to whether the SIF can accept a claim after December 31, 2011 and does not prohibit the Commission from awarding reimbursement of a claim after December 31, 2011.
8. S.C. CODE ANN. SEC. 42-7-320(2) establishes a bar to reimbursement in the event an employer or carrier does not submit all required information for consideration of accepting a claim to the SIF by June 30, 2011. This is an affirmative defense as it relates to the SIF. The SIF did not present any evidence to establish the Defendants failed to submit required information to the SIF prior to June 30, 2011. Moreover, the evidence suggests the SIF agrees the Defendants submitted all required information to the SIF prior to June 30, 2011. Accordingly, the Defendants are not barred from seeking reimbursement by operation of SEC. 42-7-320(2).

ORDER

Based on the above Findings of Fact and Conclusions of Law, the undersigned hereby affirms the decision of the single Commissioner in full and Orders,

That Defendants are not barred from seeking reimbursement from the SIF,

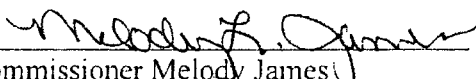
That SIF shall reimburse the Defendants for all compensation benefits payable subsequent to those payable for the first seventy-eight weeks following the injury,

That SIF shall not reimburse the Defendants for medical payments at this time,

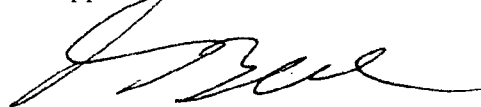
That the question of whether future medical payments are reimbursable by the SIF is premature and to be determined as future medical payments are provided,

That the single Commissioner's is hereby amended so that the date of accident referenced on page three and on page five shall read February 24, 2008.

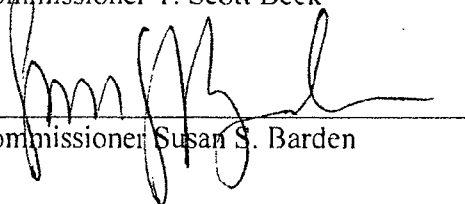
AND IT IS SO ORDERED!



Commissioner Melody James
For the Appellate Panel



Commissioner T. Scott Beck



Commissioner Susan S. Barden

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States mail addressed to any unrepresented party.

By Valerie Deller on July 15, 2013

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APPEARANCES:

COMMISSION PANEL:

Melody James, Chair
Susan Barden
Scott Beck

Latonya Dilligard Edwards, Esquire

Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
Attorney for the Defendant (S.C. Second Injury Fund)

James H. Lichty, Esquire

McAngus, Goudelock & Courie
1320 Main Street, 10th Floor
Columbia, South Carolina 29201
Attorney for the Defendants

INDEX

PAGE

Certificate 12

EXHIBITS

(There were no exhibits marked during this hearing.)

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 **COURT REPORTER:** Today is April 16th, 2013. This is
2 South Carolina Workers' Compensation Case
3 Number 0810152. This is the case of Patricia
4 Fore, Claimant, versus Griffco of Wampee, Inc.,
5 Employer, and Commerce & Industry Insurance
6 Company and S.C. Second Injury Fund are the
7 Carriers. The Appellant is the Defendant, S.C.
8 Second Injury Fund represented by LaTonya D.
9 Edwards. The Respondent, Commerce & Industry
10 Insurance Company is represented by James H.
11 Lichty.

12 **MS. EDWARDS:** I'll be very brief. The Second Injury
13 Fund is requesting reversal of the decision
14 below based on three reasons. The first is
15 that we believe that the reimbursement claim is
16 barred by 42-7-320. That section, of course,
17 outlines the funds termination and indicates
18 that the Second Injury Fund shall not accept a
19 claim for reimbursement after December 31st,
20 2011, and since shadowed with the statute, we
21 certainly interpret that to mean that its
22 mandatory language and not discretionary, we
23 also believe that the statute -- because the
24 statute does not make any provision for claims
25 that have not been accepted on or before

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 December 31st, 2011, that supports our
2 interpretation, and that subsection is
3 42-7-320(b)(3). Now, the other reasons that
4 we're requesting reversal are two-fold -- well,
5 really one, but one big one. The pre-existing
6 condition we assert did not substantially
7 increase the carrier's liability for permanent
8 disability. The decision below has already
9 held that that Second Injury Fund is not
10 required to pay for the medical cost based on
11 the evidence that was in the record, so we're
12 not responsible for that, but we're also
13 asserting that we're not responsible for any
14 substantial increase in permanent disability,
15 and we base that on the following. At Carrier
16 APA Pages 1 through 2 and 17, the previous
17 condition, of course, is diabetes, that is
18 entitled to a presumption. We don't dispute
19 that. The treating physician indicated that
20 the diabetes probably resulted in a higher
21 percentage of a permanent disability.
22 Additional medical records indicate, of course,
23 as I just cited -- I'm sorry -- that the
24 diabetes -- I'm sorry. Additional medical
25 reports indicate that treating physician could

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 not determine how the diabetes -- how much the
2 diabetes affected the fusion. The claimant did
3 have a fusion procedure, and that the diabetes
4 was not a deterrent to proceeding with surgery,
5 and once again, those pages for your reference,
6 are Carrier APA Pages 1 through 2 and Page 17.
7 And at Carrier APA Pages 38 through 44 and 71
8 and 72, the Claimant also ultimately did
9 receive a fusion in 2010, and there's no
10 indication that the diabetes had an impact on
11 the procedure, either healing, delayed recovery
12 and such. Also, as it relates to pre-existing
13 condition and the work injury, not combining,
14 at Carrier APA Page 18, the treating physician
15 indicated that the Claimant's condition
16 developed from the workplace exposure and
17 indicated that prior to the work injury, the
18 Claimant was not experiencing any pain in her
19 back or her leg, and once again, that's at
20 Carrier APA Page 18, and after she sustained
21 the work injury is when she developed the
22 chronic symptoms that necessitated surgery. At
23 Carrier APA Pages 34 through 37, the Claimant
24 did receive some physical therapy as a
25 consequence of the work related injury which we

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 also believe supports the fact that it was the
2 work injury that created all of Claimant's
3 condition and the permanent disability as
4 opposed to the pre-existing condition being
5 combined with that, and she also received some
6 medication and injections for pain management
7 at Carrier APA Pages 52, 54 and 56 through 57,
8 and while there were reservations about giving
9 the Claimant the injections for pain, because
10 she had diabetes, she did, in fact, receive the
11 recommended injections, and so we also -- and
12 that's at Carrier APA Page 59. So, we also
13 would assert that that also supports our
14 argument that the diabetes did not affect the
15 Claimant's work related exposure -- I'm sorry
16 -- the work related injury and the consequence
17 thereof. So, that's the conclusion of my
18 argument. I'd be happy to entertain any
19 questions you might have.

20 **(Whereupon, there were no questions.)**

21 **MS. EDWARDS:** Okay. Thank you.

22 **MR. LICHTY:** Thank you very much. May it please the
23 Commission. I'll try to keep it, brief, as
24 well. In looking at this file, you can tell
25 that clearly the Claimant had a pre-existing

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 condition of diabetes. You can tell that the
2 medical record clearly establishes that, as a
3 result of these diabetes, when Ms. Fore went in
4 for surgery, the diabetes contributed to a
5 non-union of a lumbar fusion site.
6 Dr. Woogin's opinion is very clear on this.
7 Dr. Woogin's is very clear that, as a result of
8 the diabetes, she has a substantially greater
9 impairment as a result of her injury. He does
10 answer that her medical treatment, at least to
11 date, was not substantially increased, and
12 that's why the Commissioner split the award and
13 said the Second Injury Fund pays for indemnity,
14 but not yet medical. The findings of the
15 Commissioner with regard to medical is that
16 it's premature, because as it stands right now,
17 Ms. Fore is a candidate for a revision surgery,
18 a revision surgery brought about by the
19 non-union of her surgical site which is the
20 result of diabetes. So, we feel that not only
21 does the evidence clearly support this
22 Commissioners's findings with regard to
23 permanency, but that, eventually, that it that
24 will support findings with regard to medical
25 treatment, as well. That's not before the

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 Appellant Panel right now. That's just the lay
2 of the land for this case.

3 **COMMISSIONER BARDEN:** Can you just make sure we have
4 the correct date of accident, because you've
5 got a couple different dates in here, or at
6 least, we see a couple different dates.
7 There's a February 24th, 2008, but there's also
8 a February 21st, 2009, and I know that's not
9 right. Should it be February 24th, 2008? If
10 you look on Page 3 -- and I know that's not
11 right, because there's a 2008 claim, and that
12 would bar reimbursement from B under ...

13 **MR. LICHTY:** No, this is not a 2008 claim.

14 **COMMISSIONER BARDEN:** Is it a 2009 injury?
15 You've got -- your brief, the first page, says
16 the date of the injury is February 24th, 2008,
17 and on Page 3 of the order is February 21st,
18 2009. So, I mean, one of those isn't right.

19 **MR. LICHTY:** Right. I would go with the order.
20 Early on the outset of this case, there was a
21 number transposed at the end of the date,
22 because I think this issue has come up once
23 before when we were dealing with original order
24 from Commissioner Roche, but I believe it is a
25 2008 date of accident. I'd have to go back.

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 I don't have the file with me, but I'd have to
2 go back and check the original order.

3 **MS. EDWARDS:** It is 2008.

4 **COMMISSIONER BARDEN:** Yes, it would have to be.

5 **MS. EDWARDS:** It is 2008.

6 **COMMISSIONER BARDEN:** We just want it to be right.

7 **MR. LICHTY:** If we got this far and missed that, we
8 would be in a whole world of trouble.

9 **COMMISSIONER BARDEN:** So, you're not sure whether
10 it's the 21st or the 24th or when it is?

11 **MR. LICHTY:** Yeah, the 21st or 24th is the issue --
12 or the 28th -- and I apologize.

13 **COMMISSIONER BARDEN:** I'm sorry. What did you say?
14 What is it?

15 **MR. LICHTY:** The 24th.

16 **COMMISSIONER BARDEN:** The 24th?

17 **MR. LICHTY:** It is the 24th.

18 **MS. EDWARDS:** It's the 21st.

19 **COMMISSIONER BARDEN:** I guess a few days don't
20 matter. We're just trying to get the right
21 date. **MR. LICHTY:** Right. It was -- the right
22 year was 2008, and that's a little sloppy on my
23 part. I apologize for that. Going back to the
24 underlying argument, however, I've addressed
25 why the record supports compensability under

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 the Act, and the fact that there's no evidence
2 to contradict any of Dr. Woogin's opinions,
3 meaning that the underlying decision is
4 correct. Just with regard -- and I addressed
5 this in my brief, but I'll address it briefly
6 here. With regard to the argument that the
7 legislative change weren't meant to extend to
8 prevent the Commission from ordering the Second
9 Injury Fund from reimbursing on a claim that it
10 had denied. Certainly, the notice provision of
11 the claim was met. The Fund was placed on
12 notice in a timely fashion. The fund opted not
13 to accept the claim for reimbursement at the
14 time, requiring us to adjudicate the matter in
15 front of the Commission. I don't think the
16 Legislator's intent was to allow the Fund to
17 get claims effectively denied by denying them
18 itself. I don't think the legislature intended
19 to prohibit my client from seeking
20 reimbursement before the Commission if there
21 was a dispute between the Fund and my client
22 regarding the reimbursement, and I don't think
23 the statute can be read to impose a band on the
24 Commission from ordering the Fund to pay. That
25 would conclude my response, and I would also

PATRICIA FORE V. GRIFFCO OF WAMPEE, ET AL.

1 answer any questions from the Commission.

2 (Whereupon, there were no questions.)

3 **COMMISSIONER JAMES:** Thank you.

4 **MS. EDWARDS:** I don't have anything further.

5 **COMMISSIONER JAMES:** This concluded the hearing.

6 **(Whereupon, the Full Commission Panel Hearing**
7 **concluded at 9:12 o'clock a.m.)**

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NOTICE OF POSSIBLE
SECOND INJURY FUND
CLAIM

W.C.C. No. 810152
Carrier Code _____
Employer Code _____
Carrier File No. 709-659592
S.I.F. No. 146237

Employee: Patricia Fore
Address: 111 Third Street E
Leesburg, GA 31763

Social Security # _____
Date of Accident: 2/24/2008

Employer: Griffco of Wampee Inc.
Address: 8729 Highway 90
Longs, SC 29568

Carrier: Commerce & Industry
Address: 70 Pine Street
New York NY 10270

Employee _____
Attorney: _____
Address: _____

Carrier _____
Attorney Policy Number: _____
Address: Policy Period: _____

SUBSEQUENT INJURY:

Nature of Second Injury:
Hurt lower back lifting large slab of meat

Current Status:
still treating, non-union of lumbar fusion per doctor; claim still open

Treating Physicians:
Dr. Mark A. Wolgin

Average Weekly Wage:	<u>\$ 449.36</u>	Compensation Rate:	<u>\$ 299.59</u>
Date of 1st Temp. Total:	<u>11/19/2009</u>	Date Back to Work:	_____
Weeks of All Benefits Paid:	_____	Medicals to Date:	<u>\$ 63,750.93</u>

NATURE OF PRIOR IMPAIRMENT:
Listed Impairment (1-33): _____
Other (34 a or b): _____

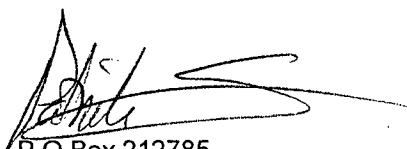
Refer to Section 42-9-400, Paragraph (d)
(2) Diabetes

KNOWLEDGE REQUIREMENT:

XXXXXXXXXXXXXXXXX -Employer knew about pre-existing condition.
(Please attach affidavit, application, etc.)
-Employer withheld existence of pre-existing condition from
employer. (Please attach application, physical, etc.)
-Employee was unaware of existence of pre-existing
condition. (Please attach affidavit)

THESE FORMS MUST BE PROVIDED
BEFORE CLAIMS CAN BE PROCESSED:

- (1) All narrative medical reports
- (2) Form 12-A
- (3) Form 15
- (4) Current Form 18
- (5) Any W.C.C. Order

Signature: 
Address: P O Box 212785
Columbia, South Carolina 29221

Date of Claim: 3/10/11

In support of such notice and without precluding the right to establish further facts as may be
developed, the preceding allegations are set forth subject to proof at a Hearing.

PLEASE RETURN THIS FORM AND ATTACHMENTS WITHIN 14 DAYS OF RECEIPT. SEND A
COPY TO THE WORKERS COMPENSATION COMMISSION.

June 20, 2011

Wayne Koon
Welch Consulting.
P.O. Box 212785
Columbia, SC 29221

RE: Patricia Fore VS Griffco of Wampee
SIF#: 146237 WCC#: 0810152

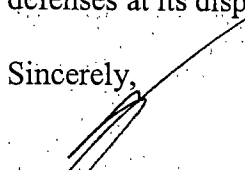
Dear Wayne:

I have completed my evaluation and feel that this claim does not satisfy Second Injury Fund criteria for acceptance and reimbursement.

Although Dr. Wolgin appears to support a Second Injury Fund claim in some respects, he answered "No" to the question of combination/aggravation. After reviewing the medical narratives it is clear why he responded in this fashion. I can find no indication in the medicals that diabetes in any way complicated this claim. As things currently stand I feel obligated to issue this denial.

This should be considered a general denial and the Fund reserves the right to utilize any other defenses at its disposal should you decide to pursue this claim.

Sincerely,


Philip L. Johnson
Claims Analyst
Ext. 118

PJ/jmd

cc: S.C. Workers' Compensation Commission

SC Workers' Compensation Commission

1333 Main Street, Suite 500 • Post Office Box 1715

Columbia, South Carolina 29202-1715

(803)737-5723



WCC File #: 0810152

Carrier File #: 709-659592

Carrier Code #:

Employer FEIN #:

Patricia Fore

Claimant's Name SSN

111 Third Street E

Leesburg, Georgia 31763

Address City State Zip

(843) 246-9239

Home Phone #

James H. Lichty

Preparer's Name

Work Phone #

McAngus Goudelock & Courie

Law Firm

Griffco of Wampee, Inc.

Employer's Name

8729 Highway 90

Longs, South Carolina 29568

Address City State Zip

Commerce & Industry Insurance Company c/o Chartis
Claims, Inc.

Insurance Carrier

(803) 227-2288

Phone Number

Check applicable claims and complete all blanks.

1. The employee sustained a compensable accidental injury to the back (part of the body) on February 21, 2008 (m/d/yyyy) in Horry (county), State of South Carolina (state).
2. That the Second Injury Fund was put on notice of the claim on October 5, 2009 (date).
Agreement on: The carrier has not concluded disability for this claim at this time but the Claimant's attorney has recently requested a hearing to determine the amount of disability suffered by the Claimant and the Defendants request the
3. Second Injury Fund's liability for this claim be adjudicated at the same time. (date).
4. That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. Code Section 42-9-40 (d):
 - a. Listed Impairment – (1) – (33) Diabetes
 - b. (34) (a) _____
 - c. (34) (b) _____
5. ☒ a. That the impairment preexisted;
☒ b. That the impairment was permanent; and
☒ c. That the impairment is a physical condition.
6. ☒ That the prior impairment combined with or was aggravated by the subsequent injury.
☒ That the combination/aggravation substantially increased the liability of the carrier for: ☐ disability ☐ medical or ☐ both.
7. ☒ That the impairment was a hindrance or obstacle to employment or re-employment.
8. ☒ a. That the employer has knowledge of the prior impairment;
☐ b. That the impairment was unknown to the employee and the employer; or
☐ c. That the employee concealed the prior impairment from the employer.
9. ☒ That the subsequent injury would not have occurred "but for" the prior impairment.
10. That the above claim qualifies for reimbursement under S.C. Code Section 42-9-410 because:
This Claimant suffered from a pre-existing diabetic condition, which is a listed condition under S.C. CODE ANN. §42-9-400. The authorized treating physician states the pre-existing diabetes contributed to the non-union of the Claimant's lumbar fusion following her injury and that the prior impairment caused the carrier to incur higher medical expenses and cause the Claimant to suffer greater disability should qualify this claim for SIF recovery.
11. The Defendants reserve the right to allege additional grounds for this claim upon the completion of further discovery and as circumstances may warrant.
12. Other grounds for claim: _____

Signature

October 26, 2011

Date (m/d/yyyy)

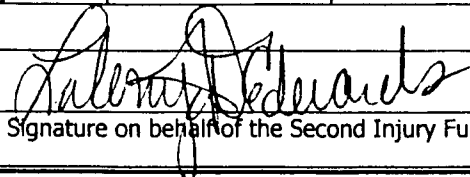


WCC File #: **0810152**
Carrier File #: **709-659592**
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Patricia Fore SSN: _____ Employer's Name: Griffco of Wampee, Inc.
Address: 111 Third Street East Address: 8729 Highway 90
City: Leesburg State: SC Zip: 31763 City: Longs State: SC Zip: 29568
Home Phone: (843) 246-9239 Work Phone: () - Insurance Carrier: Commerce & Industry Insurance Company c/o Chartis Claims, Inc.
Preparer's Name: Latonya D. Edwards Law Firm: Boykin & Davis, LLC Preparer's Phone #: (803) 254-0707

The Second Injury, in answer to the claim, respectfully shows:

1. It is ☐ acknowledged ☒ denied that the employee sustained a compensable accident; The claim is being investigated.
2. It is ☐ acknowledged ☒ denied that the notice was given to the Second Injury Fund; _____
3. It is ☐ acknowledged ☒ denied that the disability claim has been concluded.
4. It is ☐ acknowledged ☒ denied that the impairment is: As alleged or any permanent physical impairment serious enough to be a hindrance or obstacle to employment.
5. a. It is ☐ admitted ☒ denied that the impairment pre-existed.
b. It is ☐ admitted ☒ denied that the impairment was permanent.
c. It is ☐ admitted ☒ denied the impairment is physical.
6. It is ☐ admitted ☒ denied that the impairment combined with or was aggravated by the subsequent injury.
7. It is ☐ admitted ☒ denied that the combination/aggravation substantially increased the carrier's liability for ☐ disability ☐ medical or ☐ both: _____
8. It is ☐ admitted ☒ denied that the impairment was a hindrance or obstacle to employment or re-employment.
9. a. It is ☐ admitted ☒ denied that the employer had knowledge of the impairment.
b. It is ☐ admitted ☐ denied that the impairment was unknown to the employee and employer.
c. It is ☐ admitted ☐ denied that the employee concealed the impairment.
10. It is ☐ admitted ☐ denied that the subsequent injury would not have occurred "but for" the prior impairment.
11. It is ☐ admitted ☐ denied that the claim qualifies for reimbursement under S.C. Code Section 42-9-410;
12. The Carrier's claim is barred by the Statute of Limitations pursuant to S.C. Code Section 42-15-40;
13. Other grounds for denial: The Second Injury Fund will object to any APA submission that was not submitted by June 30, 2011 pursuant to S.C. Code Ann. § 42-7-320(B)(2). The Fund requests that all reimbursement issues be adjudicated prior to December 31, 2011 to comply with 42-7-320(B).


Signature on behalf of the Second Injury Fund

November 10, 2011
Date (m/d/yyyy)

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5739
www.wcc.sc.gov



PRE-HEARING BRIEF
WCC File No: 0810152

Patricia Fore

Claimant's Name SSN

111 Third Street E
Leesburg, Georgia 31763

Address City State Zip
(843) 246-9239

Home Phone #

Work Phone #

James H. Lichty

Preparer's Name

Griffco of Wampee, Inc.

Employer's Name

8729 Highway 90
Longs, South Carolina 29568

Address City State Zip

Commerce & Industry Insurance Company c/o Chartis
Claims, Inc.

Insurance Carrier

(803) 227-2288

Phone Number

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Comp. Rate: \$299.59 2. AWW: \$449.36 Date of Injury February 21, 2008
3. Type of injury and body part(s): Back, left hip/leg, right hip/leg.
4. Facts in controversy: Whether this claim is reimbursable by the Second Injury Fund.
5. Legal issues involved: S.C. Code Ann. §42-9-400; all issues raised at #4, above
6. Unusual aspects: None.
7. Witnesses (designate if expert) Thad Griffin; other representatives of Employer/Carrier.
8. Exhibits: Knowledge statement of Employer/Thad Griffin.
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance): Pursuant to R.67-612: Orthopaedic Associates, Inc.; Loris Healthcare System; Phoebe Putney Memorial Hospital; Doctors Care; Strand Regional Specialty Associates; Ortholmaging; Clinical Neurodiagnostics; Ortho Sport Physical Therapy; Southwestern Home Care & Medical Service.
10. Name, address, and specialty, if any, of the treating physician: Mark Wolgin, M.D., Orthopaedic Associates, Inc., 2002 Palmyra Road, Suite 100, Albany, Georgia 31707.
11. Impairment rating(s); body part(s); physician and date of opinion: By Order of the Commission dated January 18, 2012, Claimant has 40% PPD to the back. This Order is currently on appeal.
12. I am amending my Form 50/51 in the following manner: N/A.

I verify the contents of this form are accurate and true to the best of my knowledge.

SIGNATURE

Email: jlichty@mgclaw.com

DATE OF HEARING: March 7, 2012

On behalf of ☐ Claimant ☒ Employer

Time needed for hearing: 30 minutes

RECEIVED

FEB 21 2012

(FRONT DESK)

SC Workers' Comp Comm

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
Commissioners reserve the right to admit expert witnesses at hearings.

WCC FORM # 58 REV. DATE 9/07

58

PRE-HEARING BRIEF

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0810152

PATRICIA FORE,

Employee,

Claimant,

vs.

GRIFFCO OF WAMPEE, INC.,

Employer,

AND

COMMERCE & INDUSTRY INSURANCE
COMPANY C/O CHARTIS CLAIMS, INC.,

Carrier,

Defendants.

**NOTICE OF WITNESSES AND
WRITTEN MEDICAL REPORTS
TO BE INTRODUCED AS
DIRECT EVIDENCE ON BEHALF
OF DEFENDANT**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND STEPHEN
B. SAMUELS, ESQUIRE:

YOU ARE NOTIFIED that the Defendants, pursuant to the provisions of the South
Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws
(Cum. Supp. 1988) submit the following medical records and other documents as evidence:

APA#	DOCTOR	PRACTICE	DATES	PAGES
1.	Mark A. Wolgin, M.D.	Orthopaedic Associates, Inc.	12/27/01-02/10/11	1-24
2.		Loris Healthcare System	02/04/06;11/30/07; 02/24/08	25-33
3.		Phoebe Putney Memorial Hospital	11/17/08-05/21/10	34-59
4.		Doctors Care	05/01/09	60
5.		Strand Regional Specialty Associates	05/08/08	61-65
6.		OrthoImaging	09/19/08-02/25/10	66-70

7.	Leonard Jones, BS	Clinical Neurodiagnostics	05/19/10	71-73
8.	Julie M. Scott, P.T.	Ortho Sport Physical Therapy	09/30/08, 09/01/10- 09/27/10	74-86
9.		Southwestern Home Care & Medical Services	05/24/10 -06/01/10	87-99
Ex. 1	Letter from Thad Griffin		08/16/10	1 pg
Ex. 2	WCC Order dated January 18, 2012			16 pgs

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise oppose this evidence and, should you desire to exercise this right, you are to promptly schedule the deposition of any provider whose records are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina Workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Defendants.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Defendants: Thad Griffin.


 JAMES H. LICHTY
 MCANGUS GOUDELOCK & COURIE, L.L.C.
 Post Office Box 12519, Capitol Station
 Meridian, 1320 Main Street, 10th Floor
 Columbia, South Carolina 29211-2519
 (803) 779-2300
 Attorneys for the Employer/Carrier

Columbia, South Carolina
 February 21, 2012

WELCH

Consulting
Group

PO Box 212785
Columbia, SC 29221
Office: 803-750-7799
Fax: 803-750-0092
Toll Free: 866-750-7799

February 10, 2011

Dr. Mark A. Wolgin
Orthopaedic Associates, Inc.
619 Pointe North Blvd.
Albany, Ga. 31721

RE: Patricia Ann Fore SSN:

Date of Injury: 2/24/08

Medical records indicate that Patricia Fore has a long history of insulin-dependent diabetes before the 2008 injury to the lumbar spine. We are seeking your opinion, within a reasonable degree of medical certainty and based on medical records if diabetes played a part in this injury and treatment.

YES NO

☒ ()

Did patient either have or most probably have diabetes prior to the 2/24/08 of the lumbar spine?

DID THE INJURY

☒ () *the diabetes however may have contrib to her fusion not uniting*
Most probably aggravate or combine with the patient's diabetes?
IF THIS IS THE CASE:

☒ ()

In your opinion, did the fact that your patient had diabetes most probably cause him/her to lose more time from work than he/she would have had from the injury alone?

☒ ()

Probably
Did the fact that your patient had diabetes most probably result in a substantially higher percentage of permanent impairment than he/she would have had from the injury alone?

☒ ()

Have the medical costs related to this injury most probably been substantially increased due to the existence of diabetes?

We would appreciate if you would make a few remarks as to how diabetes may have affected treatment in this claim. Please make comments on attached sheet.

Diagnosis of any other conditions prior to 2/24/08:

Doctor's Signature: MWolgin

Date: 2/21/11

If you have any questions, please contact Wayne Koon of this office. Second Injury Fund # 146237

WELCH

Consulting
Group

PO Box 212785
Columbia, SC 29221
Office: 803-750-7799
Fax: 803-750-0092
Toll Free: 866-750-7799

Additional comments as to how diabetes may have affected the injury and recovery of the 2/14/08 claim to the lumbar spine

I can't say how much each of these factors affected/prevented the healing of her fusion, but

Diabetes
obesity/overweight
Smoking

all contributed to the nonunion.

The pt. is a candidate for revision surgery but is not interested.

We have discussed wt loss & smoking cessation on mult visits.

M Wolyn
MD

2/21/11

12-21-10

PATRICIA FORE

DOB: 01-10-65

S: The patient feels that she is basically the same, not much improvement since her last visit. She has had continued pain mainly on her right side with radiation down to the buttock in the groin area with no numbness or symptoms below the knee on the right. She is taking care of a 3-year-old and has to do relatively frequent bending, lifting and twisting in that regard.

O: Sensory and motor exam intact in both lower extremities. Straight leg raise negative bilaterally.

X-RAYS: Views of the lumbar spine show no evidence of hardware loosening, but difficult to assess whether interbody fusion is occurring.

- A:
1. Status post TLIF, right approach L4 through S1.
 2. History of diabetes, smoking and overweight.

P: I spoke at length with the patient and her husband about the options. We are approaching the 8-month mark, at which we could get a CAT scan to assess the fusion or see if there is another cause of her pain. I am concerned that some of her lifting activities are exacerbating her symptoms, but after our discussion the patient wanted to get the CAT scan of her lumbar spine. It will be up to her whether to proceed with any revision procedure if she is not healed. If she is healed, there may be an option for hardware removal. We also discussed dorsal column stimulator as a treatment option. In the meantime, we have refilled her Vicodin and she will be out of work until further notice. We will see her back after her lumbar CT scan, which will be scheduled for mid 01-11.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson. Fax: (866) 573-8132

11-23-10

DOB: 01-10-65

- S:** Date of surgery: 05-19-10. The patient notes slow improvement. She has pain mainly in her back. She has been trying to do some walking and walking upwards of half a mile, but has had to rest on occasions with those types of activities. The patient is gaining weight, but she contributes that to her diabetes and being on Actos. The patient notes no numbness in her legs. She has gone from one to two Vicodin per day.
- O:** Motor and sensory exam intact in both lower extremities. Straight leg raise negative bilaterally.

IMAGING STUDIES: Views of the lumbar spine notable for no evidence of hardware loosening, but difficult to assess whether fusion is occurring at the L4 through S1 fusion.

- A:**
1. Status post right approach L4 through S1 TLIF.
 2. History of diabetes, smoking and overweight.
 3. Resolved right hip greater trochanteric bursitis.

P: The patient is encouraged to continue to be as active as possible. Walking would pose no risk to her surgery. We will see her back for recheck in 30 days since every time I have made a 2-month appointment the Work Comp carrier has asked her to return in 30 days. In the meantime, we will refill her Vicodin and Ambien. On return visit, we will get AP and lateral views of the lumbar spine. The patient will be off work until further notice.

Mark A. Wolgin, M.D./ctm
cc: Ms. Cathy Nelson. Fax: (866) 573-8132

10-19-10

PATRICIA FORE

DOB: 01-10-65

S: Date of surgery: 05-19-10. The patient noted about 3:00 in the morning severe pain which was intolerable. The only difference in her activity was that she tried sleeping on a bed for the first time. The pain was severe involving her right flank going to the right hip and going around to the groin area. No radiating pain or numbness to the legs. The patient cannot recall any trauma that caused her symptoms. No problem with bowel or bladder control. She has not been increasing her pain medications recently, taking between one or two Norco per day.

O: The patient has tenderness over the posterior lumbar region on the right and also over the greater trochanteric region, but no irritability of the hips is noted. Motor and sensory exam intact in both lower extremities.

X-RAYS: Views of the lumbar spine show no evidence of hardware loosening or change of position of the interbody spacers.

- A:
1. Status post TLIF, right approach L4 through S1.
 2. Greater trochanteric bursitis, right side.
 3. History of diabetes, smoking and overweight.

DISCUSSION: The patient has quit smoking as of about 10 days ago.

P: The patient noted that her trochanteric bursa was hurting and it felt like it did before she had her trochanteric injection. She wanted to have that injection repeated.

Following informed consent and with local anesthesia with ethyl chloride and Betadine prep, the trochanteric region on the right was injected with a mixture of 9 cc of Lidocaine and 1 cc of Depo-Medrol. The patient had complete relief of her hip pain and her back pain was even better to some degree, but still was present when she was getting herself off the exam table.

The patient already has an appointment for next month. She should return sooner if needed. We will refill her Norco since she is here now, although she does not particularly need it at this point but will not have to come back for a refill in a week or two. We will also give her some Ambien for help with sleeping and on return I would like AP and lateral views of the lumbar spine.

The patient has been through a course of therapy for a month without much relief. We will hold off before ordering any further therapy at this time.

Mark A. Wolgin, M.D./ctm
cc: Ms. Cathy Nelson. Fax: (866) 573-8132

09-30-10

PATRICIA FORE

DOB: 01-10-65

S: Date of surgery: 05-19-10. The patient has noted some episodes in the last 2 weeks where with coughing or sneezing the patient has gone down to her knees due to severe pain in her back which occurs suddenly. She has no numbness in her legs. She is able to continue with her work which is 3 hours per day 3 days per week helping in an office setting.

O: There is some mild tenderness more on the right than the left in the lumbosacral region, but no spasm is noted. Motor and sensory exam intact in both lower extremities.

X-RAYS: Views of the lumbar spine show no evidence of hardware loosening or lytic change around the interbody spacers.

A: 1. Status post TLIF, right approach L4 through S1.
2. Resolved right greater trochanteric bursitis.
3. History of diabetes, smoking and overweight.

P: The patient I feel is having her symptoms due to the sudden stress on her surgery from the Valsalva type maneuver of a cough or sneeze, but I do not feel there is any particular danger to her surgical progress. I recommend that when she feels those sensations coming on that she brace herself so that she does not potentially fall, but I think she will likely continue to improve. We will refill her Norco 7.5/325 and encouraged smoking cessation. We will see her back for recheck in 2 months with AP and lateral views of the lumbar spine, sooner if needed. If her symptoms are continuing, I would consider CT scan at the 8-month postop mark.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson. Fax: (866) 573-8132

08-27-10

PATRICIA FORE

DOB: 01-10-65

S: Date of surgery: 05-19-10. The patient has noted in the last night that she has actually felt a bit better and has been able to sleep on her bed. She has had some gradual improvement in the last 2 weeks. She was interested in possibly pursuing some type of sit-down work. She is taking one or two Vicodin per day, mainly to help her sleep.

O: The patient has some mild tenderness at the superior aspect of her right greater trochanteric region. Otherwise, motor and sensory exam intact in both lower extremities. Straight leg raise negative bilaterally.

X-RAYS: Views of the lumbar spine show good position of the L4 through S1 hardware with no evidence of hardware cutout and there is a suggestion of some calcification occurring at the 4-5 level. S-1 difficult to see due to overlapping iliac wings.

A: 1. Status post TLIF, L4 through S1 right approach.
2. Right greater trochanteric bursitis.
3. History of diabetes, smoking and overweight.

P: I had met with the Work Comp nurse, Cathy Nelson, on 08-20-10 who was asking about this case and whether the patient could be referred to therapy. I feel the patient could be referred at this point and we will fill out the forms in that regard. Also, the patient was given a note that she could do limited work if available, mainly sedentary work with the avoidance of bending, lifting or twisting and a 5-10 pound weightlifting limit. Recommend continue with bone growth stimulator. We will see the patient back in 6 weeks, sooner if her condition worsens. If the tenderness over her hip becomes worse, she could return sooner for another trochanteric injection.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson. Fax: (866) 573-8132

08-20-10

PATRICIA FORE

DOB: 01-10-65

Cathy Nelson is seen regarding this case. Ms. Nelson was asking about whether the patient would benefit from a therapy program to, if nothing else, be sure that she is progressing and showing adequate effort. I did not have any objection to that, but in our discussion we weighed the possibility of calling the patient to start her in therapy now versus waiting until the next appointment and decided that we would discuss it at the patient's next visit. The patient certainly would need to be reevaluated sooner if her condition worsened. Otherwise, I think that it would be appropriate to start a formal therapy program at our next meeting.

Mark A. Wolgin, M.D./ctm
cc: Ms. Cathy Nelson. Fax: (866) 573-8132

07-20-10

PATRICIA FORE

DOB: 01-10-65

S: Date of surgery: 05-19-10. The patient feels better after her right trochanteric injection. She is getting by with two Vicodin per day. She is still unable to lay down in a bed. She tried some swimming, but with kicking her legs had more pain.

O: The patient has some mild tenderness over the greater trochanteric area on the right hip and just anterior and superior to it, but no frank irritability noted. Mild bilateral lower extremity edema noted.

X-RAYS: Views of the lumbar spine show good position of the hardware and some evidence of healing, especially at the 4-5 level.

- A:**
1. Status post TLIF, L4 through S1 right approach.
 2. Greater trochanteric bursitis, right side.
 3. History of diabetes.

DISCUSSION: The patient has had improvement of her leg pain, but still has significant back pain.

P: Recommend that she begin weaning herself out of her brace over the next month. She should continue with swimming exercises, especially if she has ability to advance her activities slowly. Also, any other general conditioning would be helpful for her. We will refill her Vicodin and see her back in 2 months, sooner if needed, with AP and lateral views of the lumbar spine. The patient will be unable to work until further notice.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson. Fax: (866) 299-9455

06-22-10

PATRICIA FORE

DOB: 01-10-65

S: Date of surgery: 05-19-10. The patient notes that she has been worse in the last few days. She cannot recall any specific trauma, but has had pain radiating from her hip to her groin area on the right side. She has difficulty with flexing up her hip as well. No numbness in the feet. She was on Duragesic patch for a time and is off, but is going through the hydrocodone at more than 3 pills per day.

O: No irritability of the hips is noted. The lumbar wounds are well healed. No focal tenderness in that area. Sensory and motor exam intact in both lower extremities. Straight leg raise negative bilaterally. However, the patient has pain reproduced by palpating the superior aspect of her greater trochanteric bursa on the right and palpating that area reproduces the pain in the groin.

X-RAYS: Views of the lumbar spine show good position on the AP and lateral views of the hardware L4 through S1 with the right-sided fusion.

- A:
1. Status post right-approach TLIF, L4 through S1.
 2. Probable greater trochanteric bursitis, right hip.
 3. Increasing pain.
 4. History of diabetes.

P: After discussion of the options with the patient, we decided to try a trochanteric injection. Following obtaining verbal consent and with local prep with Betadine and local anesthesia with ethyl chloride, the trochanteric region in the superior aspect was injected with a mixture of 9 cc of Lidocaine and 1 cc of Depo-Medrol. The patient noted significant relief of her pain and even had relief of the groin discomfort as well. She was walking with a stick before, but was able to walk without it. We will see the patient back for recheck in one month with AP and lateral views of the lumbar spine and could consider repeating her hip injection at that time.

We were able to visit with Cathy Nelson after the patient left to review some of the patient's history and highlighted that we are anticipating possible entrance into a physical therapy program at about the three-month postop mark and the patient will be off work at least until her next visit in a month. Also, the details of the trochanteric injection were described. The patient will potentially be considered for maximal medical improvement status at the 6-12 month postoperative mark.

Mark A. Wolgin, M.D./ctm
cc: Ms. Cathy Nelson. Fax: (866) 299-9455

05-27-10

PATRICIA FORE

DOB: 01-10-65

S: Date of surgery: 05-19-10. The patient has noted some improvement in the right leg numbness. However, she notes a numbing ache that goes down her right thigh and goes down the right leg to above the ankle. She has no fever or chills. She did have to have her Duragesic patch increased to the 50 mcg dose to get adequate relief. She notes that dose has helped her better.

O: The wounds show good healing in the lumbar spine. The patient is able to demonstrate heel walk and toe walk and grossly motor and sensory exam intact throughout.

X-RAYS: Views of the lumbar spine show good position of the L4 through S1 hardware.

A: Status post right approach L4 through S1 TLIF.

P: Per her request, the patient is given a one-time dose of Soma to help with any kind of spasm feelings in her back. We discussed hopefully getting her down to the 25 mcg dose at some point. We will see her back for recheck in 6 weeks. If she needs a refill of her medications, I asked her to let us know with a few day's notice before she is out of the medicines. On return, would like AP and lateral views of the lumbar spine. She should wear her brace when up for more than 5 minutes until I see her back for the 6-week follow up. Smoking cessation encouraged. The patient is off work until further notice.

Mark A. Wolgin, M.D./ctm

MAY 1 / 2010

05-06-10

PATRICIA FORE

DOB: 01-10-65

The patient had a history and physical dictated on the Phoebe dictation line, work #5636 for surgery on 05-12-10. The patient will be seen back the week of 05-24-10. She and I discussed the nature of her surgery, which will be a right approach L4 through S1 TLIF with the understanding that surgery results cannot be guaranteed, but I do feel that she is a good candidate for the above-mentioned procedure.

The patient will be given a refill of her Vicodin. Also, smoking cessation was encouraged.

ADDENDUM: We will check with Becky in our office to see if the chairback brace has been ordered. Also, since the patient is having a multilevel fusion and is a smoker I will order a bone stimulator as well.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson, field case manager. Fax: (770) 755-5054

05/13/10 16:30
05/05/2010 20:56

COVENTRY HEALTH
2299833496

7707555054

P.
ORTHOPAEDIC ASSOCIAT

PAGE 02/02

709-659592

ORTHOPAEDIC ASSOCIATES

T. GLENN WILLIAMS, M.D.
DEA AW3178000 GA
GA License 11518

THOMAS M. GARDEN, M.D.
DEA BD1844201 GA
GA License 035846

PAUL A. MICHAEL, M.D.
DEA BW778873 GA
GA License 041172

JAMES S. MASON, D.O.
DEA BA2663015 GA
GA License 027887

MARK A. WOLSON, M.D.
DEA BW1155147
GA License 057862

P.O. BOX 407 • 619 PONTIAC NORTH BLVD. • ALBANY, GEORGIA 31721 • PHONE 229-883-4707

Name Patricia Fore Date 5-5-10

Surgery Date 5-12-10
Hospital Phoebe Putney Hospital
Raised Toilet
Walker M Walker
Home nursing for dressing changes

M.D.

Non Refill

Refill 1 2 3 - PPM - ☐ LABEL ☐ WORKMAN COMP.

4 2000 (07/18/2000) PA

PAGE 81/81



ORTHOPAEDIC ASSOCIATES

619 Pointe North Blvd.
Albany, GA 31721
Ph: 229-883-4737
Fax: 225-435-1038

T. GLENN WILLIAMS, M.D.
THOMAS M. DARDEN, M.D.
PAUL A. MICHAEL, M.D.
JAMES S. MASON, D.O.
MARK A. WOLGIN, M.D.

REFERRAL ORDER

PATIENT NAME: Patricia Fore

DATE: 4/16/10

DOCTOR:

PHONE #:

ADDRESS:

DATE OF APPOINTMENT:

REASON FOR REFERRAL: psychosocial evaluation + discography + controls

DIAGNOSIS: 722.52, 724.2

Levels L4-5, L5-5

PHYSICIAN SIGNATURE _____

COVENTRYHEAL
2294349828

05/13/10 16:30
08:33 (08-2008 FTM)

CHARTIS-ADP29 MAR 12 2010

3/11/10
FAKED TO HAWAII

03-02-10

PATRICIA FORE

DOB: 01-10-65

(704) 553-5200
70965952 ✓

- S: The patient is here to discuss surgical treatment. The patient has felt that her pain is worse in the morning and almost tolerable during the day, but then worse in the evenings. She has pain in her right low back and down the right leg to the knee with no radiating pain to the feet. The patient has noted that if she bends over it is hard to get back up. She is trying to cut down her smoking and is down to 3/4 pack per day from over 2 packs per day.
- O: Motor and sensory exam intact in both lower extremities. Straight leg raise negative bilaterally.

IMAGING STUDIES: New MRI is reviewed from 02-25-10 notable for disk desiccation and a broad-based disk bulge at the 4-5 level with evidence of stenosis at that level and slightly increased facet fluid levels indicating potential disk instability. Also, the patient has facet arthrosis and disk degeneration at the L5-S1 level, worse on the right than the left.

- A:
1. History of industrial lifting injury.
 2. Spinal stenosis, L4-5 with broad-based disk bulge.
 3. Potential instability, L4-5 with facet effusions.
 4. Facet degeneration L5-S1 with right greater than left lower extremity radiculitis.
 5. Smoking history.
 6. Overweight.
- P: The patient and I spoke at length about the options. We discussed also whether she would like to try any type of injection therapy, more limited surgery or facet injections. The patient felt that she wanted to be aggressive and go ahead and have the definitive surgery and not do anything that would not give her any type of permanent effect. I advised her that we could not guarantee the result of surgery, but I think the patient would be a candidate for a two-level transforaminal lumbar interbody fusion if the patient wanted to move in that direction. She was very clear that she did not want to do anything except that treatment.

In the meantime, we will refill her Mobic and Vicodin. I again advised her about the importance of smoking cessation. We will order a bone growth stimulator for her as well as the chairback brace. The weight loss would be helpful, but it is hard to lose weight when her back is hurting. We will see her back for a preop once authorization is given. She will be out of work until further notice. 30 minutes spent with the patient. On her return visit, I would like AP and lateral lumbar spine views.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson, field case manager. Fax: (770) 755-5054

FEB 19 2010

02-02-10

PATRICIA FORE

DOB: 01-10-65

- S:** The patient was last seen in 04-09, but it has taken up until now for her to find an attorney and get her legal case settled so that the injury is covered by the Work Comp carrier. She has now reached that point. She notes that her pain has been essentially the same or worse with pain from her low back down her right leg to about just below the knee with no associated numbness. The patient notes some relief with walking, but if she is in a standing position and leans forward slightly, she has significant pain when she stands up again. She has had no bowel or bladder incontinence. She is trying to control her pain with Tramadol and Flexeril. She has been through a course of physical therapy several months ago, but has not had any epidural injections.
- O:** The patient is able to demonstrate heel and toe walk, but with more discomfort on the right than the left. She has no focal tenderness or spasm in the lumbar spine. She has a positive straight leg raise on the right with reproduction of pain down to the medial calf and a cross-positive straight leg raise with elevation of the left leg causing right posterior buttock pain.

IMAGING STUDIES: MRI films reviewed from study date 09-08, which was notable for facet arthrosis at the 5-1 level and disk degeneration at 4-5 with slightly increased facet effusions. On that study, the patient had no significant foraminal stenosis.

- A:**
1. Status post lifting injury in industrial setting.
 2. History of low back pain, chronic.
 3. Right lower extremity radiculitis.
 4. History of diabetes and overweight.
- P:** The patient and I spoke at length about her options. Since her MRI is so old and since her symptoms have changed, I would like to get a new lumbar spine MRI. On return visit, I would also like AP and lateral views of the lumbar spine. We will order for the patient some Relafen and Vicodin to see if that can help her symptoms, but as I am seeing her at this time, it is past business hours and we will not be able to see if we can get that medication for her until tomorrow. We will see her back after her lumbar spine MRI is available for review and we will decide how to proceed. The patient is interested in moving in whatever direction would help her feel better since she has had this pain for so long. On return visit, I would like AP and lateral views of the lumbar spine and lateral flexion-extension views.

Mark A. Wolgin, M.D./ctm

02-02-10

PATRICIA FORE

DOB: 01-10-64

The patient is seen with Ms. Cathy Nelson. We discussed the overall picture of this patient's clinical course. The fact that she has had conservative treatment and her symptoms have continued, we discussed whether the patient would be at MMI at some point and also what the treatment plan would be after the upcoming MRI. Also, there was concern because the MRI reports noted severity qualifiers as "mild", as opposed to moderate or severe with regard to her low back findings and how these would relate to any potential indication for surgery.

We agreed that I would defer any further opinions until after I see the new MRI since her previous MRI was approximately a year and a half old, but the patient does have evidence of need for potential operative intervention including facet arthrosis at the 5-1 level and disk degeneration at the 4-5 level. Epidural injections might be an option. The patient did note that she has recently gone through therapy and we will see how her medication regimen works. The fact that the patient is a diabetic would not be a deterrent to proceeding with surgery per se, but we would need to watch out for infection more rigorously in view of the patient's diabetes condition.

Mark A. Wolgin, M.D./ctm

cc: Ms. Cathy Nelson, RN. Fax: (770) 755-5054

04/22/2009 23:29

2294351038

ORTHOPAEDIC ASSO

PAGE 01/02

04-17-09

PATRICIA A. FORE

DOB: 01-10-65

S: The patient has been through physical therapy. However, she feels that there has been minimal relief. She is still having pain that is about 50/50 back and leg with radiating pain from her posterior hip region on the right down to the anterior thigh and also to the anterior leg, previously down to the foot, but now down to the ankle region.

The patient has also noted some trouble with getting approval for medical care since she has had questioned whether this condition is related to her workplace setting.

O: The patient's gait is with mild antalgia favoring the right side. She has some tenderness in the low back region at the lumbosacral junction, more on the right than the left. There is very slight irritability of the hip on the right side with rotation, but the pain is referred to the posterior buttock region and not to the groin. No irritability on the left hip. Motor and sensory exam intact in both lower extremities objectively, but with subjective numbness in the lateral thigh and anterior knee region on the right, negative on the left. The straight leg raise reproduces a pulling feeling on the posterior thigh on the right, negative on the left.

IMAGING STUDIES: MRI reviewed from 09-19-08, findings are notable for normal segment at the L3-4 level. At the L4-5 level, there is a broad-based disk bulge with increased fluid in the joint, possibly consistent with instability and a small amount of foraminal narrowing, more on the right than the left. At the S-1 level, there is a mild-to-moderate amount of facet arthrosis, but the disk hydration is fairly well-maintained, but has lost some of its height.

- A:
1. Status post lifting injury in workplace setting.
 2. Chronic low back pain.
 3. Right lower extremity radiculitis.
 4. History of diabetes.
 5. History of overweight.

DISCUSSION: With regard to causation, my opinion is that to a reasonable degree of medical certainty that this patient's condition developed from her workplace exposure based on her history to me. The patient notes that she was carrying a chunk of meat which weighed between 50 and 60 pounds and she wound up backing into a stationary machine and before that event, she did not have any pain in her back or leg. After that, she has had these chronic symptoms and is even at the point of considering surgery. The patient has told me that her claim was approved for her hip, but not for her back. Clearly, in my opinion her condition is due to her back and very often there is an overlap between hip and back, such as with the shoulder and neck. Furthermore, an x-ray was taken of her hip on 09-16-08 and was not indicative of any more than degenerative changes, which would be normal for age and were not consistent with a hip injury. The views of the patient's lumbar spine did show some degenerative change at L4-5 and L5-S1.

Therefore, to summarize my opinion is that this problem is due to her back, not due to her hip.

04/22/2009 23:29

2294351838

ORTHOPAEDIC ASSO

PAGE 02/02

04-17-09

Page 2

PATRICIA FORE

DOB: 01-10-65

P: At this point, the patient can continue with trunk strengthening. Weight loss is encouraged. She is under the care of Dr. Moree who has felt that epidurals would be of little value. My concern is that she has instability and pain generation from the L4-5 segment. If she were to proceed with surgery, I would probably recommend at least a 1-level fusion of L4-5, possibly to include L5-S1 also due to the facet arthrosis at that level. The patient would need to decide if she wanted to move in the surgical direction or continue with more therapy and weight loss. Otherwise, she can continue with Tramadol, Ultram and Lodine and trunk strengthening.

For follow up, I will let the patient call for her next appointment since our hands are tied until she has some approval to move in a more aggressive direction. 30 minutes spent with the patient.

Mark A. Wolgin, M.D./ctm

cc: Mr. Stephen Samuels. Fax: (803) 779-4004

18/17/2008 08:19 2294351038

ORTHOPAEDIC ASSO

PAGE 04/25

09-23-08

PATRICIA FORE

6475

Ms. Fore presents for follow up of the MRI of her lumbar spine and right hip. Her MRI's are reviewed and I would concur with the report of the lumbar spine by Dr. Royden Daniels that there are some mild degenerative disc and facet changes in the lower lumbar spine and an L4-5 right neuroforaminal focal disc protrusion. The patient does have right leg pain. Also, the MRI of the hip read by Dr. Eaton is normal and I would concur with that report.

Today, I advised her of these findings and recommended a trial of physical therapy, directed primarily at degenerative disc disease and a bulging disc. I have placed her on Voltaren 75 mg 1 p.o. b.i.d. with food. We will see her back in 5 weeks to check her progress, hopefully she will recover quite nicely.

DIAGNOSIS: 722.52, 724.3

James S. Mason, D.O./ctm

10/13/2008 22:20 2234351038

ORTHOPAEDIC ASSO

PAGE 05/07

09-16-08

PATRICIA FORE

6475

S: Ms. Fore is a 43-year-old white female who was at work in South Carolina on 02-24-08 when she hit her right hip on the corner of a band saw. She was later seen in the emergency room, later referred to a specialist and had an injection to her hip, but never improved. Over the past 7 months, she has had persistent right hip pain with radiation from the buttock region and lateral aspect of the hip all the way down the right leg. She denies any loss of bowel or bladder control. She denies any other injuries or any other treatment, other than injection, home physical therapy and medications.

PAST MEDICAL HISTORY: Significant for hypertension and diabetes mellitus.

PREVIOUS SURGERIES: Significant for Cesarean section x 2.

CURRENT MEDICATIONS: Lantus, NovoLog and Tramadol.

ALLERGIES: PENICILLIN.

FAMILY HISTORY: Significant for diabetes mellitus.

SOCIAL HISTORY: The patient admits to tobacco use, a half-pack of cigarettes per day and denies use of ethanol. Marital status: Married. Education: Associate's degree in Business Management. Occupation: Meat cutter. Current employer: None.

REVIEW OF SYSTEMS is present in the chart and has been reviewed.

O: The patient is a mildly obese white female in no acute distress. She is alert, cooperative and oriented x 3 and appears to have a normal mood and affect. Examination of the right hip reveals tenderness to the greater trochanteric region, limited range of motion, a positive Faber test, negative heel tap test and a negative log roll test. There is a positive straight leg raise sign for leg pain, right-sided paravertebral muscular tenderness, no specific spasm and fair range of motion to the lumbar spine.

Examination of both lower extremities reveals deep tendon reflexes bilaterally symmetric at 2/4 at the Achilles tendon and patellar tendon stations. Muscle strength and tone bilaterally equal at 4+/5 all lower extremity muscle groups. Distal sensation grossly normal. The patient ambulates with a mild limp.

RADIOGRAPHS of the lumbar spine reveal some minimal degenerative change and disc space narrowing at L5-S1, which is very mild. Radiographs of the hip do not reveal any fractures, dislocations or other osseous abnormalities.

- A:
1. Low back pain.
 2. Sciatica.
 3. Hip pain.
 4. Trochanteric bursitis.

10/17/2008 03:19 2294351038

ORTHOPAEDIC ASSO

PAGE 03/25

09-16-08

PATRICIA FORE

6475

Page 2

P: The patient has had a Worker's Comp injury, now 7 months out. It has not improved and I have recommended that we proceed with MRI of both the lumbar spine and the right hip to rule out any severe underlying, acute process which has not been totally evaluated to date. If that test is normal, then we would proceed with probably some minimal therapy and rating in the near future, if that test is positive for significant Worker's Comp injuries. Certainly, that should be addressed at this time.

DIAGNOSIS: 724.3, 724.2, 726.5, 719.45

James S. Mason, D.O./ctm
cc: Worker's Compensation

1-21-02

Patricia Fore

DOB: 1-10-65

S: She is in for re-evaluation of her left little finger. She states that it no longer hurts.

O: She has full range of motion. No tenderness is noted. No swelling. No contracture.

A&P: I explained to her that she was not completely out of the woods as far as a boutonniere deformity was concerned. Should it start sagging down, she should please come to see us. She was dismissed to return to regular work. Work status: regular.

T. G. Williams, M.D./jp

12-27-01

Pat Fore

DOB: 1-10-65

- S: She is a 36-year-old female who sustained an injury of her left ring finger on 12-27-01. The patient states that she was trying to line up a lead lined door at Phoebe Putney Memorial Hospital while working for Alcon. She states that she snatched on it. She reports that it felt better following this. Splint was applied at her work, and she is in for evaluation.

PAST MEDICAL HISTORY: She is allergic to penicillin. She is on no medication. She has had no significant injuries and has never been hospitalized. The patient has been told that she has diabetes.

FAMILY HISTORY: Father died of a blood clot on the brain, and her mother died of renal failure. Family history is positive for diabetes.

SOCIAL HISTORY: She is married. She completed high school and 2 years of college. The patient smokes cigarettes and occasionally consumes alcohol. She is a construction worker for Alcon. She has not missed any work.

REVIEW OF SYSTEMS: Completely unremarkable.

- O: She is a pleasant, well-developed, well-nourished, middle-aged female. Examination of her left hand revealed some swelling and tenderness about the PIP joint. She has good sensation to pin prick and has good capillary filling. Tenderness is noted along both the lateral and medial sides of the PIP joint, but no instability could be detected. X-rays were obtained. No bony abnormality was noted.

A&P: I felt that she may have injured the central slip, which would produce a boutonniere deformity. Aluminum foam splint was fashioned with her PIP joint in full extension and 30° of flexion of the DIP joint. She will check again with us in 1 week.

T. G. Williams, M.D./jp

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
4000 HWY. 9 EAST
LITTLE RIVER, SOUTH CAROLINA 29566

PATIENT NAME: FORE, PATRICIA A
MEDICAL RECORD NUMBER: Z149984
ACCOUNT NUMBER: Y0317479
ATTEN. PHY.: MEACHER, DAVID B MD
AGE: 43Y

ADMISSION DATE: 02/24/2008
DISCHARGE DATE:
ROOM NUMBER:
LOCATION: SM CER
DICTATING PHYSICIAN: David Meacher, MD
DICTATING DATE/TIME: 02/24/2008 11:07:37

EMERGENCY ROOM EVALUATION

1050: 43-year-old white female with history of insulin-dependent diabetes arrives ambulatory describing pain in her lateral right hip and thigh with a "Charley horse type muscle pain" radiating to her lower leg today. Patient recalls turning and accidentally hitting the lateral aspect of her right hip against a table saw February 21, 2008. No fall or other injury. Table saw did not contact her distal thigh, knee, or lower leg. Patient was able to continue working that day and yesterday. Patient experienced some soreness localized to her right lower extremity.

Past medical history: Insulin-dependent diabetes.

Social History: Smoker.

Vital Signs: Blood pressure: 157/88. Pulse: 94. Respirations: 18. Oral temperature: 98.8. Oxygen saturation: 98%.

Physical Exam: Alert, very talkative, well-developed white female who appears in no acute distress.

Right hip, thigh, knee, lower leg: No deformity. No discoloration. No edema. No focal tenderness on palpation. Patient actively and fully extends and flexes right knee without problem. Passive-right hip internal and external rotation without reproducible pain.

Right hip x-ray: No fracture. No dislocation.

Discharge Diagnosis: Lateral of right hip, thigh contusion with distal paresthesias.

Discharge Instructions:

1. Ibuprofen, 800 mg, p.o., t.i.d. p.r.n. pain. Dispense #30.
2. Flexeril, 5 mg, one, p.o., t.i.d. p.r.n. pain. Dispense #30.
3. Vicodin, 5.0/500 mg, 1-2, p.o., q.4-6h. p.r.n. pain not relieved by ibuprofen and Flexeril. Dispense #15.
4. Ice pack to painful tissues for 1 hour periods next several days.
5. Followup: Dr. Ramsbottom, 3 or 4 days, if symptoms not improving.
6. Return if symptoms increase or change.

David Meacher, MD

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
LITTLE RIVER, SOUTH CAROLINA
PATIENT NAME: FORE, PATRICIA A
ACCOUNT NUMBER: Y0317479

cc:

This document has been electronically signed by David Meacher, MD on 02/24/2008 10:53:27.

Lori's Healthcare System

EMERGENCY DEPARTMENT

FORE, PATRICIA A. MEACHER, DAVID E. MO

2149980

02/24/08

01/10/88

Room

6

Labels: <i>Fore, Pectoraria.</i>	Sex: <i>M</i>	Trips/Tons: <i>0953</i>	Date: <i>12/14/75</i>
<i>43</i> Yr: <i>43</i>	Immunization: <i>DOB</i>	Room Temp: <i>100</i>	LAP: <i>NO / LNY / NR</i>
OUT: ☐ Ink: ☐	<i>10/16/75</i>		
Primary Physician: <i>Eam. S. Bottom</i>	Exam Temp: <i>1050</i>	Pregnant: ☐ Yes ☐ No	
		Denies: ☐ Yes ☐ No	
Chief Complaint: <i>Right Calf & Hip, Hurt</i>		Leotating: ☐ NA ☐ No	
		Tetanus: ☐ Unk	
<i>feble pain with hip throu day.</i>		AK: ☐ YL ☐ + 8 yr	
		Weight: ☐ Actual ☐ Lib ☐ Set	

Priority Level:
☒ Non-Urgent ☐ Re-malt
☐ Urgent ☐ Emergency

Mode of Transportation:
☒ ambulatory ☐ carried
☐ wheelchair ☐ stretcher.

Accompanied by:
☐ self ☐ friend
☐ family/spouse ☐ police
☐ parent ☐ EMS

☐ code yellow ☐ NA
 called

JUNE 1964			
Time Received	Received by	Ref.	Page No.
Condition Code:	Comment:		
1 2 3 4			
B/P	Pulse	Resp.	SpO2

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1125	146	87	88	18	—	1000

VISUAL ACUITY		☒ NA
☒ Acuity	L _____ R _____	☐ Corrected
☐ Blind	L _____ R _____	☐ Pain
☐ Photosensitive		☐ Burning
☐ Unable to see		

SECRET

CBC	Urine Drug Screen	CXR 1 Port
CBCAD	ETOH	CXR Pa/La
BMP	HFP	C-spine/xtable/lateral
CMP	PT/PTT	C-Spine
Blood CBS x's	Trophitin	LS Spine
urine HCG	Amylase	Abd Series
HCG Serum	Sed Rts	Pelvic
ABG	Lipase	CT Head
EKG	Strep Screen Throat	CT Chest
Cardiac Workup	Wet Prep	CT Abd
Trauma Workup	GGCP (Chlamydia/UC)	CT Pelvis
TNK Workup		CT Abd Galle
U/RUC (Papanicolaou & G; indicated)		CT Pelvis Colic
UA		
UC		

O₂ at _____ L per _____

Baseline look	
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Ice Park & Lido
(R) Hip Thigh. (1125) W
R. refused - states "I
can make one at home."

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Nurea

I acknowledge and understand that I have had EMERGENCY / OUT-PATIENT
TREATMENT ONLY and that I may be released before all medical questions are

TREATMENT ONLY WAS THAT I MAY BE RELEASED BEFORE MY MEDICAL PROGRESS IS KNOWN OR UNCLE. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED ABOVE. I ALSO UNDERSTAND THAT X-RAYS OR BLOOD TESTS WILL BE PERFORMED BY A RADIOLOGIST OR INTERNAL

and the EMERGENCY/ OUTPATIENT DEPARTMENT will notify me in case of a change in diagnosis. If for any reason you have difficulty in obtaining information

I UNDERSTAND THE VERBAL AND WRITTEN INSTRUCTIONS I HAVE JUST RECEIVED

PATIENT OR SIGNIFICANT OTHER

X-Termin Fore

TENDING PHYSICIAN SIGNATURE

Date & Time Patient Left Emergency Department: All

PATENT OR SIGNIFICANT OTHER

X-tatin fore

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
4000 HWY 9 EAST
LITTLE RIVER, SC 29566
843-390-8160

PROFESSIONALLY INTERPRETED BY:
CAROLINA RADIOLOGY ASSOCIATES

Name: FORE, RICHIA A
Phys: MEACHER, DAVID E MD
DOB: 01/10/1965 Age: 43 Sex: F
Acct: Y0317479 Loc: EMCER
Status: DEP ER
Radiology No:
Unit No: Z149984
Radiologist: JOHN M RAZOOK, M.D.

REASON FOR EXAM: P - PAIN

OTHER REASON: HIT TABLE SAW ON THURSDAY ER 6

EXAMS: 000675265 RT HIP - COMP MIN 2 VIEWS

DATE: 02/24/2008

RIGHT HIP COMPLETE 2/24/2008

INDICATION: PAIN AND SORENESS, LATERAL HIP.

FINDINGS: AP pelvis, AP and frogleg views of the right hip were obtained. Bone density is within the range of normal. Hip joints are symmetric and the femoral heads are smooth in contour. No evidence of fracture, dislocation, or bony destruction.

Bilateral tubal ligation clips are noted.

There are tiny phleboliths within the left true pelvis.

IMPRESSION:

1. UNREMARKABLE RIGHT HIP.

A

John M. Razook, MD
Electronic Signature
2008-02-25 16:11:16.387000000

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
4000 HWY 9 EAST
LITTLE RIVER, SC 29566
843-390-8160

PROFESSIONALLY INTERPRETED BY:
CAROLINA RADIOLOGY ASSOCIATES

Name: FORD, PATRICIA A.
Phys: MEACHER, DAVID E. MD
DOB: 01/10/1965 Age: 43 Sex: F
Adct: Y0327479 Loc: SMCER
Status: DEP ER
Radiology No:
Unit No: Z149984
Radiologist: JOHN M RAZOOK, M.D.

REASON FOR EXAM: P - PAIN

OTHER REASON: HIT TABLE SAW ON THURSDAY ER 6

EXAMS: 000675265 RT HIP - COMP MIN 2 VIEWS

DATE: 02/24/2008

<Continued>

DD: 02/24/2008/DT: 02/24/2008

Reported By: JOHN M RAZOOK, M.D.

CC: J GARNETT RAMSBOTTOM JR

Technologist: SUE BELSKI, RT(R)

Transcribed Date/Time: 02/24/2008 (2048)

Transcriptionist: RAD.AVRREO

Printed Date/Time: 02/25/2008 (1642)

PAGE 2

CHART COPY

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
4000 HWY 9 EAST
LITTLE RIVER, SOUTH CAROLINA 29556

PATIENT NAME: FORE, PATRICIA A
MEDICAL RECORD NUMBER: Z149984
ACCOUNT NUMBER: Y0305842
ATTEN: PHY: WRIGHT, JAMES F MD
AGE: 42Y

ADMISSION DATE: 11/30/2007
DISCHARGE DATE: 1
ROOM NUMBER:
LOCATION: SMCR
DICTATING PHYSICIAN: James Wright, MD
DICTATING DATE/TIME: 11/30/2007 19:28:37

EMERGENCY ROOM EVALUATION

Sore near her right eye.

HPI: This patient developed a draining skin abscess in 2 locations on her mons pubis. Subsequent to this she developed a lesion on the right arm and a lesion just to the right of a right orbit. She has been applying warm soaks, she and drained the lesion by her eye and prior to this her eye swollen shut, the swelling is much diminished. She has no fever, no headache to the neck is.

PMH is significant for type 2 diabetes. Allergy to penicillin.
Status post C-section
Current medications include insulin. No herbal alternative medicines
Tobacco use no ethanol or illicit substances
ROS as noted above no other symptoms or complaints.

The patient is alert, verbally responsive in no acute distress.
There is a healing abscess on this can to the right of the orbit on the right side. There is some erythema and mild swelling around the periorbital tissue which appears to be resolving. No pustules, no fluctuant areas, no lymphangitis. There is minimal cervical adenopathy ipsilateral.
There is a similar lesion on the medial aspect of the right arm at the elbow.
There also lesions on the mons pubis which have drained and are healing.
Remainder is negative

Assessment: Skin abscesses, very suspicious for MRSA

RX Septra DS 1 p.o. b.i.d. for 7 days. Recommend continuing warm soaks and periorbital tissue. Follow up with Dr. Ramsbottom. She is given information on MRSA

Any new or worsening symptoms to return to ER for evaluation. His charge stable.
I have advised her on the use of bacteriacidal soaps

James Wright, MD

cc:

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
LITTLE RIVER, SOUTH CAROLINA

PATIENT NAME: FORE, PATRICIA A.
ACCOUNT NUMBER: Y0305142

This document has been electronically signed by James Wright, MD on 11/30/2007 19:15:54.

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
4000 HWY 9 EAST
LITTLE RIVER, SC 29566

PATIENT NAME: FORE, PATRICIA A
MEDICAL RECORD NUMBER: Z149984
ACCOUNT NUMBER: Y0213350
ATTN. PHY.: RUBINTON, PAUL MD

ADMISSION DATE:
DISCHARGE DATE:
ROOM NUMBER:
LOCATION: SMCEP
DICTATING PHY.: RUBINTON, PAUL MD
DICTATING DATE/TIME: 02/06/06 0834

EMERGENCY ROOM EVALUATION

HPI: Pt here for wound recheck to third right finger. Sutures placed Saturday (x8).

ROS: all systems negative otherwise.

PMH: DM

PSH: denies

MEDS: Insulin

ALLERGIES: PCN

PEX: noncontributory.

PE:

Vitals: AVSS

GA: NAD

EXT: sutures in place, no signs of erythema, pus, or gross swelling

A: Wound recheck

P: Pt should f/u with her MD for suture removal, 8-10 days after original placement of sutures.

Paul Rubinton, MD

cc:

LORIS HEALTHCARE SYSTEM
SEACOAST MEDICAL CENTER
4000 HWY 9 EAST
LITTLE RIVER, SOUTH CAROLINA 29566

PATIENT NAME: FORE, PATRICIA A
MEDICAL RECORD NUMBER: Z149984
ACCOUNT NUMBER: Y0213270
ATTEN. PHY.: WRIGHT, JAMES F MD
AGE: 41Y

ADMISSION DATE: 02/04/2006
DISCHARGE DATE: A
ROOM NUMBER:
LOCATION: SMCR
DICTATING PHYSICIAN: James Wright, MD
DICTATING DATE/TIME: 02/04/2006 16:36:29

EMERGENCY ROOM EVALUATION

Laceration to finger.

HPI: Patient cut her right third digit on a meat saw this afternoon.

Past medical history significant for diabetes, status post cystectomy, C-section. NKDA except penicillin.
Last tetanus unknown.

Social history significant tobacco use otherwise unremarkable.

ROS: As above otherwise negative.

Wound has been cleansed with peroxide and a dressing applied.

ROS as above

Vital signs normal, no distress.

There is a skin flap raised on the ulnar aspect of the distal phalanx of the right third digit. 2 mm section of the nail has been avulsed. The bone appears to be intact. Neurovascular is intact otherwise. Parts of the skin do appear pale. Remainder of the physical exam is negative.

Assessment: Laceration right third digit

The area was cleansed with Betadine dilute; a digital nerve block with 0.25% bupivacaine was applied to the digit area and the tissue was debrided sharply. The skin flap was tacked in place with 5-0 interrupted Prolene sutures. Antibiotic ointment and dressing were applied.

Recommend return in 48 hours for wound check. To leave her dressing intact until that time. E-Mycin 333 mg t.i.d. #15; Vicodin ES p.o. q.i.d. p.r.n. pain #15

Suture removal in 7 to 10 days.

Any new or worsening symptoms to return to ED. Discharged stable

James Wright, MD

cc:

This document has been electronically signed by James Wright, MD on 02/04/2006 16:33:51.

AMA
FORE, PATRICIA ANN 05/19/10
1012500363 01/10/85 45Y
05/05/10 WOLGIN, MARK A
9100425

PHOEBE PUTNEY
MEMORIAL HOSPITAL
P.O. BOX 1828 / ALBANY, GEORGIA 31702

Physical Therapy Daily Progress Note

Date: 05/21/10

Morning Time: 8:25-8:50

Co-treat with ☐OT ☐COTA

Pain Scale: ☐Nsg. Notified ☒Not rated but consented ☐No complaints ☐Pt unable to rate 2°

Nsg already administered pain meds

Subjective: "I would rather be at home." "This hurts so much"

Rolling L→R: Supine→Sit: med/mir Sit→Stand: min/2 Sit pivot: Stand pivot: SBA

Gait training: ☐Gait belt intact Weight bearing status: Full Distance: 100' Device: RW Assistance: SBA

Surface: ☒Level ☐Unlevel ☐Stairs : with assist

Treatment:

Supine. Sitting in BS chair. Patient given max @ to down back brace and given instruction on how to apply. Gait training on alone focusing on endurance and balance. Patient then transfers BTB. Supine→sit completed 4 reps as patient educated on log-roll technique. At left supine upon comfort.

☐Nsg. Notified ☒Pt left with needs in reach ☐Progress discussed with PT

Goals met (#):

Assessment:

Patient with max c/o pain in back throughout treatment.

Patient completes tasks within tolerance.

Recommendations: ☒Same as eval ☐Other: Home Health

Plan: ☒Cont with plan of care. ☐Reassessment ☐Discharge ☐Other:

Signature/Title: Schneka Seay, PTA 02244

Afternoon Time:

Co-treat with ☐OT ☐COTA

Pain Scale: ☐Nsg. Notified ☐Not rated but consented ☐No complaints ☐Pt unable to rate 2°

Subjective:

Rolling L→R: Supine→Sit: Sit→Stand: Sit pivot: Stand pivot:

Gait training: ☐Gait belt intact Weight bearing status: Distance: Device: Assistance:

Surface: ☐Level ☐Unlevel ☐Stairs : with assist

Treatment:

☐Nsg. Notified ☐Pt left with needs in reach ☐Progress discussed with PT

Goals met (#):

Assessment:

Recommendations: ☐Same as eval ☐Other:

Plan: ☐Cont with plan of care. ☐Reassessment ☐Discharge ☐Other:

Signature/Title:



AMA
FORE, PATRICIA
1012500363
05/05/10
9100425

05/19/10
WOLGIN, MARK A
01/10/85 45Y

**PHOEBE PUTNEY
MEMORIAL HOSPITAL**
P.O. BOX 1828 / ALBANY, GEORGIA 31702

Occupational Therapy Daily Progress Note

Date: 5/21/10

Time: 8:10-2:40pm

Charge(s): 256

Co-treat with ☐PT ☐OTA

Pain Scale: ☐Nsg. Notified ☐Not rated but consented ☐No complaints ☐Pt unable to rate 2"

Subjective: "I'm ready to go home." ^{just received pycotin.}

ADL's: Grooming: Upper body dressing: Lower body dressing: Upper body bathing:

Lower body bathing: Toileting: SBA Toilet Transfer: SBA using grab bar/RW

Sitting balance: Fair+ Standing balance: Fair

Rolling/Scouting: Supine-->Sit: min (A) Sit-->Stand: CBA from bed Sit pivot: Stand pivot: Gait:

Treatment:
Found supine. Pt. seen by OT for self-care. Re-tx using adaptive equipment to ↓ risk of injury due to bank precautions. Pt. sat edge via log-rolling - required cueing for safety & proper technique. Pt. donned socks using sock-aid with SBA. Pt. donning chairback brace with SBA. Sit-->stand CBA to mobilize to restroom with CBA - educated on safe toilet use. Pt. transitioned on/off toilet with SBA. Pt. then stood to wash hands & sink side of bed using reacher to don undergarments with SBA. Pt. returned supine. Husband present. Brace doffed.

☐Nsg. Notified ☐Pt left with needs in reach ☐Progress discussed with OT

Goals met (#): 1,3,5,6

Equipment Given: Long Handled Bath Sponge

Assessment: It appears too tight - Nsg. notified. Pt. eager to go home - needs cueing for safety.

Recommendations: ☒ Same as eval ☐ Other:

Plan: ☒Cont with plan of care. ☐Reassessment ☐Discharge ☐Other:

Signature/Title: Jason Jennings, OTR/L

AMA 05/19/10 Ord#34 1012500363 9 904-01 9100425
 C FORE, PATRICIA ANN Sex: F S
 I 1012500363 01/10/65 45Y 4P Adm: 05/19/10 Smk: YES O2: I
 L 8100425 WOLGIN, MARK A DOB: 01/10/65 45Y Cnd: I
 Ag: HT: 5'6.0" / 167.6cm Prc: PPTIAL
 Ord'g Phys: WOLGIN, MARK A Wt: 261lbs / 118.200kg Prc: 31701
 Prf'g Phys: Att Phys: WOLGIN, MARK A S
 Transp: PORT Phys Grp: *ORTHOPEDIC ASSOC. I
 Freq: 1 Stop D/T: 05/19/10 05:24P

0175 PHYSICAL THERAPY EVAL AND TREAT

Instructions:

PT CONSULT (BEGIN POST OP DAY 1),
 EVAL / TREAT, WEIGHT BEAR AS
 TOLERATED, BILATERAL LOWER EXTREMITI

Comment:

Physical Therapy Initial Evaluation

Diagnosis: L4-S, Fusion S Date: 5-20-10

History: 65 y old female had injury at work while holding 60 lbs
on something. She has been with back pain + leg pain
pt tried epidural

PMH: C-section, Tubal Clamping, L4-S, transforaminal interbody fusion
DM, HTN, Tobacco Abuse

Precautions: Precautions: ☐ WB status: ☐ Hip ☒ Fall ☐ Contact ☐ DNR ☐ Seizure ☐ Respiratory ☐ Cardiac
☒ Safety ☐ Monitor BP ☐ Monitor SpO₂ ☐ Other:

Social/Home Setup: ☐ lives alone ☒ with spouse in a 1 story ☒ #steps 3 handrails yes ☐ ramp
 # of children other:

Prior Level of Function: ☒ Independent in ADLs ☒ Independent in gait ☐ requires assistance with:
with pain

DME owned: ☐ none ☐ straight cane ☐ quad cane ☐ wheelchair ☐ standard walker ☐ rolling walker ☐ shower chair ☐ tub bench
☐ BSC ☐ Crutches brace arrived around 10:30am

S: Pain Scale: 0 1 2 3 4 6 7 8 9 10 Location: Back incision site ☐ Unable to Assess ☐ Nsg. notified

O: ☒ Follows multi step commands with 100 % accuracy
☒ Orientation 4/4 ☐ Alertness ☒ Safety/Judgment: good ☐ Vision: glasses ☐ Hearing:
☒ Memory: good ☐ Attention span ☐ Other:

Pt's Goal: go quit hurting
 Other:

ROM		WFL	Limited	Comments:
	RUE	☒	☐	
	LUE	☒	☐	
	RLE	☒	☒	
	LLE	☒	☒	<u>pain at hip when pt sat on Recliner</u> <u>with LE elevated</u>

Order Priority: ROUTINE Ord#33 1012500363 9 904-01 9100425 CNEY
 Date/Time Svc: 05/19/10 05:23P FORE, PATRICIA ANN Sex: F SPTIAL
 Dx: AMA/05/12/10 Adm: 05/19/10 Smk: YES O2: IW 31702
 Ag: PENICILLIN DOB: 01/10/65 45Y Cnd: Is
 Ord'g Phys: WOLGIN, MARK A Ht: 5'6.0" / 167.6cm Prc: Pr
 Prf'g Phys: Wt: 261lbs / 118.200kg Prc: Pr
 Transp: PORT Att Phys: WOLGIN, MARK A St
 Freq: 1 Stop D/T: 05/19/10 05:23P Phys Grp: *ORTHOPEDIC ASSOC. ID

0145 OCCUPATIONAL THERAPY ORDER

Instructions:

OT CONSULT, BEGIN ON POST OP DAY 1
 IF NOT PROGRESSING TOWARD ADT.'S

AMA 05/18/10
 FORE, PATRICIA ANN 01/10/65 45Y
 1012500363
 05/05/10 WOLGIN, MARK A
 9100425

Occupational Therapy Initial Evaluation

Diagnosis: DDD

Date: 5/20/10

History: 4 bylo w/Adm 5/19/10 for TLF L4-S1 2° DDD/facet arthrosis

PMHx:

DH, HTN, chronic pain

Precautions: ☐ W/B status: ☐ Hip ☐ Fall ☐ Contact ☐ DNR ☐ Seizure ☐ Respiratory ☐ Cardiac ☐ Safety ☐ Monitor BP
☐ Monitor SpO₂ Other: brace when up

Home Setup: ☐ walk-in shower ☐ One story ☐ Two story ☐ Dramp ☐ Stairs to enter 6 ☐ Handrails R/L B
☐ Other:

Prior Level of Function: ☒ Independent in ADLs ☐ Independent in gait ☐ Requires assistance with:

Social Hx: ☐ Lives alone ☒ Lives with: spouse ☐ Retired # of children 2 ☐ Smoker
☐ Other: 11 & 3 yrs old

DME/ADL Equipment Owned: ☐ Tub/shower bench ☐ Reacher ☐ Shower chair ☐ Quad/ single cane ☐ 3-in-1 commode ☐ Wheelchair
☐ Walker ☐ Power chair ☐ Home oxygen ☐ Nebulizer ☐ Other: none

S: Pt's Goal: "To get moving."

Pain Scale: ☐ NO PAIN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☒ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Location: ☐ Nursing Notified

O: Cognition: ☒ Orientation X4 ☒ Alertness WFL ☒ Ability to follow 1 step commands with 100% accuracy
☒ Memory WFL ☒ Safety WFL ☒ Insight/Judgment WFL ☒ Attention Span WFL ☐ Other:

Communication: ☒ Clear and appropriate ☐ Hard of hearing ☐ Unclear ☐ Other:

Activity Tolerance: ☒ Good ☐ Decreased ☐ Other:

Visual/Perceptual: ☐ Glasses ☐ Legally blind ☐ Other:

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

OPERATIVE REPORT

NAME: FORE, PATRICIA ANN

MR #: 9100425

DOB: 01/10/1965

ROOM NO: 9 904-01

ACCT #012500363

ADMIT: 05/19/2010

SURGEON: MARK WOLGIN, M.D.

SURGICAL DATE:

TYPE: I

05/19/2010

PREOPERATIVE DIAGNOSIS:

1. Discogenic pain with disk degeneration at L4-5 with bilateral facet arthrosis, L5-S1.
2. Right lower extremity radiculitis.

POSTOPERATIVE DIAGNOSIS:

1. Discogenic pain with disk degeneration at L4-5 with bilateral facet arthrosis, L5-S1.
2. Right lower extremity radiculitis.

PROCEDURE:

1. Minimally invasive transforaminal lumbar interbody fusion, right approach, L-4 through S-1.
2. Complete facetectomy, L4-5, L5-S1, right side with decompression of L-4, L5, and S-1 nerve roots.
3. Subtotal discectomy, L4-5, L5-S1.
4. Posterior lumbar interbody fusion, L4-5, L5-S1.
5. Use of Capstone interbody spacers, size 12x26 mm, L4-5, L5-S1.
6. Use of bone morphogenetic protein and autograft, L4-5, L5-S1.
7. Posterolateral fusion, L4-5, L5-S1.
8. Pedicle screw fixation using Sextant pedicle screws by Medtronic.
9. Use of operating microscope.
10. Use of fluoroscopy.
11. Real time neuro monitoring with free running EMGs and screw stimulation and intraoperative stimulated EMGS for screw placement assessment.

SURGEON: Mark Wolgin.

ANESTHESIA: General.

ANESTHETIST: Brock Hatcher, CRNA.

INDICATIONS FOR OPERATION:

A 45 year-old female greater than one year ago sustained a back injury when in an industrial setting. She fell with injury to her back. It took her upwards of a year to even have the work-comp system approve her claim. The patient has had approval for surgery. She has failed to improve with nonoperative care.

FINDINGS AT OPERATION:

There was evidence of facet arthrosis at S-1 on the right. The left side was not examined openly. On the

NAME: FORE, PATRICIA ANN
PHYS: MARK WOLGIN, M.D.
REPORT: OPERATIVE REPORT

L4-5 level the patient had evidence of disk degeneration and desiccation. After the annulotomy was made the surgery was somewhat difficult due to the patient's size and the fact that she had large epidural veins, but no cerebral spinal fluid leak was created. Also of note, on the left side at the S-1 screw when the tap was put in place initially the threshold was 8.5 milliamps which was thought to be too low, and the second placement revealed 8 milliamps and then a third which seemed to be a much more high confidence screw placement, had 9 milliamps, but the screw position was accepted due to the fact that the patient had two other holes in this pedicle. While the S-1 screw was put in place there was no alteration of the free running EMGs of the S-1 nerve root on the left. No complications were noted with the procedure.

PROCEDURE:

Following informed consent the patient was brought into the operating room. General anesthesia was induced. The patient was given Vancomycin 1 gram for antibiotic prophylaxis. After general anesthesia was induced the patient had a Foley catheter placed and sequential compression devices were placed on her calves. The neural monitoring equipment was set up. The patient was turned into the prone position on the Jackson table with the Hall frame, taking care to pad her bony prominences and avoid pressure over the ulnar nerves. The patient had the lumbar region prepped and draped in the usual sterile fashion. The midline was marked out as was 4.5 cm to the right and left. Using lateral fluoroscopic view a needle was introduced parallel to the L5-S1 disk space at the paramedian line on the right side and after the trajectory to the disk was identified an incision about 5 cm in length was made on the right side of that 4.5 cm paramedian line. The dissection was carried down through subcutaneous tissue. Cauterizing bleeders as they were encountered. The dissection extended down to the fascia which was incised in line with the incision. Using the needle from the Medtronic system the needle was docked on the inferior aspect of the L-5 facet and then again with the position confirmed fluoroscopically, dilating tubes were used up to size 26 mm and once the size 8 cm tube was put in place again with position confirmed fluoroscopically the operating microscope was brought in and all the work through the tubes was done with the operating microscope. The patient had a small amount of muscle removed from over the trailing edge of the lamina. The entire facet was exposed as was then pars interarticularis. High speed bur was used to drill away the medial aspect of the lamina and across the pars, saving the drillings for use as autograft. The inferior facet was able to be removed in one piece and the cartilage removed and soft tissue removed, and that piece was morcellized for use as autograft. Cartilage was removed from the superior facet and then the drillings from the superior facet were also saved for autograft. The exiting L-5 and traversing S-1 nerve roots were decompressed. There was a moderate amount of epidural fat and a fair amount of veins which required cautery in order to gain access to the disk, but after this hemostasis was achieved the patient had the disk exposed. Annulotomy was performed with a bayoneted knife. The BMP was mixed up on the sponge while the annulotomy and discectomy was done. Discectomy was done with a combination of pituitary rongeurs, Kerrison rongeurs, curettes, down scraping, and the shavers until subtotal discectomy was performed with bleeding bone on both sides. It was noted that a size 10 would be too loose and therefore the shavers were used from the Medtronic system up to size 11 and 12. A 12x26 implant was able to be chosen. At each level two BMP sponges were used and at each level the sponges were cut in half longitudinally. One half sponge was cut into small pieces and mixed with the drilled bone to form a BMP/drilled bone slurry, and this material was packed into the middle of the spacer. The nerves were held out of place and the Capstone implant was able to be put in place after first putting an additional half sponge on the right and a half sponge on the left in the intervertebral space. The patient had a small amount of autograft fat placed behind the spacer. Care was taken to be sure that there was no nerve injury or cerebral spinal fluid leak. Bleeding was controlled with a small amount of Gelfoam in the interspace for a few moments and then the Gelfoam was removed. The fat was placed behind the capsule spacer, as mentioned. Posterolateral fusion was then done by first putting

NAME: FORE, PATRICIA ANN
PHYS: MARK WOLGIN, M.D.
REPORT: OPERATIVE REPORT

additional fat over the exposed nerve roots and laying the bone slurry, the half sponge of BMP, and the remaining autograft pieces over the posterolateral region, and then the tube was removed. The identical procedure was done at the 4-5 level with the only difference being a slight angulation difference. Otherwise at no level was there any excessive bleeding or cerebral spinal fluid leak created or nerve injury. After the interbody and posterolateral fusion at L4-5 the patient had the tube removed. The operating microscope was removed. Fluoroscopic view was brought in and with AP and lateral views the pedicles at L-4 were able to be identified, and taking care not to breach the medial wall using a Jamshidi needle the pedicles were able to be cannulated starting at the lateral aspect of the facet at the base of the transverse process. After a guide wire was placed in the L-4 pedicles then the view was moved down to S-1 and the S-1 pedicles were somewhat more difficult to visualize even with multiple different views, even though these pedicles are very large. The patient had no problem on the right side placing the wire but on the left the pedicle was a bit more difficult to visualize, even though this was then nonoperative side. The patient had the dilating tubes used and then a tap was used and the tap was stimulated and the findings of the EMG intraoperative stimulation were noted above in the FINDINGS AT OPERATION section. The patient had the screws put in at L-4 and S-1 with 6.5x40 at L-4, 6.5x35 at S-1, and then the screw guide was used for the L-5 screw to help guide the Jamshidi needle and guide wire into the pedicle of L-5. On both sides the screw threshold was acceptable. At L-5 first the right side was done for the screws and then the left side. There was no evidence of any sign of cerebral spinal fluid leak created. AP and lateral fluoroscopic views were used frequently to visualize the pedicles and to follow the screw placement. The patient had the rods placed using the sextant device, the arc, and this was done through a superior stab hole in the region that was still prepped with no contact with any type of rib as the rod was being passed. The patient had verification that the rods were through the screw heads and the nuts were tightened on the end of the rod. All the instruments were removed. AP and lateral fluoroscopic views were taken and the patient had a wet sponge to clean the wound, and then closure was done with #1 Vicryl for the fascia layer, 3-0 Vicryl for the more superficial layer, Mastisol, Steri-Strips, 2x2s, Tegaderm. As of time of dictation the Foley catheter is being left in.

ESTIMATED BLOOD LOSS: 250 cc.

SPECIMENS, COMPLICATIONS, DRAINS: None.

MARK WOLGIN, M.D.

MW:ch

Dictated: 05/19/2010 2:33 P

Transcribed: 05/20/2010 1:32 P

Job ID: 001500294

cc: HANNA A. LIN, M.D.
MARK WOLGIN, M.D.

Signed: Mark Wolgin, MD
05/25/2010 13:23 EDT

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

HISTORY AND PHYSICAL EXAMINATION

NAME: FORE, PATRICIA ANN

MR #: 9100425

ROOM NO:

DOB: 01/10/1965

PHYSICIAN: MARK WOLGIN, M.D.

ACCT #012500363

ADMITTED:

TYPE: A

PREOP HISTORY AND PHYSICAL

DATE OF SURGERY: 5/12/10

PROPOSED SURGERY:

Right approach minimally invasive L4-5, L5-S1 transforaminal lumbar interbody fusion.

HISTORY OF PRESENT ILLNESS:

This patient is a 45 year-old female who was initially seen in February of 2009. Patient at that time had an injury one year previous to that initial visit where she was holding about 60 pounds of some type of item in her work as a meat cutter. She stepped back in an awkward manner and had a twisting injury that affected her low back. The patient felt a pop and has had pain ever since then. The pain is worse with bending and she has had episodes of pain radiating down the right leg to the lateral ankle. She has had no associated numbness. She had no problem with bowel or bladder control. She wound up being seen in the office with MRI from 9/19/08 notable from disc desiccation and bulging at the 4-5 level with stenosis at that level as well as facet arthrosis at the 5-1 level. We discussed her options for treatment. We tried to do some generalized conditioning and weight loss. The patient was also seeing Dr. Moree at that time for pain management. The patient was again seen on 4/17/09 noting that with therapy she is still having about 50-50 back and leg pain. There was some question as to whether the patient's work place exposure caused her condition and it appeared to me that clearly her symptoms were due to her industrial exposure. Patient was continued with epidurals. We were discussing surgery more at that time. We were not able to proceed with any more aggressive treatment due to the Worker's Comp approval process and the fact that her claim was still in litigation.

The patient was seen again in February of this year, it had taken many months in the interim for her to have the case covered by the Work Comp carrier with the assistance of an attorney as her advocate. Patient noted the pain was essentially the same or worse with pain down the right leg to just below the knee with no associated numbness, no bowel or bladder incontinence. We ordered a new MRI and decided to see her back after that study was done. The patient was seen next again on 3/2/10 to discuss surgical treatment. I mentioned to her that the smoking is a problem for potential healing of any type of surgical fusion and she was advised to discontinue that habit but as we discussed also that surgery could not be guaranteed she felt that her current condition was not sustainable and wanted to proceed with operative treatment. The patient finally has had approval for her surgery with the plan for fusion L4 through S1 right sided approach and patient is here now for a preop.

NAME: FORE, PATRICIA ANN
PHYS: MARK WOLGIN, M.D.
REPORT: HISTORY & PHYSICAL

PAST MEDICAL HISTORY:

Illness include:

1. Diabetes.
2. High blood pressure.

PAST SURGICAL HISTORY:

1. Cesarean section times two.

CURRENT MEDICATIONS:

1. Insulin.
2. Vicodin.
3. Tramadol.
4. NovoLog.

ALLERGIES:

1. PENICILLIN causes hives and throat closing, possible anaphylaxis.

FAMILY HISTORY:

Family history positive for diabetes.

SOCIAL HISTORY:

Patient smokes one-half pack per day. She does not drink. She is out of work but previously worked as a meat cutter lifting weights upwards of 80 to 100 pounds for the chunks of meat that she was working on.

REVIEW OF SYSTEMS:

Review of systems is notable for breast masses and diabetes related vision changes.

PHYSICAL EXAMINATION

VITAL SIGNS:

Patient appears her stated height and weight 5 foot 6 inches, 215 pounds.

HEAD/NECK:

Extraocular movements intact. Oropharynx without lesions. Neck:

Trachea midline.

CHEST:

No crepitation.

CARDIAC:

Regular, rate and rhythm.

ABDOMEN:

Mildly protuberant but no guarding.

SPINE:

There is some mild diffuse tenderness in the lumbar region. No spasm noted.

EXTREMITIES:

No focal tenderness in the upper or lower extremities. No muscle asymmetry noted.

NEUROLOGIC:

Motor and sensory exam is intact in both lower extremities. Straight leg raise on the right reproduced back pain and some mild degree of pain on the left. Elevation of the left leg however does not reproduce any back pain. Deep tendon reflexes are 1+ and symmetric at the knee and ankle. Patient demonstrates normal heel and toe walk.

IMAGING STUDIES:

MRI from 2/25/10 notable for disc desiccation and broad base disc bulge at the 4-5 level with central and lateral recess stenosis and also increased fluid levels at that level which indicates some facet instability. Patient also has facet arthrosis and disc degeneration at L5-S1 worse on the right than the left.

NAME: FORE, PATRICIA ANN
PHYS: MARK WOLGIN, M.D.
REPORT: HISTORY & PHYSICAL

ADMISSION DIAGNOSIS:

1. History of a lifting injury in industrial setting.
2. Spinal stenosis L4-5 with broad based disc bulge with potential instability and facet effusions.
3. Facet degenerative and disc degeneration L5-S1, right greater than left.
4. Right greater than left lower extremities radiculitis.
5. History of overweight.
6. History of diabetes.
7. History of smoking.

PLAN:

I advised the patient and her husband on several occasions that although the results of surgery cannot be guaranteed, I feel that she is a candidate for surgical treatment. I feel that she could have her problem addressed with a minimally invasive technique which has been outlined for her along with the risks and alternatives on my web site. She has been through conservative treatment and has had continued pain. She is clear in her desire to proceed with surgery and demonstrates understanding of the risks. The risks are outlined to include but are not limited to bleeding, infection, nerve or blood vessel damage, need for re-operation or problems with anesthesia as well as spine related risks including spinal fluid leak, adjacent organ injury, even paralysis and death. The patient will likely be hospitalized two or three days. Again smoking cessation was encouraged. Patient will be seen back about two weeks after surgery.

MARK WOLGIN, M.D.

MW: fsm

Dictated: 05/06/2010 2:59 P

Transcribed: 05/06/2010 3:22 P

Job ID: 001495636

cc: HANNA A. LIN, M.D.

MARK WOLGIN, M.D.

CATHY NELSON, Field Case Manager

Fax: 770 755-5054

Signed: Mark Wolgin, MD
05/07/2010 18:17 EDT

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

DISCHARGE SUMMARY

NAME: FORE, PATRICIA ANN

MR #: 9100425

DOB: 01/10/1965

ACCT #012500363

ADM: 05/19/2010

DISCHARGE: 05/21/2010

PHYSICIAN: MARK WOLGIN, M.D.

PROCEDURE PERFORMED:

Right approach minimally invasive L4-5, L5-S1 transforaminal lumbar interbody fusion.

HOSPITAL COURSE:

The patient was admitted following the above-mentioned surgery. She was kept on PCA and kept the Foley in until the midday the first day after surgery. The night of the first day she was started on Duragesic patch 25 mcg which helped her pain to a point where she felt able to walk better. Her wounds had been without evidence of infection. She remains neurologically intact. She is cleared for discharge with the advise to wear her brace when out of bed. The brace felt a bit tight on her, but that is probably because she has been a little bit swollen in the abdomen likely from inactivity. The patient's brace was the same one that she wore and for which she was fitted preoperatively, but was back at our office during a brief period when there was question as to whether the work compensation carrier would authorize dispensing the brace. Otherwise, the patient was given a prescription for Percocet 5/325 one to 2 p.o. b.i.d. p.r.n., #50 tablets and Duragesic patch 25 mcg apply 1 every 72 hours, #10 patches. The patient has a followup appointment arranged for the first week in June. The patient is advised about wound care and shower care trying to keep the dressings dry until there is no drainage from the wounds.

Signed: Mark Wolgin, MD
05/25/2010 13:25 EDT

MARK WOLGIN, M.D.

MW: web

JobID: 001501185

Dictated: 05/21/2010 3:37 P

Transcribed: 05/23/2010 2:57 P

cc: ALAN K. BROWN, M.D.

HANNA A. LIN, M.D.

MARK WOLGIN, M.D.

MA 05/19/10
FORE, PATRICIA ANN
1012500363 01/10/65 45Y
3305/10 WOLGIN, MARK A
8100425



Operative / Invasive Physician Progress Note

Pre-Procedure

I and / or my designee, through the use of videotapes, pamphlets, booklets, or other means of communication have presented the risks, benefits, and alternatives associated with the planned procedure, anesthesia, and the use of blood to the patient and or the person authorized to give consent. These have been discussed as appropriate and questions have been answered.

Patient, diagnostic results, and plan of care have been reviewed. No Significant findings / changes since History & Physical. Patient is an appropriate candidate to proceed. Or note the following:

Time: 8:00 Date: 5/19/10 Physician Signature: [Signature]

Post Procedure Note

Physician: [Signature] Assistant: #0294

Procedure: L4-S1 TLIF

EBL: 250 cc Specimen: 0

Findings: L45 DDD

Post Op Diagnosis: L5 S1 Facet arthrosis

Progress Note: Stable

Cancer Diagnosis: Clinical and/or Working Stage: (T N M)

Time: 1430 Date: 5/19/10 Physician Signature: [Signature]

Short Stay Dismissal Note (patient stay less than 48 hours):

Current Condition of Patient:

See Physicians orders and Instructions for discharge per hospital policy and follow-up care.

Time: Date: Physician Signature:



AMA
C FORE, PATRICIA ANN 05/19/10 Ord#34 1012500363 9 904-01 9100425
I 1012500363 07/10/65 45Y 4P FORE, PATRICIA ANN Sex: F S
I 8100425 WOLGIN, MARK A Adm: 05/19/10 Smk: YES O2: I NEY
A9 1012500363 07/10/65 45Y DOB: 01/10/65 45Y Cnd: I
Ord'g Phys: WOLGIN, MARK A Ht: 5'6.0" / 167.6cm Prc: PPITAL
Prf'g Phys: Wt: 261lbs / 118.200kg Prc: 31702
Transp: PORT Att Phys: WOLGIN, MARK A S
Freq: 1 Stop D/T: 05/19/10 05:24P Phys Grp: *ORTHOPEDIC ASSOC. I

0175 PHYSICAL THERAPY EVAL AND TREAT

Instructions:

PT CONSULT (BEGIN POST OP DAY 1),
EVAL / TREAT, WEIGHT BEAR AS
TOLERATED, BILATERAL LOWER EXTREMITI

Comment:

Ly-5, Fusion S0 Physical Therapy Initial Evaluation

Diagnosis: Ly5, Stenosis + Disc Desiccation Date: 5-20-10

History:

54 y old female had injury at work while holding 60 lbs
on something. She has been with back pain + leg pain
for 1 week of physical

PMH:

C-section, Tubal Clamping, Ly-5, transforaminal interbody fusion
DM, HTN, Tobacco Abuse

Precautions: Precautions: ☐ WB status: ☐ Hip ☒ Fall ☐ Contact ☐ DNR ☐ Seizure ☐ Respiratory ☐ Cardiac
☒ Safety ☐ Monitor BP ☐ Monitor SpO2 ☐ Other:

Social/Home Setup: ☐ lives alone ☒ with spouse in a 1 story ☒ #steps 3 handrails yes ☐ ramp
of children other:

Prior Level of Function: ☒ Independent in ADLs ☒ Independent in gait ☐ Requires assistance with:
with pain

DME owned: ☐ None ☐ straight cane ☐ Quad cane ☐ wheelchair ☐ standard walker ☐ rolling walker ☐ shower chair ☐ tub bench
☐ BSC ☐ Crutches Brace arrived around 10:30 am

S:

Pain Scale: 0 1 2 3 4 6 7 8 9 10 Location: Back incision site ☐ Unable to Assess ☐ Nsg. notified

O: ☒ Follows multi step commands with 100 % accuracy

☒ Orientation K4 ☐ Alertness: ☒ Safety/Judgment: good ☐ Vision: glasses ☐ Hearing:

☒ Memory: good ☐ Attention span ☐ Other:

Pt's Goal: to get hunting

Other:

ROM		WFL	Limited	Comments:
	RUE	☒		
	LUE	☒		
	RLE		☒	
	LLE	☒		<u>pain at hip when pt sat in Recliner</u> <u>with LE elevated</u>

AMA
FORE, PATRICIA ANN
1012500383
05/05/10
9100425

05/18/10
01/10/85 45Y
WOLGIN, MARK A

**PHOEBE PUTNEY
MEMORIAL HOSPITAL**

45 year old male/female for L4-S1 transforaminal
interbody fusion Prior Surgeries: C-section x2

Last Anesthesia: Block 2007 Problems: ☒ None ☐ Nausea Other: EIC back injury
Last Hospital Treatment? ☐ PPMH When: Feb. 2010 Why: EIC back injury
Familial Anesthetic Problem: ☒ No ☐ Yes Describe:
PT's <12 y.o. Delivery/Birth/Developmental Problems? ☐ No ☐ Yes Describe:
Primary Physician: DR. Hannah Zin Last visit: 3 wks.

☐ DENIES	SOCIAL History Smoke: ☒ Yes ☐ No ☐ Quit: Amount: <u>3 cigarettes</u> ppd times <u>30+</u> yrs Alcohol: ☐ Yes ☒ No Amount: <u></u> Street Drugs: ☐ Yes ☒ No Type: <u></u> Amount: <u></u> Last used: <u></u>
☒ DENIES	NEURO ☐ ☐ Impaired Speech ☐ Not Oriented to Person/Place/Time ☐ Developmental Delay Affected How? <u></u> ☐ Dementia ☐ Migraines ☐ Vertigo ☐ Unsteady Gait ☐ Poor Historian ☐ Seizures Type: <u></u> Frequency: <u></u> Last seizure: <u></u> ☐ Stroke When? <u></u> Residual Deficits: ☐ Yes ☐ No ☐ Speech Change ☐ Swallowing ☐ Weakness Where? <u></u> ☐ Sensation Loss Where? <u></u> ☐ Other: <u></u>
☐ DENIES	CARDIAC ☒ ☒ HTN ☐ Coronary Disease ☐ Prior MI When? <u></u> CABG/When? <u></u> ☐ Angioplasty When? <u></u> ☐ Chronic Angina/Chest Pains from heart? Frequency: <u></u> ☐ Worsening of angina the past 3 months? Did MD evaluate this? ☐ Yes ☐ No When? <u></u> How many SL NTO's in last month? <u></u> ☒ Able to walk 2 blocks on level ground ☐ Yes ☐ No ☐ Murmur Hx of Prophylactic Antibiotics: ☐ Yes ☐ No ☐ Pacemaker ☐ ICD Last interrogation? <u></u> ☐ Irregular Rhythm Type: <u></u> Tx: <u></u> ☐ Heart Failure Hx ☐ Orthopnea <u></u> pillows at night ☐ Increase/worsening of any cardiac symptoms in past 3 months? What/When? <u></u> Did MD evaluate this? ☐ Yes ☐ No When? <u></u> Results: <u></u> ☐ Any recent Cardiac Eval? What/When? <u></u> Results: <u></u> Name of Cardiologist: <u></u> Last visit? <u></u> ☐ Other: <u></u>
☒ DENIES	Pulmonary ☐ ☐ Asthma Frequency of Attacks: <u></u> ☐ Daily use of Inhalers ☐ PRN use ☐ Hospital Admissions for Asthma ☐ COPD/Emphysema Last bronchitis? <u>1 yr.</u> ☐ Hospitalized in past year for this When/Where? <u></u> ☐ Sleep Apnea ☐ CPAP/BPAP User O ₂ : ☐ Yes ☐ Later / Route: ☐ Continuous ☐ As Needed ☐ Productive Cough ☐ Recent URI When? <u></u> ☐ Fever--Temp <u></u> ☐ Other: <u></u>

☒ DENIES	GI ☐ ☐ Liver Disease/Problems ☐ Cirrhosis ☐ History of Jaundice ☐ Hepatitis ☐ GERD ☐ None ☐ Only with certain foods ☐ Symptoms Every Day ☐ Completely Controlled with Meds? ☐ Yes ☐ No ☐ Hiatal Hernia ☐ Gastroperic/Delayed Emptying of Stomach ☐ Recent Nausea/Vomiting with present illness ☐ Other: <u></u>
☒ DENIES	GU ☐ ☐ Renal Disease How Long? <u></u> ☐ Dialysis (When/Type) <u></u> ☐ Incontinence ☐ Hx Prostate ☐ Retention ☐ Other: <u></u>
☒ DENIES	Hematological ☐ ☐ Anemia ☐ Bleeding / Clotting Disorder ☐ Bruises Easily ☐ Gums Bleed Easily ☐ Autologous Donation for this Surgery? ☐ ASA / Anti-Coagulant Date: <u></u>
☐ DENIES	Endocrine ☒ ☐ Thyroid Disease ☐ I ☐ II ☐ Treated ☐ Goiter ☐ Difficulty Swallowing ☒ Diabetes How Long? <u>20 yrs.</u> ☒ IDDM ☐ Oral Medications ☐ Diet ☐ Recent admits for Diabetes Complications When? <u></u> ☐ Steroids in past 12 months ☐ Steroid Replacement ☐ Other: <u></u>
☐ DENIES	Musculoskeletal ☒ Back Pain: ☒ Hx ☐ Chronic ☒ Lumbar ☒ Sacral ☒ ROM Neck Pain: ☐ Hx ☐ Chronic ☐ Cervical ☐ Thoracic ☐ ROM ☐ Other: <u></u>
☒ DENIES	Psychiatric ☐ ☐ Depression ☐ Anxiety / Panic ☐ Bipolar D/O ☐ Schizoaffective Dr. <u></u> ☐ Other: <u></u>
☐ DENIES	Miscellaneous ☐ ☐ History of Contagious Disease ☐ TB ☐ HIV/AIDS ☐ TN? Dental: ☐ Caps ☐ Unable to open mouth fully ☐ Anything Removable? What? ☐ Dentures ☐ Partial ☐ Bridge Any Loose Teeth? ☐ Yes ☒ No Where? <u></u> FOR FEMALES ONLY: Is there any possibility that you can be pregnant? ☐ Yes ☒ No ☐ Other: <u></u> Information Collected By <u>Virginia Crooks</u> 5-5-10 1330



PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

HISTORY AND PHYSICAL EXAMINATION

NAME: FORE, PATRICIA ANN

MR #: 9100425

ROOM NO:

DOB: 01/10/1965

PHYSICIAN: MARK WOLGIN, M.D.

ACCT #012500363

ADMITTED:

TYPE: A

PREOP HISTORY AND PHYSICAL

DATE OF SURGERY: 5/12/10

PROPOSED SURGERY:

Right approach minimally invasive L4-5, L5-S1 transforaminal lumbar interbody fusion.

HISTORY OF PRESENT ILLNESS:

This patient is a 45 year-old female who was initially seen in February of 2009. Patient at that time had an injury one year previous to that initial visit where she was holding about 60 pounds of some type of item in her work as a meat cutter. She stepped back in an awkward manner and had a twisting injury that affected her low back. The patient felt a pop and has had pain ever since then. The pain is worse with bending and she has had episodes of pain radiating down the right leg to the lateral ankle. She has had no associated numbness. She had no problem with bowel or bladder control. She wound up being seen in the office with MRI from 9/19/08 notable from disc desiccation and bulging at the 4-5 level with stenosis at that level as well as facet arthrosis at the 5-1 level. We discussed her options for treatment. We tried to do some generalized conditioning and weight loss. The patient was also seeing Dr. Moree at that time for pain management. The patient was again seen on 4/17/09 noting that with therapy she is still having about 50-50 back and leg pain. There was some question as to whether the patient's work place exposure caused her condition and it appeared to me that clearly her symptoms were due to her industrial exposure. Patient was continued with epidurals. We were discussing surgery more at that time. We were not able to proceed with any more aggressive treatment due to the Worker's Comp approval process and the fact that her claim was still in litigation.

The patient was seen again in February of this year, it had taken many months in the interim for her to have the case covered by the Work Comp carrier with the assistance of an attorney as her advocate. Patient noted the pain was essentially the same or worse with pain down the right leg to just below the knee with no associated numbness, no bowel or bladder incontinence. We ordered a new MRI and decided to see her back after that study was done. The patient was seen next again on 3/2/10 to discuss surgical treatment. I mentioned to her that the smoking is a problem for potential healing of any type of surgical fusion and she was advised to discontinue that habit but as we discussed also that surgery could not be guaranteed she felt that her current condition was not sustainable and wanted to proceed with operative treatment. The patient finally has had approval for her surgery with the plan for fusion L4 through S1 right sided approach and patient is here now for a preop.

NAME: FORE, PATRICIA ANN
PHYS: MARK WOLGIN, M.D.
REPORT: HISTORY & PHYSICAL

PAST MEDICAL HISTORY:

Illness include:

1. Diabetes.
2. High blood pressure.

PAST SURGICAL HISTORY:

1. Cesarean section times two.

CURRENT MEDICATIONS:

1. Insulin.
2. Vicodin.
3. Tramadol.
4. NovoLog.

ALLERGIES:

1. PENICILLIN causes hives and throat closing, possible anaphylaxis.

FAMILY HISTORY:

Family history positive for diabetes.

SOCIAL HISTORY:

Patient smokes one-half pack per day. She does not drink. She is out of work but previously worked as a meat cutter lifting weights upwards of 80 to 100 pounds for the chunks of meat that she was working on.

REVIEW OF SYSTEMS:

Review of systems is notable for breast masses and diabetes related vision changes.

PHYSICAL EXAMINATION

VITAL SIGNS:

Patient appears her stated height and weight 5 foot 6 inches, 215 pounds.

HEAD/NECK:

Extraocular movements intact. Oropharynx without lesions. Neck:

Trachea midline.

CHEST:

No crepitation.

CARDIAC:

Regular, rate and rhythm.

ABDOMEN:

Mildly protuberant but no guarding.

SPINE:

There is some mild diffuse tenderness in the lumbar region. No spasm noted.

EXTREMITIES:

No focal tenderness in the upper or lower extremities. No muscle asymmetry noted.

NEUROLOGIC:

Motor and sensory exam is intact in both lower extremities. Straight leg raise on the right reproduced back pain and some mild degree of pain on the left. Elevation of the left leg however does not reproduce any back pain. Deep tendon reflexes are 1+ and symmetric at the knee and ankle. Patient demonstrates normal heel and toe walk.

IMAGING STUDIES:

MRI from 2/25/10 notable for disc desiccation and broad base disc bulge at the 4-5 level with central and lateral recess stenosis and also increased fluid levels at that level which indicates some facet instability. Patient also has facet arthrosis and disc degeneration at L5-S1 worse on the right than the left.

NAME: FORE, PATRICIA ANN
PHYS: MARK WOLGIN, M.D.
REPORT: HISTORY & PHYSICAL

ADMISSION DIAGNOSIS:

1. History of a lifting injury in industrial setting.
2. Spinal stenosis L4-5 with broad based disc bulge with potential instability and facet effusions.
3. Facet degenerative and disc degeneration L5-S1, right greater than left.
4. Right greater than left lower extremities radiculitis.
5. History of overweight.
6. History of diabetes.
7. History of smoking.

PLAN:

I advised the patient and her husband on several occasions that although the results of surgery cannot be guaranteed, I feel that she is a candidate for surgical treatment. I feel that she could have her problem addressed with a minimally invasive technique which has been outlined for her along with the risks and alternatives on my web site. She has been through conservative treatment and has had continued pain. She is clear in her desire to proceed with surgery and demonstrates understanding of the risks. The risks are outlined to include but are not limited to bleeding, infection, nerve or blood vessel damage, need for re-operation or problems with anesthesia as well as spine related risks including spinal fluid leak, adjacent organ injury, even paralysis and death. The patient will likely be hospitalized two or three days. Again smoking cessation was encouraged. Patient will be seen back about two weeks after surgery.

MARK WOLGIN, M.D.

MW: fsm

Dictated: 05/06/2010 2:59 P

Transcribed: 05/06/2010 3:22 P

Job ID: 001495636

cc: HANNA A. LIN, M.D.

MARK WOLGIN, M.D.

CATHY NELSON, Field Case Manager

Fax: 770 755-5054

Signed: Mark Wolgin, MD
05/07/2010 18:17 EDT

AMA 05/18/10
FORE, PATRICIA ANN
1012500383 01/10/65 45Y
05/05/10 WOLGIN, MARK A
9100425



Ambulatory Medical History

PART 1 Patient Addressed as: Patricia Patient Type: ☐ OPS ☒ AMA ☐ ANS ☐ OBS ☐ DDC ☐

Anticipated Procedure/Site: "Fuse my lower spine"

Anticipated Anesthesia: ☐ Conscious Sedation ☒ General Block ☐ Epidural/Spinal ☐ MAC ☐ Local ☒ Anesthesia Info Given

☐ Last Blood Transfusion:

Vital Signs: BP 149/86 P 93 Resp 20 Pulse Ox 97 Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

FUNCTIONAL ASSESSMENT

Mobility: Risks for Falls: ☒ ☐ ☒ Steady Gait ☐ Unsteady Gait

Skin:

☒ Normal ☐ Bruising ☐ Jaundice ☐ Cyanosis ☐ Ashen
☐ Skin CAs ☐ Psoriasis ☐ Rash ☐ Fecchymosis ☐ Laceration
☐ Burn ☐ Ulceration ☐ Dandage Location: _____
Other: _____

Potential for Restraints: ☒ None Apparent ☐ Moderate ☐ High

Dietary:

☐ Usual Diet Regular Or: _____

Special Dietary Needs: _____

☒ Good ☐ Fair ☐ Poor Appetite

Pediatric Diet: ☐ Bottle ☐ Cup ☐ Breast ☐ at Night

☐ Juice ☐ Formula

Sensory: ☐ Hearing Difficulty

☒ Vision Difficulty

glasses

☐ History of Glaucoma

Self-Care Needs:

☒ Home ☐ Steps ☐ W/C Access ☐ Extended Care

☐ Lives Alone ☒ With Others ☒ Can Assist ☐ Can Not Assist

ADL: ☒ Self Care ☐ Needs Assistance ☐ Total Care Caregiver: _____

Transportation: ☒ Private

Husband

☐ Medical

☐ Public

Home Health: _____

OP TX: _____

Education: Grade: _____

☐ High School ☐ Tech ☒ College

☐ School ☐ Work: _____

Advanced Directive Chart: ☐ Copy ☐ Substance ☒ Info

☐ Special Cultural / Religious Need: _____

Baptist / Christian

☐ Personal / Financial Indications That Impact Hospitalization: _____

NO

Discharge Needs: ☒ None ☐ Referred

Pre-Op Testing Nurses Notes: _____

Initial Assessment: ☒ Phone

☐ Visit

☐ Update

☐ Med Record

Patient Language: English or

☐ Interpreter

Nurse Signature / Date / Time: _____

Virginia Crocker

5-5-10

1330

The information that I have given concerning my medical history is true and correct to the best of my knowledge. I understand that I and/or my caregiver are responsible for reading all educational information regarding my self-preparation, pain management, and post-procedure care needs. My responsibility includes asking questions as needed. For my safety, I will obey all instructions and will make arrangements to have responsible transportation and home care available. I hereby release the hospital and any of its employees from any liability from the loss or damage of valuables and/or personal items that I have chosen to bring and keep at the hospital.

Signature of patient or caregiver: Patricia Fore

Date: 5-6-10

Time: 1640

Procedure/site Verified: ☒ Patient ☒ Permit ☒ Schedule ☐ Variance! Notified: _____

Time: _____

Date: 5-11-10

Time: 0550

Admitting Nurse Signature: Shirley Brantley RN

Updated By: _____

Date: _____

Time: _____



OPS-000002-1 (R 05/04/2007) -

DTS0006

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

PAIN MANAGEMENT

NAME: FORE, PATRICIA ANN

MR #: 9100425

DATE OF SERVICE: 02/27/2009

ACCT #903202213

PHYSICIAN: LAMAR H. MOREE, M.D.

AGE: 44

REASON FOR VISIT:

Ms. Fore is seen today for a pain management follow-up visit. She continues to complain of ongoing lower back pain. She describes this pain as a dull, throbbing, aching sensation that radiates down her right leg. Today she rates her pain at a 6 on a pain scale of 1 to 10.

PHYSICAL EXAMINATION:

On physical examination there is moderate tenderness to palpation to the lumbosacral spine and over the right sciatic notch. She has a positive straight leg raise test in the right lower extremity at a 45 degree angle. There is a left contralateral straight leg raise test that is positive at a 45 degree angle also. Deep tendon reflexes are 2+ and physiologic in both lower extremities at the level of the knees and ankles. Pedal pulses are 2+ bilaterally, equal and intact.

IMPRESSION:

1. Right L4-L5 sciatic radiculopathy secondary to disc bulge at this level as a result of work related trauma sustained in February 2008.
2. Obesity.
3. Diabetes.
4. Ongoing tobacco abuse.

PLAN:

Ms. Fore will receive a prescription for Ultram 50 milligrams to be given one pill by mouth four times per day quantity #120, Lodine 400 milligrams to be given one pill by mouth twice a day with food quantity #60. She will also receive samples of Zanaflex 2 milligrams to be given one pill by mouth every evening quantity #30.

FOLLOW-UP INSTRUCTIONS:

Follow up instructions include following up with Dr. Moree or PAC in one month here at the Phoebe Putney Pain Management Center.

Dictated by: Russell Dowdy, PAC

Lamar H. Moree, M.D.

LAMAR H. MOREE, M.D.

NAME: FORE, PATRICIA ANN
PHYS: LAMAR H. MOREE, M.D.
REPORT: PAIN MANAGEMENT

LHM: fsm

Dictated: 03/02/2009 9:10 A

Transcribed: 03/04/2009 2:37 P

Job ID: 001338836

cc:

Signed: LAMAR MOREE, MD
03/04/2009 18:29 EST

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

PAIN MANAGEMENT

NAME: FORE, PATRICIA ANN

MR #: 9100425

DATE OF SERVICE: 01/30/2009

ACCT #900102798

PHYSICIAN: LAMAR H. MOREE, M.D.

AGE: 44

REASON FOR VISIT:

Ms. Fore is seen today for a pain management follow-up visit. She continues to complain of ongoing lower back pain. She describes this pain as a dull, throbbing, aching sensation that radiates down her right leg. Today she rates her pain at a 6 on a pain scale of 1 to 10.

PHYSICAL EXAMINATION:

On physical examination there is moderate tenderness to palpation to the lumbosacral spine and over the right sciatic notch. She has a positive straight leg raise test in the right lower extremity at a 45 degree angle. There is a left contralateral straight leg raise test that is positive at a 45 degree angle also. Deep tendon reflexes are 2+ and physiologic in both lower extremities at the level of the knees and ankles. Pedal pulses are 2+ bilaterally, equal and intact. Ms. Fore is unable to ambulate on her heel with the right lower extremity.

IMPRESSION:

1. Right L4-L5 sciatic radiculopathy secondary to disc bulge at this level as a result of work related trauma sustained in February 24, 2008.
2. Obesity.
3. Diabetes.
4. Ongoing tobacco abuse.

PLAN:

Ms. Fore will receive a prescription for Ultram ER 200 milligrams to be given one pill by mouth daily quantity #30, Zanaflex 4 milligrams to be given one pill by mouth every evening quantity #30, gabapentin 300 milligrams to be given one pill by mouth three times per day quantity #90.

FOLLOW-UP INSTRUCTIONS:

Follow up instructions include following up with Dr. Moree or PAC in one month here at the Phoebe Putney Pain Management Center.

Dictated by: Russell Dowdy, PAC

Lamar H. Moree, M.D.

LAMAR H. MOREE, M.D.

NAME: FORE, PATRICIA ANN
PHYS: LAMAR H. MOREE, M.D.
REPORT: PAIN MANAGEMENT

LHM: fsm

Dictated: 01/30/2009 6:22 P

Transcribed: 02/03/2009 6:55 P

Job ID: 001326919

cc:

Signed: LAMAR MOREE, MD
02/05/2009 9:03 EST

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

PAIN MANAGEMENT

NAME: FORE, PATRICIA ANN

MR #: 9100425

DATE OF SERVICE: 12/05/2008

ACCT #833604635

PHYSICIAN: LAMAR H. MOREE, M.D.

AGE: 43

REASON FOR VISIT:

Ms. Fore is in today for a pain management office visit. She continues to complain of ongoing low back pain. She describes this pain as a dull, chronic, throbbing sensation that radiates down her right leg. Today she rates the pain a 7 on a pain scale of 1 to 10.

PHYSICAL EXAMINATION:

On physical examination there is no tenderness to palpation over the lumbosacral spine at the present time. There is also some slight muscle spasms noted in the right lumbar paraspinal musculature. She has a slight noticeable tenderness to palpation to the right sciatic notch. She has a positive straight leg raise test in the right lower extremity at a 45° angle. There is also a positive straight leg raise test in the left lower extremity which is contralateral at a 45° angle. Deep tendon reflexes are 2+ and physiologic in both lower extremities at the level of the knees and ankles. Pedal pulses are 2+ bilaterally, equal and intact. Ms. Fore is able to walk on her toes at the present time. She is unable to ambulate on her heel with the right lower extremity. Pedal pulses are 2+ bilaterally, equal and intact. There is no motor weaknesses noted in the lower extremities at the present time bilaterally.

IMPRESSION:

1. Right L4-L5 sciatic radiculopathy secondary to disc bulge at this level as a result of work related trauma sustained 2-24-08.
2. Obesity.
3. Diabetes.
4. Ongoing tobacco abuse.

PLAN:

Dr. Moree feels that Ms. Fore has a right L4-L5 sciatic radiculopathy due to previous work related trauma. Dr. Moree feels that Ms. Fore will benefit from receiving a prescription of Zanaflex 4 milligrams to be given one pill by mouth every evening quantity 30, gabapentin 300 milligrams to be given one pill patient three times a day quantity 90, Ultram ER 200 milligrams to be given one pill by mouth daily quantity 30. She also received samples of Ultram ER 200 milligrams to be given one pill by mouth daily and Zanaflex 4 milligrams capsules to be given one pill by mouth every evening.

We will continue to monitor Ms. Fore's progress.

FOLLOW-UP:

Her follow-up instructions include following up with Dr. Moree or the PA in one month here at the Phoebe Putney Pain Management Center.

NAME: FORE, PATRICIA ANN
PHYS: LAMAR H. MOREE, M.D.
REPORT: PAIN MANAGEMENT

Dictated BY RUSSELL DOWDY, PAC

Lamar H. Moree, MD

LAMAR H. MOREE, M.D.

LHM: th

Dictated: 12/09/2008 7:24 A

Transcribed: 12/09/2008 1:09 P

Job ID: 001306660

cc:

Signed: LAMAR MOREE, MD
12/09/2008 14:44 EST

PHOEBE PUTNEY MEMORIAL HOSPITAL
P.O. BOX 1828
ALBANY, GEORGIA

PAIN MANAGEMENT

NAME: FORE, PATRICIA ANN

MR #: 9100425

DATE OF SERVICE: 11/17/2008

ACCT #832200861

PHYSICIAN: LAMAR H. MOREE, M.D.

AGE: 43

INITIAL CONSULTATION

REASON FOR CONSULTATION:

Ms. Fore is a 43 year-old female referred for evaluation and treatment by Dr. Jim Mason. She complains of dull, aching, lower back pain that radiates into her right buttock, down her right leg and into her right foot. Her symptoms began on 2/24/08 when she injured herself while at her job as a meat cutter. She states she was carrying a 60 pound slab of meat and injured her back. She states her symptoms have progressed since her initial injury. She states her pain is increased by applying pressure to her lower back and all physical activity. She states her symptoms are worse at night than in the day. She states her pain is partially diminished with heat and frequent positional changes. She states her pain relief goal is decreased pain, increased physical activity, sleep and return to work.

PAST SURGICAL HISTORY:

Ms. Fore's past medical history is significant for previous cesarean section times two, previous left breast mass excision, previous tubal ligation, previous tonsillectomy and adenoidectomy.

PAST MEDICAL HISTORY:

Ms. Fore has a history of obesity. She has a history of diabetes of 13 years duration.

FAMILY HISTORY:

Her mother died at 65 from chronic renal failure secondary to diabetes. Her father died in his 60's secondary to ethanol abuse and cerebral hemorrhage.

REVIEW OF SYSTEMS:

Ms. Fore's review of systems is negative for neurological, psychiatric, respiratory, cardiac, hepatic or renal dysfunction. She has no previous history of hematologic or immunological disease.

SOCIAL HISTORY:

Ms. Fore is a meat cutter. She is a 1/2 pack per day smoker for 35 years. She consumes no alcohol.

MEDICATIONS:

Her current medications are NovoLog, Humulin insulin, Darvocet and Voltaren.

ALLERGIES:

She is allergic to **PENICILLIN**, this allergy is manifest as urticaria.

DIAGNOSTIC STUDIES:

NAME: FORE, PATRICIA ANN
PHYS: LAMAR H. MOREE, M.D.
REPORT: PAIN MANAGEMENT

She has undergone a lumbar MRI scan which is consistent with a bulging disc at the L4-5 level.

PHYSICAL EXAMINATION:

The lumbar spine is nontender. There is slight muscle spasm noted in the right lumbar paraspinal musculature. There is tenderness on palpation of the right sciatic notch. Straight leg raise test is significantly positive to an angle of 45° in the right lower extremity. The left contralateral straight leg raise test is positive to an angle of 45°. Deep tendon reflexes are 2+ and physiologic bilaterally in the lower extremities at the level of the knees and ankles. Ms. Fore is able to toe walk. She is unable to heel walk on her right lower extremity. Pedal pulses are intact bilaterally.

IMPRESSION:

1. Right L4-5 sciatic radiculopathy secondary to bulging disc at this level as a result of work related trauma sustained on 2/24/08.
2. Obesity.
3. Previous cesarean section times two.
4. Previous left breast mass excision.
5. Previous tonsillectomy and adenoidectomy.
6. Previous tubal ligation.
7. Diabetes.
8. Ongoing tobacco abuse.

I feel Ms. Fore has right L4-5 sciatic radiculopathy due to previous work related trauma. She has previously undergone epidural steroid injection therapy without benefit. She is a brittle diabetic. I am somewhat hesitant to initially pursue lumbar epidural steroid injection therapy as I feel the steroid exposure may be detrimental to her diabetes. I will initially place her on a two week trial of tizanidine 4 milligrams at bedtime and gabapentin 300 milligrams three times a day. I have cautioned her as to the potential side effects of these medications. I shall see her in followup in two weeks to assess her response to this therapeutic trial.

Lamar H. Moree, M.D.

LAMAR H. MOREE, M.D.

LHM: th

Dictated: 11/17/2008 6:51 P

Transcribed: 11/19/2008 11:59 A

Job ID: 001299107

cc:

JAMES MASON, D.O.

Signed: LAMAR MOREE, MD
11/20/2008 9:28 EST

DOCTORS CARE

[illegible]

STRAND REGIONAL SPECIALTY ASSOCIATES

FOLLOWUP VISIT

Patricia Fore

DOB: 1/10/1965

Date: 5/8/2008

Chart #: 79185

SSN:

CHIEF COMPLAINT: Right hip pain.

SUBJECTIVE: This is a 43-year-old meat cutter and wrapper who was working back in February when she slipped and hit her right hip on the band saw. She had immediate pain localized just to the lateral hip. Few days later, she started having shooting pains down from her hip to her knee and cramping pain. She was seen in the ER where she was given pain medication. Goody Powders seem to work best. Denies any numbness or tingling down either leg. No pain over the anterior groin.

PAST MEDICAL HISTORY: She is a diabetic and on Lantus and NovoLog. She is a smoker. Denies any reflux. No history of asthma.

MEDICATIONS: Lantus, NovoLog p.r.n., Sildec, Tylenol, BC powders, and Aleve.

ALLERGIES: PENICILLIN.

PHYSICAL EXAMINATION:**GENERAL:**

This is a pleasant, middle-aged female, in no acute distress.

VITAL SIGNS:

Height 5 feet 5½ inches. Weight 230 pounds. Pulse is 98.

RIGHT HIP:

She is markedly tender over the greater trochanter with some soft tissue thickening there. Nontender to palpation over the anterior groin. No pain with hip flexion or external rotation. There is minimal discomfort with internal rotation over the greater trochanter. Trace quad atrophy. Positive Ober's. No midline tenderness. She is minimally tender over the sciatic notch. No SI tenderness. Distally, focal motor strength is intact without deficits.

LUMBAR SPINE:

DIAGNOSTIC TESTS: Right hip AP and lateral films were obtained and reveal no evidence of fracture. No destructive lesions noted. Mild hip DJD.

ASSESSMENT: Traumatic right trochanteric bursitis with possible mild sciatica.

Fore, Patricia
Chart#: 79185

PLAN: We will get her in physical therapy for modalities and strengthening. I think she also needs some desensitization over the injury site. Under aseptic conditions, I injected her trochanteric bursa with 1 mL betamethasone, 2 mL of 1% plain lidocaine. We discussed routine steroid precautions. Since she is a diabetic, she is aware that her blood glucose may run high for the next day or two. She should adjust her NovoLog sliding scale as needed. Prescription give for tramadol. I have cautioned her against taking the BC Powders, Sildex, and Aleve. She needs to take one of the anti-inflammatories only and discussed routine GI precautions.

FOLLOWUP: As needed.



Erin L. Finley, PA-C

EK/smk

Atlantic T. - 34-0015
 Select P.T. -
 347-7141

Rehabilitation Services



Conway Medical Center Campus

Phone: 843.347.8066 / 843.234.5113

Fax: 843.347.0910 / 843.234.5114

Patient Name: Patricia Fort Date: 5/8/08

Diagnosis: Post-traumatic trochanteric bursitis + hip contusion

Referring Physician: Doss Scintia

(Signature required to treat patient)

Social adjustment services required? ☐ yes ☒ no Functional limitations prior to injury? ☐ yes ☒ no

Please treat this patient 2-3 times a week for 4 weeks.

EVALUATION

☒ Evaluate/Treat

☐ ROM

☐ Sensory

☐ Hand

☐ ADL

☐ Aquatics

☐ CYBEX

☐ BTE

EXERCISE

☐ BTE

☐ CYBEX

☐ AROM

☐ PROM

☒ Strengthening

☒ Home Program

☐ Gait Training

☒ Therapeutic

EQUIPMENT/INSTRUCTION

☐ Dynasplint

☐ TENS Unit

☐ Crutches

☐ Walker

☐ Splint/Brace Fabrication

☐ Other:

TREATMENT GOALS

☐ Increase ROM

☐ Increase Strength

☒ Improve Function

☒ Decrease Pain

☐ Decrease Edema

MODALITIES - p

☐ Hot Pack/Ice

☐ Fluidotherapy

☒ Massage

☐ TENS

☐ Interferential E. Stim.

☐ Phonophoresis

☐ Ultrasound

☐ Traction

☐ Wound Care

☐ Paraffin

☐ EMS Unit

☐ Whirlpool

desensitization

PROTOCOLS

☐ Cervical

☐ Lumbosacral

☐ Lumbosacral with

☐ Material Handling

☐ Rotator Cuff Surgery

☐ Tendon

☐ Hand

☐ ACL

☐ Rotator Cuff

☐ SX/Tendonitis

☐ Post Op Arthroscopy

☐ RSD

☐ TMJ

☐ Other:

☐ Specify:

PRECAUTIONS/SPECIAL INSTRUCTIONS/COMMENTS:

THERAPIST

PHYSICIAN

SRSA PATIENT INFORMATION SHEET

Name: Patricia Fore Today's Date: _____
 Age: 43 Sex: F Right ☒ Left ☐ Handed _____
 Occupation: Meat cutter / wrapper
 INJURY RELATED TO: _____
 Work ☒ Sports _____ Auto _____ Other _____ No known Injury _____
 Site of Injury: Right ☒ Left ☐ Date of Injury: 2-24-08
45 5 1/2" W 230 P 98
 REASON FOR TODAY'S VISIT:
Something is bad wrong with hip
 Please Describe: continuous pain in joint (hip) and it will run down leg

Have you had problems in this area before? ☒ No ☐ Yes (describe) _____
 Have you been treated by anyone else for this problem? ☐ No ☒ Yes (Who) Seacoast Hosp (EE)
Doctors care center
 PAST MEDICAL HISTORY:

Illness / Medical Conditions: ☐ None	Previous Surgeries: ☐ None
<u>Diabetes 12 yrs</u>	<u>C-Section March 07</u>

Have you or any family members had anesthesia problems? NO
 MEDICATIONS you are presently taking (including over-the-counter): ☐ None

<u>Lantus 80 AM 30 pm</u>	<u>Sulindac 200mg</u>
<u>Novolog as needed</u>	<u>Tylenol, BC, Goodies</u>
	<u>Alieve</u>

DRUG ALLERGIES:
☐ No ☒ Yes (If yes, Please list) Pen

	Yes/No		Yes/No		Yes/No
Asthma	☐	Blood Clots	☐	Cancer	☐
Heart Problems	☐	Ulcers	☐	Arthritis	☐
Blending Problems	☐	Hiatal Hernia	☐	Smoking	☒
Diabetes	☒	Reflux	☐	Fevers	☐
Hepatitis	☐	Stomach Problems	☐	Weight Loss	☐

Referred By: Drs. Care
 Patient Signature: Patricia Fore

(PLEASE FILL THIS FORM OUT COMPLETELY!)

SRSA 009 12-15-07

08/22/2008 05:09 SRSA Med Records

05/02/2008 PRI 10:45 FAX 843 248 0535 DOCTORS CAB

(FAX) 843 497 2515

OCT -12 01 (MON) 09:32 STRAND REGIONAL SPECIALTY ASSN

TEL 803 497 2515

P. 001



Strand Regional Specialty Associates

PHYSICIAN REFERRAL

(Scheduling Department)

Direct Phone (843) 892-2170 Fax (843) 892-2145

PLEASE FORWARD ALL NOTES YOU HAVE PERTAINING TO THIS PATIENT
PLEASE FORWARD A COPY OF PATIENTS INSURANCE CARD (Front & Back)

Date Ordered: 5/2/08

Patient: Patricia Fore

Phone #: 303-5705

Date of Birth: 1-10-65

Social Security #

Address: 3091 Old Pearis Ferry Rd Conway

Referring Physician: Arthur N. Kosow, MD

Referring to: Ortho - no preference

79185

PH# 248-40209
FAX# 248-0535

Neurological Surgery
D DAVID B. KRE, JR., M.D.
D EUGENE M. GIDDONS, M.D.
D LUCAS A. MCGEE, M.D. - PPH-BS

Neurology
D BARBARA L. SARR, D.O.
D MICHAEL MCCAFFREY, M.D.
D GEORGE M. SANDOZ, M.D.
D JEFF A. BENJAMIN, D.O.
D PRUDENCE L. OWSEN, D.O.

Orthopedic Surgery & Sports Medicine
D THOMAS J. CHAMBERS, M.D.
D JERRY A. SCHEINWALDER, JR., M.D.
D FREDERICK J. HAMILTON, D.O.
D DAVID EVERMAN, M.D.
D ERIN L. KIRBY, PA-C

Ophthalmology
D GEORGE M. SANDOZ, M.D.

Reason for Referral: @ hip pain

Date of Injury (if applicable):

Consult/Physician Study (last):

Diagnosis:

Clinical Information:

Insurance Company: (copy of card please) Cigna

Ref # (if requested):

Employer:

Appointment Date:

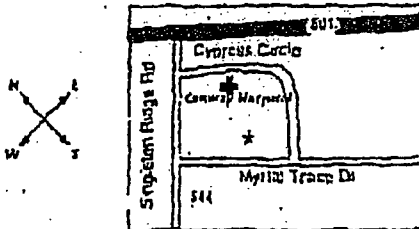
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Appointment Location:

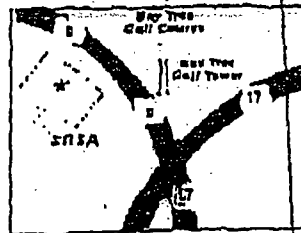
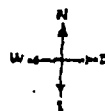
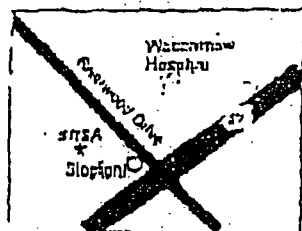
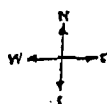
With Doctor:

CONWAY • 234-1210
2075 Cypress Circle, Suite 200

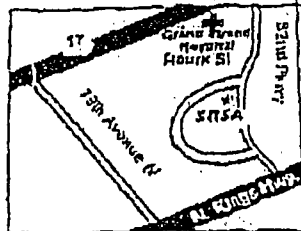
LITTLE ROCK • 390-8033
4300 Hwy D East, Suite 285



MURRELLS INLET • 357-8008
4367 Piedmont Drive, Suite 120



MYRTLE BEACH • 440-2232
8170 Market Street



MAR. 1. 2010 8:37AM

OR1HU

CHARTIS-ADP29 MAR 05 2010
NU 4411 F. 0/10



PATIENT: Fore, Patricia
DOB: 1/10/1965
MRN: 2873
DOCTOR: Mark Wolgin, MD
EXAM DATE: 2/25/2010
ID #: MR6475

✓ 709-659592

HISTORY: Chronic low back pain. Right leg radiculitis.

TECHNIQUE: Multiplanar, multisequence image acquisitions were performed throughout the lumbar spine.

FINDINGS:

Alignment and bony structures: Normal alignment. Marrow signal intensity normal.

Conus medullaris: Normal size, signal and position.

T12-L1 disc space: Normal.

L1-2 disc space: Normal.

L2-3 disc space: Normal.

L3-4 disc space: Normal.

L4-5 disc space: Disc desiccation. Mild bulge. Probable small superimposed central protrusion. Mild bilateral facet hypertrophy. Mild crowding of the lateral recess nerve roots. Minor foraminal narrowing.

L5-S1 disc space: Slight disc desiccation. Minor facet degenerative change.

IMPRESSION:

1. Bulge and possible tiny central protrusion at L4-5 is noted along with mild facet hypertrophy. No frank nerve root compression. Probable mild crowding of the lateral recess nerve roots.
2. Minor disc degenerative change at L5-S1.
3. Left adnexal 3.5 cm cystic lesion is noted. This is likely ovarian in origin. Ultrasound correlation as a baseline for follow up may be useful. Interval follow up is suggested in six to eight weeks to ensure stability or resolution.

Michael Smith, M.D.
MS/r

DD: 2/26/2010
DT: 2/26/2010

619 POINTE NORTH BLVD. - ALBANY, GA 31721
PH (229)878-4321 - FAX (229)888-0565
AFTER HOURS PH (229)883-4707

MAR. 1. 2010 8:37AM ORTHO

PATIENT: Fore, Patricia
DOB: 1/10/1965
EXAM DATE: MRI LUMBAR SPINE WITHOUT CONTRAST

Job: 10034151

This document has been electronically reviewed and signed.

Michael D. Smith MD

10/13/2008 22:20 2294351038

ORTHOPAEDIC ASSO

SEP. 22. 2008 9:30AM

BY 40

NO. 1202



PATIENT: Kora, Patricia
DOB: 1/10/1965
MRN: 6475
DOCTOR: James Mason, MD
EXAM DATE: 9/19/2008

EXAM: MRI LUMBAR SPINE WITHOUT CONTRAST

HISTORY: Right radiculopathy. Low back pain.

TECHNIQUE: Multiplanar, multisequence image acquisitions were performed throughout the lumbar spine.

FINDINGS:

Alignment and bony structures: Anatomic alignment with normal lordosis. Bony structures normal.

Conus medullaris: Normal size, signal and position.

T12-L1 disc space: Normal.

L1-2 disc space: Normal.

L2-3 disc space: Normal.

L3-4 disc space: Normal.

L4-5 disc space: Mild degenerative disc disease. Mild disc bulge and facet changes cause mild canal narrowing. Small focal right neural foramina focal disc protrusion angled superiorly contacts the exiting right L4 nerve root, sagittal T2 image 8-9. Fat persists in the foramen and this is not severely stenotic. The left neural foramen is patent.

L5-S1 disc space: Decreased T2 signal indicates minimal degenerative disc disease. Canal and neural foramina are patent. There are mild facet degenerative changes.

IMPRESSION: There are mild degenerative disc and facet changes in the lower lumbar spine. L4-5 small right neural foramina focal disc protrusion is present.

Royden Daniels, M.D.
RD / dw

DD: 9/19/2008
DT: 9/20/2008
Job: 6875405

2726 LEDO ROAD - SUITE 2 - ALBANY, GA 31707

PH (229)878-4321 - FAX (229)878-5156

After Hours (229)883-4707

03/21/10

08:23

COVENTRY HEALTH

7707555054

10/17/2008 05:13 2294551438
SEP. 22. 2008 9:31AM NW 40

ORTHOPAEDIC ASSO

NO. 1282

PATIENT: Fore, Patricia
DOB: 1/10/1965
EXAM DATE: MRI LUMBAR SPINE WITHOUT CONTRAST

This document has been reviewed and electronically signed.

Lynda D. Davis MD

10/17/2008 03:19 2294351878

ORTHOPAEDIC ASSO

PAGE

SEP. 22. 2008 9:30AM n THO

NO. 1282



PATIENT: Fore, Patricia
DOB: 1/10/1965
MRN: 6475
DOCTOR: James Mason, MD
EXAM DATE: 9/19/2008

EXAM: MR STUDY RIGHT HIP

HISTORY: Pain since February.

TECHNIQUE: T1 and proton density weighted fat sat coronal, T2 transverse and T1 and T2 sagittal image series were made.

FINDINGS:

Bony structures: Unremarkable.

Musculotendinous elements: Muscle signal appears normal throughout with nothing to suggest strain, contusion or hematoma. I do not see a bursal fluid collection. The common hamstring, gluteus minimus and gluteus medius tendons are all normal.

Miscellaneous: I do not see a joint effusion. The acetabular labrum is not very well shown.

IMPRESSION: Normal examination.

S. Boyd Eaton, MD
SE/dw

DD: 9/19/2008
DT: 9/20/2008
Job: 6873188

This document has been electronically reviewed and signed.

S. Boyd Eaton MD

2726 LEDO ROAD - SUITE 2 - ALBANY, GA 31707

PH (229)878-4321 - FAX (229)878-5156

After Hours (229)883-4707



Clinical Neurodiagnostics LLC

P.O. Box 2259 Griffin, GA 30224 Tel: (404) 642-0259 Fax: (770) 421-1401

CLINICAL NEURODIAGNOSTICS, LLC

P.O. Box 2259 Griffin, Georgia 30224

(404) 642-0259

INTRAOPERATIVE NEUROPHYSIOLOGIC MONITORING REPORT

Patient Name: Fore, Patricia
Patient Number: 051910-01
Date of Service: 05-19-2010
Provider: Leonard Jones/Ateer Sheth MS, CNIM
Surgical Procedure: Posterior Spinal Fusion L4-S1
Surgical Diagnosis: Spinal Stenosis, Degenerative Disc and Facet, Radiculitis, Back Pain
Monitoring Protocol: Free Run EMG, Upper and Lower SSEP, Stimulating EMG
Facility: Phoebe Putney Memorial Hospital
Surgeon: M. Wolgin, MD
Total Hours: 8

Clinical Summary

Patient is a 45 year old female with lower back pain radiating to lower extremities with pain greater in the right than the left. Patient presents spinal stenosis with radiculitis, degenerative disc and degenerative facet greater on the right side than the left. Medical history reveals hypertension, diabetes, tubal clamping, two c-sections, and a smoker. Patient will undergo a posterior lumbar interbody fusion. Monitoring protocol was followed as ordered by Dr. Wolgin.

Report of Monitoring

The patient was met in the preoperative area and the procedure of intraoperative monitoring was explained to her. Surface stimulating electrodes were placed at the Ulnar nerves and Posterior Tibial nerves for SSEP stimulation. Upon intubation subdermal electrodes were placed in the Vastus Lateralis, Tibialis Anterior and Gastrocnemius muscles bilaterally to monitor and maintain free-running EMG. Additional subdermal electrodes were placed in the scalp locations of Fz, Cz', C3', C4', A1 to record somatosensory evoked potentials. A ground was placed in the left shoulder region. An anode was placed in the lower belly region for possible pedicle screw stimulation by a ball tipped probe. The patient was then connected to an Endeavor with IOM software. Pre-incision baselines were obtained and the surgeon was notified.

Baselines SSEP for upper extremity detected normal latency values for N20/P23. Baseline SSEP for lower extremity detected a increase in latency values for P37/N45. The surgeon was informed and the procedure continued. Baseline EMG did not detected any pre-incision myotonic activity consistent with a radiculopathy. The surgeon was informed and the procedure continued. The surgeon was notified of the neural structures being monitored throughout the procedure.

The patient was managed anesthetically utilizing desoflurane ranging from 3.25-4.30% expiratory concentrations. Muscle relaxants were used for intubation and exposure.

There were no significant episodes of sustained EMG discharges throughout the procedure, and there were no deviations of baseline somatosensory evoked potentials.

Following pedicle screw placement, the surgeon began pedicle screw testing at approximately 12:50. Patient testing results was as follows LEFT L4: 18.5, L5: 23.0, S1: 9.0, RIGHT L4: 22.5, L5: >20.0, S1: 16.5. The surgeon was informed and the procedure continued.

Following closure of the surgical procedure, the patient was disconnected from the monitoring equipment, and monitoring was discontinued. A postoperative assessment revealed no new neurological deficits.

Leonard Jones

Leonard Jones, BS

Ateer Sheth, MS, CNIM

Anthony Giatras, MD Neurologist

AMA 05/18/10
FORE, PATRICIA ANN
1012500363
05/05/10 01/10/85 45Y
9100425 WOLGIN, MARK A
1 1012500363 05/05/10 01/10/85 45Y WOLGIN, MARK A 9100425



Clinical Neurodiagnostics LLC

P.O. Box 2259 Griffin, GA 30224 Tel (404) 642-0259 Fax (770) 431-1491

PHYSICIAN'S ORDER

DATE: 05/19/10

INITIAL: LJ

PATIENT:

ID: 05/19/10-01

AMA 05/18/10
FORE, PATRICIA ANN
1012500383 01/10/85 45Y-
05/05/10 WOLGIN, MARK A
9100425
P. 1-570-0000 FAX 1-570-0001 WWW.1-570-0001

DIAGNOSIS: Spond Stenosis & Radiculitis, Degenerative Disc & Facet

NEURODIAGNOSTICS

- ☒ NEEDLE EMG - 2 Extremities
- ☒ NEEDLE EMG - 4 Extremities
- ☐ NEEDLE EMG - Anal Sphincter
- ☐ NEEDLE EMG - Cranial Nerve
- ☒ Upper SSEP
- ☒ Lower SSEP

- ☐ EEG
- ☐ TCMEP
- ☐ BAER
- ☐ Nerve Conduction
- ☒ Other Test: (specify) Stim EMG
- ☐ Other Test: (specify)

Physician's Signature

Wolgin, Mark MD

Physician's Printed Name



ORTHO SPORT PHYSICAL THERAPY

619 Pointe North Blvd. • Albany, Georgia 31721
Phone 229-883-8914 • Fax 229-888-0565



Progress Evaluation

Discharge Evaluation

Patient: Patricia Gou Date: 9/27/10
Physician: Wolfe DOB: 1-10-64 SS #: -
Diagnosis: S/P L4-S1 fusion
Period Covered: 9/1/10 to 9/27/10
Total Visits: 10 # of Missed Visits: -

Subjective: Pt reports really no pain since IE; do
constant pain on (R) side of LB; T is getting T &
walking T & inclines; T is T & steps; do "internal" &
Objective: 6/10 today 8/10 @ worst
do consists of Ther ex for L-com/stab; M/H/K; HEP

L-KOM V=50° I=10°; Difficulty progressing K2 2" pt's do pain
gait: impaired & T speed; ↓ stance (R) LE
Transfers: (I) sup → sit; & log roll

Assessment: T do pain & work duties - sits in/out of
chair & going up & down stairs; pain constant &
in nature but exacerbated & T act level
T pain & coughing / sneezing; NO longer having
muscle pain or soreness; now able to walk on
shoes/socks; can lay down for quarter ant. of time b/c

Plan: D/C @ this time & instruction to cont & HEP & exp. pain
unable to complete ex during K2 2" do pain

Thank you for allowing me to assist in the care of your patient.

Julie M. Scott, PT, C355
Physical Therapist

9/27/10
Date

Physician's Report: (Please complete and return)

Continue physical therapy treatment
D/C physical therapy treatment

Frequency: qd biw tiw weekly

Duration: weeks

Comments:

POOR IMAGE QUALITY

ORTHO SPORT PHYSICAL THERAPY

P.O. BOX 407 • 619 Pointe North Blvd. • ALBANY, GEORGIA 31702
FEDERAL ID #58-2471372

CHARTIS-ADP02 OCT 15 2010

T. GLENN WILLIAMS, M.D., A.A.O.S., F.A.C.S.
THOMAS M. DARDEN, JR. M.D., A.A.O.S., F.A.C.
PAUL A. MICHAEL, M.D., A.A.O.S., F.A.C.S.
JAMES S. MASON, D.O., F.A.O.A.O.
MARK A. WOLGIN, M.D., A.A.O.S., F.A.C.S.

ORTHOPAEDIC
ASSOCIATES

COMMENTS/NOTES

CPT	UNITS	DESCRIPTION
97001		PHYSICAL THERAPY - EVALUATION
97002		PHYSICAL THERAPY - RE-EVALUATION
97010		APPLICATION - MODALITY - COLD PAK / ICE
97010		APPLICATION - MODALITY - MOIST HEAT
97012		TRACTION - MECHANICAL
97014	1	ELECTRICAL STIMULATION (UNATTENDED)
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)
97016		VASOPNEUMATIC DEVICES - COMPRESSION
97018		PARAFFIN BATH
97026		INFRARED LASER
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.
97033		IONTOPHORESIS EA 15 MIN.
97035		ULTRASOUND EA 15 MIN.
97039		PHONOPHORESIS - UNLISTED MODALITY
97110	2	THERAPEUTIC EXERCISES EA 15 MIN.
97112		NEUROMUSCULAR RE-ED AROM AAROM-PROM EA 15 MIN.
97116		GAIT TRAINING EA 15 MIN.
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.
97150		THERAPEUTIC PROCEDURES - GROUP (2 OR MORE)
97530		HOMER PROGRAM EA 15 MIN.
97545		WORK HARDENING INITIAL 2 HOURS
97750		PHYSICAL PERFORMANCE TEST/ECE EA 15 MIN.
E0730		TENS
64550		TENS APPLICATION
99070		MISCELLANEOUS SUPPLIES
99071		EDUCATIONAL MATERIALS

10/9/27/10

Refer to MD
Note ~ chart

POOR IMAGE QUALITY

090310
090310

ICD-9	CPT	DESCRIPTION	PRICE
722.52	724.4		
V58.78			

DATE	TIME	PATIENT	REASON	PRICE BALANCE
09/27/10	11.00	PATRICIA FORE	BACK MD NOTE 9-30	PAT 0.00 INS 576.00
TICKET NO	DR#	DOCTOR	LOCATION	D.O.B
404035	10	SCOTT NPT	ALBANY, BONE JOINT C	01/10/65
PATIENT NO.	RESPONSIBLE PARTY	PHYS	REFERRING DR	
PT6075	GRIFFSCO OF-WANPEE INC	000 0000	WOLGIN MD	
S	M	F	ADDRESS	CITY/STATE
X			8729 HWY 90	
E	C	A	OVER 60	OVER 30
			0.00	0.00
			CURRENT	TOTAL DUE
			576.00	576.00
			PT	BC
			8	90
			CS	INITIAL
			0	0
INSURANCE COMPANY			POLICY I.D.	
ALIGN NETWORKS			I	
SSN				
			V58.78	AFTERCARE FOLLOWING SURGERY OF

Medications Date Size Frequen Count

I certify that all above services have been rendered by me.

Allen M Scott, PT, CSE
THERAPIST SIGNATURE



ORTHO SPORT PHYSICAL THERAPY



ORTHOPAEDIC
ASSOCIATES

P.O. BOX 407 • 619 Pointe North Blvd. • ALBANY, GEORGIA 31702
FEDERAL ID #58-2471372

T. GLENN WILLIAMS, M.D., A.A.O.S., F.A.C.S.
THOMAS M. DARDEN, JR. M.D., A.A.O.S., F.A.C.S.
PAUL A. MICHAEL, M.D., A.A.O.S., F.A.C.S.
JAMES S. MASON, D.O., F.A.O.A.O.
MARK A. WOLGIN, M.D., A.A.O.S., F.A.C.S.

CPT	UNITS	DESCRIPTION
97001		PHYSICAL THERAPY - EVALUATION
97002		PHYSICAL THERAPY - RE-EVALUATION
97010		APPLICATION - MODALITY - COLD PAK/ICE
97010		APPLICATION - MODALITY - MOIST HEAT
97012		TRACTION - MECHANICAL
97014	1	ELECTRICAL STIMULATION (UNATTENDED)
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)
97016		VASOPNEUMATIC DEVICES COMPRESSION
97018		PARAFFIN BATH
97026		INFRARED LASER
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.
97033		IONTOPHORESIS EA 15 MIN.
97035		ULTRASOUND EA 15 MIN.
97039		PHONOPHORESIS - UNLISTED MODALITY
97110		THERAPEUTIC EXERCISES EA 15 MIN.
97112		NEUROMUSCULAR RE-ED AROM AAROM-PROM EA 15 MIN.
97116		GAIT TRAINING EA 15 MIN.
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.
97150		THERAPEUTIC PROCEDURES GROUP (2 OR MORE)
97530		HOME PROGRAM EA 15 MIN.
97545		WORK HARDENING INITIAL 2 HOURS
97750		PHYSICAL PERFORMANCE TEST/FCE EA 15 MIN.
E0730		TENS
64550		TENS APPLICATION
99070		MISCELLANEOUS SUPPLIES
99071		EDUCATIONAL MATERIALS

COMMENTS/NOTES 9/23/10

At reports her back is hurting today, on the (side). Its not no pain but internal pain.

Re only consists of mil/IFC x 15 mins to L

At not able to participate in PT today 2nd pain. At is also pain on side of L3. At not showing any progress @ this time. Mobility and not able to do stretches on mat.

At Cont Rx per POC

ICD-9	CPT	DESCRIPTION	PRICE
724.4			
722.52			
V51.71			

DATE		TIME		PATIENT		REASON		PRIOR BALANCE	
09/23/10		8.00		PATRICIA FORE		BACK JKR		PAT 0.00 INS 382.00	
TICKET NO		DR #		DOCTOR		LOCATION		DOB	
406795		11		GAINT		ALBANY BONE JOINT C		01/10/65	
PATIENT NO.		RESPONSIBLE PARTY		REFERRING DR.					
PT6476		GRIFFSCO OF WAMPEE INC		000 0000 WOLGIN, MD					
S		M		F		ADDRESS		CITY/STATE	
X						8729 HWY 90			
OVER 90		OVER 80		OVER 70		CURRENT		TOTAL DUE	
0.00		0.00		0.00		382.00		382.00	
INSURANCE COMPANY		POLICY ID.		PT		BC		CS	
ALIGN NETWORKS		Y						INITIAL	
SSN #								PAY CHOICE	
								CASH	
								CHECK	
								CREDIT CARD	
								BALANCE DUE	

Medications Date Size Frequen Count

I certify that all above services have been rendered by me.

Janethy B. Gaint PTA 1970
[Signature]



ORTHOPAEDIC
ASSOCIATES



ORTHO SPORT
PHYSICAL THERAPY



P.O. BOX 407 • 519 Points North Blvd. • ALBANY, GEORGIA 31702
FEDERAL ID #58-2471372

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MARK A. WOLGIN, M.D., A.A.O.S., F.A.C.S.

CPT	UNITS	DESCRIPTION
97001		PHYSICAL THERAPY - EVALUATION
97002		PHYSICAL THERAPY - RE-EVALUATION
97010		APPLICATION - MODALITY - COLD PAK / ICE
97010		APPLICATION - MODALITY - MOIST HEAT
97012		TRACTION - MECHANICAL
97014	1	ELECTRICAL STIMULATION (UNATTENDED)
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)
97016		VASOPNEUMATIC DEVICES COMPRESSION
97018		PARAFFIN BATH
97026		INFRARED LASER
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.
97033		IONTOPHORESIS EA 15 MIN.
97035		ULTRASOUND EA 15 MIN.
97039		PHONOPHORESIS - UNLISTED MODALITY
97110	2	THERAPEUTIC EXERCISES EA 15 MIN.
97112		NEUROMUSCULAR RE-EDUCATION PROM EA 15 MIN.
97116		GAIT TRAINING EA 15 MIN.
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.
97150		THERAPEUTIC PROCEDURES GROUP (2 OR MORE)
97530		HOME PROGRAM EA 15 MIN.
97545		WORK HARDENING INITIAL 2 HOURS
97750		PHYSICAL PERFORMANCE TEST/ECG EA 15 MIN.
E0730		TENS
64550		TENS APPLICATION
99070		MISCELLANEOUS SUPPLIES
99071		EDUCATIONAL MATERIALS

COMMENTS / NOTES

⑦ 9/16/10
S. CHARTIS-ADP-5. DGT 7.5.2010
is better today, not
handing today

① Rx began in the
per for for some
stability of LG, in
addition of 11CS x 5.
i 15sec hold for a
of 34mm. 050310
050310

② COR IMAGE QUALITY
PT is T participation
PT today. PT can't
discontinuation @ side of
in sacral region. Pain
in supine position.

③ Cont Rx per PK

ICD-9	CPT	DESCRIPTION	PRICE
724.4			
722.52			
V58.78			

DATE		TIME	PATIENT	REASON	PRIOR BALANCE
09/17/10		9:00	PATRICIA FORE	BACK INJ	AT 0.00 NS 350.00
TICKET NO.	DR #	DOCTOR	LOCATION	DOB	TODAY'S CHARGE
404028	11	BALNT	ALBANY GONE JOINT C	01/10/65	108.00
PATIENT NO		RESPONSIBLE PARTY		PH#	REFERRING DR
PT6475		GRIFFITH OF WAREE INC		000 0002	WOLGIN MD
S	M	F	ADDRESS	CITY/STATE	ZIP CODE
			8729 HWY 90		
EC	OVER 90	OVER 60	OVER 30	CURRENT	TOTAL DUE
	0.00	0.00	0.05	350.00	350.00
INSURANCE COMPANY		POLICY ID.		PAY CHOICE	
ALIX NETWORKS				CASH CHECK CREDIT CARD	
BALANCE OVER					
SSN # V58.78 AFTERCARE FOLLOWING SURGERY					

Medications Date Size Frequen Count

I certify that all above services have been rendered by me

④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊀ ㊁ ㊂ ㊃ ㊄ ㊅ ㊆ ㊇ ㊈ ㊉ ㊐ ㊑ ㊒ ㊓ ㊔ ㊕ ㊖ ㊗ ㊘ ㊙ ㊚ ㊛ ㊜ ㊝ ㊞ ㊟ ㊠ ㊡ ㊢ ㊣ ㊤ ㊥ ㊦ ㊧ ㊨ ㊩ ㊰ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺ ㊻ ㊼ ㊽ ㊾ ㊿
THERAPIST SIGNATURE

CHARTIS-APR 03 OCT 05 2010



ORTHO SPORT PHYSICAL THERAPY



T. GLENN WILLIAMS, M.D., A.A.O.S., F.A.C.
THOMAS M. DARDEN, JR. M.D., A.A.O.S., F.
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FEDERAL ID 858-2471372

ORTHOPAEDIC
ASSOCIATES

CPT	UNITS	DESCRIPTION	COMMENTS/NOTES
97001		PHYSICAL THERAPY-EVALUATION	⑥ 9/15/10
97002		PHYSICAL THERAPY-RE-EVALUATION	
97010		APPLICATION-MODALITY-COLD PAK/ICE	
97012		APPLICATION-MODALITY-MOIST HEAT	
97012		TRACTION-MECHANICAL	
97014	1	ELECTRICAL STIMULATION (UNATTENDED)	
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)	
97016		VASOPNEUMATIC DEVICES COMPRESSION	
97018		PARAFFIN BATH	
97026		INFRARED LASER	
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.	
97033		IONTOPHORESIS EA 15 MIN.	
97035		ULTRASOUND EA 15 MIN.	
97039		PHONOPHORESIS UNATTENDED MODALITY	
97110		THERAPEUTIC EXERCISES EA 15 MIN.	
97112		NEUROMUSCULAR RE-ED AROM AROM-PROM EA 15 MIN.	
97116		GAIT TRAINING EA 15 MIN.	
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.	
97150		THERAPEUTIC PROCEDURES GROUP (2 OR MORE)	
97530		HOME PROGRAM EA 15 MIN.	
97545		WORK HARDENING INITIAL 2 HOURS	
97750		PHYSICAL PERFORMANCE TEST/FCE EA 15 MIN.	
E0730		TENS	
64550		TENS APPLICATION	
99070		MISCELLANEOUS SUPPLIES	
99071		EDUCATIONAL MATERIALS	

3. pt reports her
is really sore today
she doesn't think she
can do anything. P.
request not to do
anything

0. R. consist of mil
15 mins -> LB

1. pt advised to pass
a PT and stretch in
N = 1 mobility
+ ms tightening. P.
pain on @ side of
wraps around @ hip

A. Cont. w. pt. post

ICD-9	CPT	DESCRIPTION	PRICE
72.1.4			
72.2.52			
V58.78			

DATE		TIME	PATIENT	REASON	PRIOR BALANCE
09/15/10		9:00	PATRICIA FORE	BACK PAIN	BAT 0.00 NS 360.00
TICKET NO	DR #	DOCTOR	LOCATION	DOB	TODAY'S CHARGE
404027	11	GAINT	ALBANY BONE JOINT C	01/10/65	22.00
PATIENT NO	RESPONSIBLE PARTY		PH#	REFERRING DR	TODAY'S PAYMENT
PT647E	GRIFFSCO OF WAMPEE INC		000 0000	WOLGIN MD	
SEX	M	F	ADDRESS	CITY/STATE	ZIP CODE
			8729 HWY 90		
P	OVER 90	OVER 60	OVER 30	CURRENT	TOTAL DUE
	0.00	0.00	0.00	360.00	360.00
INSURANCE COMPANY		POLICY ID		PAY CHOICE	
ALIGN NETWORKS		J		CASH	
				CHECK	
				CREDIT CARD	
				BALANCE DUE	
SSN #		VSD.75 AFTERCARE FOLLOWING SURGERY OF		THERAPIST SIGNATURE	

Medications Date Size Frequen Coun

I certify that all above services have been rendered by

Therapist Signature

BOOK IMAGE QUALITY

ORTHO SPORT PHYSICAL THERAPY

P.O. BOX 407 619 Ponte North Blvd. ALBANY GEORGIA 31702
FEDERAL ID #58-2471372

CHA 3-ADP01 OCT 04 2010

T. GLENN WILLIAMS, M.D., A.A.O.S., F.A.C.S.
THOMAS M. DARDEN, JR. M.D., A.A.O.S., F.A.
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MARK A. WOLGIN, M.D., A.A.O.S., F.A.C.S.

ORTHOPAEDIC
ASSOCIATES

CPT	UNITS	DESCRIPTION	COMMENTS/NOTES
97001		PHYSICAL THERAPY EVALUATION	S- pt. stated that she's doing better today, but her back is a little sore.
97002		PHYSICAL THERAPY RE-EVALUATION	
97010		APPLICATION MODALITY COLD PAK/ICE	O- Rx began 2 ther ex per f chart for a total of 35 min for ROM + stability of the LB. In addition to Piriformis stretch - 5 reps x 15 sec hold
97010		APPLICATION MODALITY MOIST HEAT	
97012		TRACTION MECHANICAL	Rx concluded 2 IFC/MHR in the LB + Ionto patch 2 day 80 mA to the LB
97014		ELECTRICAL STIMULATION (UNATTENDED)	
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)	A- pt. 2 ↑ mobility since last visit, 2 ↑ 90 pain when performing piriformis stretch pain level was 9/10.
97016		VASOPNEUMATIC DEVICES COMPRESSION	
97018		PARAFFIN BATH	P- continue POC
97026		INFRARED LASER	
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN	090310 090310
97032		IONTOPHORESIS EA 15 MIN	
97035		ULTRASOUND EA 15 MIN	
97039		PHONOPHORESIS UNLISTED MODALITY	
97110		THERAPEUTIC EXERCISES EA 15 MIN	
97112		NEUROMUSCULAR RE-ED PROM AROM PROM EA 15 MIN	
97116		GAIT TRAINING EA 15 MIN	
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN	
97150		THERAPEUTIC PROCEDURES GROUP (2 OR MORE)	
97530		HOME PROGRAM EA 15 MIN	
97545		WORK HARDENING INITIAL 2 HOURS	
97750		PHYSICAL PERFORMANCE TEST/CE EA 15 MIN	
E0730		TENS	
64550		TENS APPLICATION	
99070		MISCELLANEOUS SUPPLIES	
99071		EDUCATIONAL MATERIALS	

ICD-9	CPT	DESCRIPTION	PRICE
724.1			
722.52			
V58.79			

DATE		TIME	PATIENT	REASON	PRIOR BALANCE
09/13/10		9:00	PATRICIA FORE	BACK PAIN	0.00
TICKET NO		DR #	DOCTOR	LOCATION	D.O.B
104026		11	GAINT	ALBANY BONE JOINT C	01/10/65
PATIENT NO		RESPONSIBLE PARTY		PH#	REFERRING DR
PT6475		GRIFFSCO OF WAMPEE INC		090.0000	WOLGIN MD
B	M	F	ADDRESS	CITY/STATE	ZIP CODE
		X	8729 HWY 90		
OVER 90		OVER 60	OVER 30	CURRENT	TOTAL DUE
0.00		0.00	0.00	130.00	130.00
INSURANCE COMPANY		POLICY I.D.		PAY CHOICE	
ALIGN NETWORKS		Y 1		CASH	
SSN 1		V58.78		AFTERCARE FOLLOWING SURGERY OF	
				CHECK	
				CREDIT CARD	
				BALANCE DUE	

Medications Date Size Frequen Count

0.00
130.00

TODAY'S CHARGE

158.00

TODAY'S PAYMENT

PAY CHOICE

CASH

CHECK

CREDIT CARD

BALANCE DUE

I certify that all above services have been rendered by me.

Timothy B. Gaint, DPT 19
THERAPIST SIGNATURE

DOOR IMAGE QUAL

ORTHO SPORT PHYSICAL THERAPY

P.O. BOX 407 • 619 Points North Blvd • ALBANY, GEORGIA 31702

FEDERAL ID #58-247-372

CHARTIS:ADP01 OCT 04 2010

T. GLENN WILLIAMS, M.D., A.A.O.S., F.A.C.S.
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JAMES S. MASON, D.O., F.A.O.A.O.
MARK A. WOLGIN, M.D., A.A.O.S., F.A.C.S.

ORTHOPAEDIC
ASSOCIATES

CPT	UNITS	DESCRIPTION	COMMENTS / NOTES
97001		PHYSICAL THERAPY-EVALUATION	(4) 9/10/10
97002		PHYSICAL THERAPY-RE-EVALUATION	
97010		APPLICATION MODALITY-GOLD PAK/ICE	
97010		APPLICATION MODALITY-MOIST HEAT	
97012		TRACTION MECHANICAL	
97014	1	ELECTRICAL STIMULATION (UNATTENDED)	
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)	
97016		VASOPNEUMATIC DEVICES COMPRESSION	
97018		PARAFFIN/BATH	
97026		INFRARED LASER	
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.	
97033	1	IONTOPHORESIS EA 15 MIN.	
97035		ULTRASOUND EA 15 MIN.	
97039		PHONOPHORESIS UNLISTED MODALITY	
97110		THERAPEUTIC EXERCISES EA 15 MIN.	
97112		NEUROMUSCULAR RE-ED AROM AAROM-PROM EA 15 MIN.	
97116		GAIT TRAINING EA 15 MIN.	
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.	
97150		THERAPEUTIC PROCEDURES GROUP (2 OR MORE)	
97530		HOMEPROGRAM EA 15 MIN.	
97545		WORK HARDENING INITIAL 2 HOURS	
97750		PHYSICAL PERFORMANCE TEST/FCE EA 15 MIN.	
E0730		TENS	
64550		TENS APPLICATION	
99070		MISCELLANEOUS SUPPLIES	
99071		EDUCATIONAL MATERIALS	

S: pt reports her k
is really sore today
and she can't do
anything.

O: Re consist of my
Tfc x 15mins → LB
to ↓ pain. Re conc.
i. Tonto i. Dec 890310
80ma → LB 890310

A: pt f ↓ mobility on
last visit & ↑ clo p
in LB. ↑ ms light

P: Cont Rr. per POC

ICD-9	CPT	DESCRIPTION	PRICE
722.52			
156.73			

DATE		TIME	PATIENT	REASON	PRIOR BALANCE
09/10/10		0.00	PATRICIA FORE	BACK JNR	BAT 0.00 NS 130.00
TICKET NO.		DR#	DOCTOR	LOCATION	DOB
484825		11	GAINT	ALBANY BONE JOINT C	01/10/65
PATIENT NO.		RESPONSIBLE PARTY		PH#	REFERRING DR.
PT6475		GRIFFSCO OF WANPEE INC		000 0000	WOLGIN MD
S	M	F	ADDRESS	CITY/STATE	ZIP CODE
X			8729 HWY 90		
OVER 90		OVER 60	OVER 30	CURRENT	TOTAL DUE
0.00		0.00	0.00	130.00	130.00
PT		BC	CS	INITIAL	PAY CHOICE
		8	90	0	CASH
INSURANCE COMPANY		POLICY ID		CHECK	
ALIGN NETWORKS		Y I		CREDIT CARD	
SSN		V58.78		AFTERCARE FOLLOWING SURGERY OF	
				BALANCE DUE	

Medications Date Size Frequen Count

I certify that all above services have been rendered by me

Linette B. Gaint PT 1970
THERAPIST SIGNATURE

POOR IMAGE QUALITY

ORTHO SPORT SIGNAL THERAPY

P.O. BOX 407 819 Paine North Blvd ALBANY, GEORGIA 31702
FEDERAL ID #58-2471372

DR. DAMON M.D., A.A.O.S., F.A.C.S.
DR. DARDEN JR. M.D., A.A.O.S., F.A.
DR. A. MICHAEL M.D., A.A.O.S., F.A.C.S.
JAMES S. MASON D.O., F.A.O.A.O.
MARK A. WOLGIN, M.D., A.A.O.S., F.A.C.S.

ORTHOPAEDIC
ASSOCIATES

COMMENTS / NOTES

CPT	UNITS	DESCRIPTION
97001		PHYSICAL THERAPY-EVALUATION
97002		PHYSICAL THERAPY-RE-EVALUATION
97010		APPLICATION MODALITY-GOLD PAK/ICE
97010		APPLICATION MODALITY-MOIST HEAT
97012		TRACTION MECHANICAL
97014		ELECTRICAL STIMULATION (UNATTENDED)
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)
97016		VASONEUMATIC DEVICES COMPRESSION
97018		PARAFFIN BATH
97025		INFRARED LASER
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.
97033		IONTOPHORESIS EA 15 MIN.
97035		ULTRASOUND EA 15 MIN.
97039		PHONOPHORESIS UNATTENDED MODALITY
97110		THERAPEUTIC EXERCISES EA 15 MIN.
97112		NEUROMUSCULAR RE-ED AROMAAROM PROM EA 15 MIN.
97116		GAIT TRAINING EA 15 MIN.
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.
97150		THERAPEUTIC PROCEDURES GROUP (2 OR MORE)
97530		HOME PROGRAM EA 15 MIN.
97545		WORK HARDENING INITIAL 2 HOURS
97750		PHYSICAL PERFORMANCE TEST/CFE EA 15 MIN.
E0730		TENS
64550		TENS APPLICATION
99070		MISCELLANEOUS SUPPLIES
99071		EDUCATIONAL MATERIALS

9/7/10
CHARTISADP05 SEP 23 2010
At reports he feels better today not as much pain

He began to then per frs for Romptc of LP for a total 41 mins. Re concluded in mil/1fc x 15 mins

At a mobility but difficulty in Pelvic Tilt.

P: Cont Rx per POC

ICD-9	CPT	DESCRIPTION	PRICE
72.11			
72.25			
V58.71			

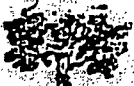
DATE		TIME	PATIENT	REASON	PRIOR BALANCE
09/07/10		3:00	PATRICIA FORE	BACK JNR	AT 0.00 NS 0.00
TICKET NO.	DR#	DOCTOR	LOCATION	D.O.B.	TODAY'S CHARGE
484023	11	GAINT	ALBANY, GEORGIA	01/10/65	108.00
PATIENT NO.	RESPONSIBLE PARTY		REFERRING DR.	TODAY'S PAYMENT	
PT6475	GRIFFSCO OF WAMPEE INC		0000 0000 WOLGIN MD		
SEX	M	F	ADDRESS	CITY/STATE	ZIP CODE
			8729 HWY 90		
OVER 60	OVER 60	OVER 30	CURRENT	TOTAL DUE	PT BC CS INITIAL
0.00	0.00	0.00	0.00	0.00	8 90 0
INSURANCE COMPANY		POLICY ID.		PAY CHOICE	
ALIGN NETWORKS		1		CASH CHECK CREDIT CARD	
SSN		V58.78 AFTERCARE FOLLOWING SURGERY OF		BALANCE DUE	
148					

Medications Date Size Frequen Count

I certify that all above services have been rendered by me

Therapist Signature

3-ADP09 SEP 24 2010



ORTHO SPORT PHYSICAL THERAPY



T. GLENN WILLIAMS, M.D., A.A.O.S., F.A.C.S.
THOMAS M. DARDEN, JR., M.D., A.A.O.S., F.A.C.
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ORTHOPAEDIC
ASSOCIATES

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FEDERAL ID #58-2471372

CPT	UNITS	DESCRIPTION
97001		PHYSICAL THERAPY - EVALUATION
97002		PHYSICAL THERAPY - RE-EVALUATION
97010		APPLICATION - MODALITY - COLD PAK / ICE
97010		APPLICATION - MODALITY - MOIST HEAT
97012		TRACTION - MECHANICAL
97014	1	ELECTRICAL STIMULATION (UNATTENDED)
G0283		MEDICARE ELECTRICAL STIMULATION (UNATTENDED)
97016		VASOPNEUMATIC DEVICES, COMPRESSION
97018		PARAFFIN BATH
97026		INFRARED LASER
97032		ELECTRICAL STIMULATION (ATTENDED) EA 15 MIN.
97033		IONTOPHORESIS EA 15 MIN.
97035		ULTRASOUND EA 15 MIN.
97039		PHONOPHORESIS - UNLISTED MODALITY
97110		THERAPEUTIC EXERCISES EA 15 MIN.
97112		NEUROMUSCULAR RE-ED-AROM/AAROM-PROM EA 15 MIN.
97116		GAIT TRAINING EA 15 MIN.
97140		MANUAL THERAPY TECHNIQUES EA 15 MIN.
97150		THERAPEUTIC PROCEDURES - GROUP (2 OR MORE)
97530		HOME PROGRAM EA 15 MIN.
97545		WORK HARDENING INITIAL 2 HOURS
97750		PHYSICAL PERFORMANCE TEST/ECE EA 15 MIN.
E0730		TENS
64550		TENS APPLICATION
99070		MISCELLANEOUS SUPPLIES
99071		EDUCATIONAL MATERIALS

COMMENTS / NOTES
② 9/3/10

S: PT reports her back has been killing her since the first visit.

C: Re consists of mup /
Tic < ROMs -> LO
in sitting.

A: PT not tolerating PT well. ↑ cl. pain in
LA. PT not able to
maintain prone, supine,
or sidelying positions

P: Cont. Rx per pax

ICD-9	CPT	DESCRIPTION	PRICE
724.4			
722.52			
158.72			

DATE	TIME	PATIENT	REASON	PRIOR BALANCE
09/03/10	8:00	PATRICIA FORE	BACK PNR	AT 0.00 HS 0.00
TICKET NO.	DR#	DOCTOR	LOCATION	DOS
404022	11	GAINT	ALBANY BONE JOINT C	01/10/65
PATIENT NO.	RESPONSIBLE PARTY	PH#	REFERRING DR.	
PT6475	GRIFFSC OF WANPEE INC	000 0000 WOLGIN MD		
SEX	M	F	ADDRESS	CITY/STATE
		X	8729 HWY 90	
OVER 90	OVER 60	OVER 30	CURRENT	TOTAL DUE
0.00	0.00	0.00	0.00	0.00
PT	BC	CS	INITIAL	
	0	90	0	
INSURANCE COMPANY	POLICY ID			
ALIGN NETWORKS	1			
SSN				

Medications Date Size Frequen Count

TODAY'S CHARGE
22.00
TODAY'S PAYMENT

PAY CHOICE
CASH
CHECK
CREDIT CARD

I certify that all above services have been rendered by me.

BALANCE DUE

Linette B. Gant, PT, 1920
THERAPIST SIGNATURE

Patient: Patricia Fore
 Diagnosis: Degenerative disk disease in lumbar spine and sciatica
 Physician: James S. Mason, D.O.
 DOB: 01-10-64
 SSN:

HISTORY: See McKenzie evaluation.

- A: Patient is a 43-year-old female with a diagnosis of degeneration of lumbar disk/sciatica presenting with increased complaints of pain with activity, decreased lumbar range of motion, palpable tenderness, radiculopathy into right lower extremity, decreased transitional mobility, antalgic gait and an overall decline in function. All of the above deficits indicate a need for skilled physical therapy intervention with patient having good rehabilitation potentials to achieve the following goals:

Short-Term Goals - 2 weeks:

- Patient will be independent with initial home exercise program to include strengthening and stretching exercises for lumbar spine.
- Decrease pain to a 5/10 when patient is performing functional activities to include getting in and out of the bed.
- Increase pain-free lumbar range of motion x 10-15° in order for patient to be able to bend over and put on her shoes and socks.
- Decrease radiculopathy in right lower extremity x 25% in order for patient to have increased ease with transitional mobility and gait.

Long-Term Goals - 4 weeks:

- Patient will be independent with final home exercise program to include strengthening and stretching exercises for lumbar spine.
- Decrease pain to a 3/10 when patient is performing functional activities to include getting in and out of the car and picking up her child.
- Increase pain-free lumbar range of motion x 30-40° in order for patient to be able to bend over and put on her shoes and socks.
- Patient will have centralization to cervical spine with no complaints of pain in right lower extremity when performing ADLs.

- P: Patient will be seen in clinic 3 x a week x 4 weeks per physician order for progression of home exercise program, therapeutic exercises and activities for range of motion and strengthening, soft tissue mobilization/manual therapy, and modalities as needed. All of the above activities will be progressed according to patient's tolerance in order to restore patient to maximal level of function.

Thank you for this referral.

Julie M. Scott, PT #6355

JMS/at

09:30:08

18/17/2008 03:19

2294351838

ORTHOPAEDIC ASSO



THE MCKENZIE INSTITUTE LUMBAR SPINE ASSESSMENT

Date 9/30/08Name Patricia GoreSex M/F

Address _____

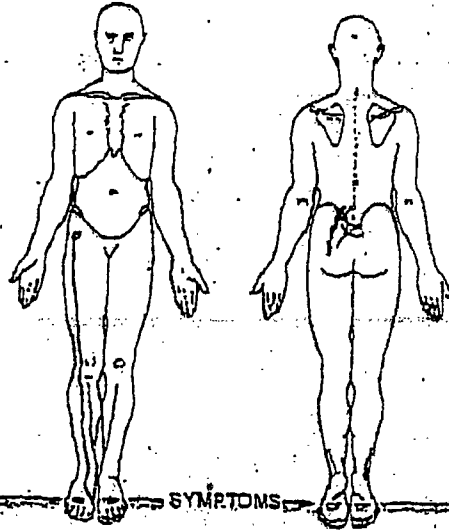
Telephone _____

Date of Birth 1/10/65Age 43

Referral: GP / Orth / Self / Other _____

Work / Leisure Meat Cutter - worked for ISA
in SC; ODU since 2/08Postures / Stresses unable to liftFunctional Disability from present episode to go to courton 11/5/08 → filing suit

Functional Disability score = _____

VAS Score (0-10) = 8/10

SYMPTOMS

HISTORY

Present symptoms 90 pain in R hip down into RLE into wristPresent since 2/29/08 →

Improving / Unchanging / Worsening

Commented as a result of carrying 50lb pork coming around saw or no apparent reason stopped workSymptoms at onset: back / thigh / leg R hip progressed into LEConstant Symptoms: back / thigh / leg dule "sharp" & med

Intermittent symptoms: back / thigh / leg

Worse

bendingsittingstandingwalkinglyingas the day progresseswhen still / on the moveother unable to put on sock; barely pick up child; right

Better:

bendingsittingstandingwalkinglyingas the day progresseswhen still / on the move

other _____

Disturbed Sleep Yes/No

Sleeping postures: prone / sup / side (R) / (L)

Surface: firm / soft / sag

Previous Episodes: 0 1-5 6-10 11+

Year of first episode _____

Previous history: NAPrevious treatments: 2 sp injections to R hip & temp. reliefNothing has stopped pain

SPECIFIC QUESTIONS

Cough / Sneeze / Strain +ve -ve

Bladder: normal / abnormal

Gait: normal / abnormal

Medications: Nil / NSAIDs / Analg / Steroids / Anticoag / Other Anti-inflamGeneral Health: Good / Fair / Poor IDDImaging: Yes / No MRI - bulging disc per dr report; x-ray R hip

Recent or major surgery: Yes / No

Night pain: Yes / No

Accidents: Yes / No

152

Unexplained weight loss: Yes / No

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1st International 2003

10/17/2008 03:19 2294351038

ORTHOPAEDIC ASSO

EXAMINATION

POSTURE

Sitting: Good Fair / PoorStanding: Good Fair / PoorLordosis: Rect Acc / NormLateral Shift: Right / Left / NilCorrection of posture: Senior / Worse / No effect

Relevant: Yes / No

Other observations:

LOS to RLE, tender c. R quadr tch 5 dog
TR / ITB

NEUROLOGICAL

Motor deficit

NL

Reflexes

Sensory deficit

NL

Dural signs

MOVEMENT LOSS

	major	mod	min	nil	pain
Flexion	<u>X</u>				
Extension		<u>X</u>			<u>No Pain</u>
Side Gliding (R)					
Side Gliding (L)					

~15° compensation
to return to stand
~15°

TEST MOVEMENTS

Describe effects on present pain - During: produces, abolishes, increases, decreases, no effect, centralising, peripheralising. After: better, worse, no better, no worse, no effect, centralised, peripheralised.

Symptoms During Testing

Symptoms After Testing

Mechanical Response

↑ Rom ↓ Rom No Effect

Pretest symptoms standing:

PIS ↑ c/o LBP ↑ rad pain (R) LE

Rep PIS

EIS NW NB

Rep EIS

Pretest symptoms lying:

FIL ↑ c/o pain

Rep FIL

↑ c/o pain ↑ rad pain (R) LEEIL No Effect

Rep EIL

No effect

If required pretest symptoms:

SGIS (R) ↑ pain ~ hipRep SGIS (R) ↑ pain ~ (R) LE

SGIS (L)

Rep SGIS (L)

STATIC TESTS

Sitting slouched

Sitting erect

Standing slouched

Standing erect

Lying prone in extension

Long sitting

OTHER TESTS

Pain ~ (R) hip ↑ EK NL pelvic segmentResisting rot ↓ c/o pain ~ (R) LE But ↑ c/o HCwhell

PROVISIONAL CLASSIFICATION

Derangement

Dysfunction

Posture

Other

Subclassification

PRINCIPLE OF MANAGEMENT

Education

Patient Care Plan

Southwestern Home Care & Medical Services

Name Patricia Jare Telephone 229-869-2954
 Address 111 3rd St East City Lebanon Age 46 Ht 61 in Wt 226 lb
 Primary Diagnosis & Client Problems C. Colgan Johnson of Spain

Client Goals Client will be free of infection throughout stay-up.
 Directions to Home Out of parking lot - D on Slappy - travel N to 11 Leaning - bear to R - find light - go to stop sign - turn D - RSH to R 3rd house on D

Functional Limitations: Mobile Allergies: AIN
 Equipment: urinal commode, extension
 Service Schedule: 1st & 3rd M & W - PANA 4hr/d x 10-12 d

A
P
P
R
O
A
C
H
E
S

PERSONAL CARE SERVICES	
☐	Bath
☒	Amputation / Transfer / Reposition <u>assist PRA</u>
☒	Dressing <u>assist PRA</u>
☐	Toileting (Bowel)
☐	Toileting (Bladder)
☐	Hair Care
☐	Oral Care
☒	Skin Care / Shaving / <u>File Nails</u>
☒	Observe Skin (Comment Below)
NUTRITION SUPPORT Type of Diet:	
☒	Prepare Meals <u>assist PRA</u>
☒	Feed Patient / Set Up Meals <u>assist PRA</u>
☐	Encourage / Record Fluids
HOMEMAKER TASKS	
☒	Vacuum / Dust <u>every day</u>
☒	Empty Trash <u>every day</u>
☒	Sweep and Mop <u>twice a week</u>
☒	Clean Patient's Room <u>every day</u>
☒	Clean Kitchen / Bathroom <u>every day</u>
☐	Laundry / Change Linens
☐	Other
Handwashing ☒ Kitchen ☐ Bath ☐ Other ☐	
☒	Escort / Errands <u>PRA</u>
☒	Remind Client to Take Medications <u>PRA</u>
☐	Diversional Activities / Exercise
☒	Caregiver Relief
☒	Monitor for Safety
☒	Discharge Plans <u>Client will be discharged when no drainage from surgical site</u>

Effective from 5/24/10 to Target Date 7/24/10
 Signature [Signature]
 Signature _____
 Signature _____
 Signature _____
 Signature _____
 Signature _____

Southwestern Homecare & Medical Services, Inc.

Skilled Visits

Patient Name: Patricia Fore

Patient SSN: _____

Date: 5-28-10

Visit Type: Initial Skill Nursing Evaluation

Time In: 10:15

Time Out: 10:45

BP: 138/70 FSBS: 110 AP: 70 RP: 70 RESP: 20 TEMP: 98 ORA WT: _____

Neurological	Yes	No	Endocrine	Yes	No	Respiratory	Yes	No	Gastrointestinal	Yes	No	Muscular/Skeletal	Yes	No
Abnormal Pupils			Diabetic			ABN Sounds			Rapid Abduction			Assist Device		
Speech Defect			Other			Irregular Rate			Pain			Unsteady Gait		
Comatose						S.O.B			Distention			Poor Balance		
Lethargic			Cardiovascular			Dyspnea			Nausea			Weakness		
Seizures			Cyanosis			Orthopnea			Vomiting			Pain		
Other			Irregular Pulses			Cough			Melena			Contractures		
MENTAL			Bounding Pulses			Productive			Diarrhea			Deformity		
Disoriented			Thrready Pulses			Non-productive			Stool Incontinence			Stiffness		
Forgetful			JVD			O2/L/M			ABN B.S.			Paralysis		
Depression			Edema			Trach			Hyper B.S.			Decreased Coordina		
Other			Chest Pain			Other			Hypo B.S.			Other		
			Numbness						Hematemesis					
EENT/ORAL			Syncope			SKIN			Constipation			GENTOURINARY		
Pain			Dysrhythmia			Rash/Lesions			Inadequate PO intake			Incontinent at times		
Discharge/ Bleeding			Dizziness			Pressure Ulcer			Fecal Impaction			Frequency		
Lesions			BREASTS			Diaphoretic			Feeding Tube(s)			Urgency		
Dryness			Discharge			Petechia			Anorexia			Dysuria		
Tinnitus			Pain			Testing			Other			Nocturia		
Prosthesis/Aids			Other			Dry/Hot/Cold			NAILS			Hematuria		
Limited Vision						Pale/Flush			Abnormalities			Caffeter		
HOH						Other						Other		
Other														

Homebound Status: Yes

Observations: Client up and about
i home. Color good - resp. even
rad. skin - labored. High apical
healer. off. Strips in place -
no drainage noted.

Skilled Interventions/Teachings: W. taken - lungs feel
clear. Abd. soft - bowel sounds
present. off. off back. Pt. said
this took them off in the doctor's
off and said they would not put
off off back on cause it's not draining
Client expressed that unit will be
very, deep to no drainage on day.
 Goals: Client free w/ infection goal
met.

Problem Identified: Pneumonia line x 4 cm
back

Communication with MD: No
 Change in Orders/Medication: No

Physical Findings

Anterior Posterior

use cm measurement				
	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Amount				
Character				
Tunneling				
Edema				
Odor				
Inflam				

MD Visit: Confirmed YES NO X DATE _____ Pt. Informed of changes YES NO

Print Nurse Name: Shirley Ellis Nurse Signature: Shirley Ellis

Supervisor: Chris Taylor Date: 6/1/10 Patient Signature: Patricia Fore

Southwestern Homecare & Medical Services, Inc.

Skilled Visits

Patient Name: Patricia Fore
Visit Type: Initial Skill Nursing Evaluation

Patient SSN: _____
Time In: 6:40

Date: 5/6/10
Time Out: 7:00

BP: 122/72 PSBS: 30 AP: 92 RP: 92 RESP: 24 TEMP: 98.6 ORA WT: _____

Neurological	Yes	No	Endocrine	Yes	No	Respiratory	Yes	No	Gastrointestinal	Yes	No	Muscular/Skeletal	Yes	No
Abnormal Pupils		☒	Diabetic	☒		ABN Sounds		☒	Rigid Abdomen		☒	Assist. Device	☒	
Speech Defect		☒	Other			Irregular Rate		☒	Pain		☒	Unsteady Gait	☒	
Comatose		☒				S.O.B.		☒	Distention		☒	Poor Balance	☒	
Lethargic		☒	Cardiovascular		☒	Dyspnea		☒	Nausea		☒	Weakness	☒	
Seizures		☒	Cyanosis		☒	Orthopnea		☒	Vomiting		☒	Pain	☒	
Other		☒	Irregular Pulses		☒	Cough		☒	Melena		☒	Contractures	☒	
MENTAL		☒	Bounding Pulses		☒	Productive		☒	Diarrhea		☒	Deformity	☒	
Disoriented		☒	Thrready Pulses		☒	Non-productive		☒	Stool Incontinence		☒	Stiffness	☒	
Forgetful		☒	JVD		☒	O2L/M		☒	ABN. B.S.		☒	Paralysis	☒	
Depression		☒	Edema		☒	Trach		☒	Hyper.B.S.		☒	Decreased Coordin	☒	
Other		☒	Chest Pain		☒	Other		☒	Hypo.B.S.		☒	Other		
		☒	Numbness		☒			☒	Hematemesis		☒			
EENT/ORAL		☒	Syncope		☒	SKIN		☒	Constipation		☒	GENITOURINARY		
Pain		☒	Dysrhythmia		☒	Rash/Lesions		☒	Inadequate PO Int		☒	Incontinence at times	☒	
Discharge/Bleeding		☒	Dizziness		☒	Pressure Ulcer		☒	Fecal Impaction		☒	Frequency	☒	
Lesions		☒	BREASTS		☒	Diaphoretic		☒	Feeding Tube(s)		☒	Urgency	☒	
Drains		☒	Discharge		☒	Petechia		☒	Anorexia		☒	Dysuria	☒	
Tinnitus		☒	Pain		☒	Tenting		☒	Other		☒	Nocturia	☒	
Prostheses/Aids		☒	Other		☒	Dry/Hot/Cold		☒	NAILS:		☒	Hematuria	☒	
Limited Vision		☒				Pale/Flush		☒	Abnormalities		☒	Catheeter	☒	
HOH		☒				Other		☒			☒	Other		
Other		☒												

Homebound Status: Yes

Observations: Client up and about
1 home. Color good - per rectum
and non-labored. Abn. heeded
in place. Client using walker &
ambulation.

Skilled Interventions/Teachings: VS taken - lungs
field clear. Abn. soft bowel,
breeder present yet SOB - Bony 10.
Also, removed home back - right
#1 red, scar not of brownish color
drainage - #3 drg. " " " " " "
brownish red - drain - dx. reappled
#4 - secured to tape. Chest rechecked
Goals: slx wld. infection. New med. hold
Goal (Client will be free of
infection throughout healing process.

Physical Findings
Anterior Posterior

use cm measurement				
	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage	red	NO	#1	NO
Amount	Red	---	dot	---
Character				
Tunneling				
Edema				
Odor				
Inflam				

Problem Identified: Wds. to lower back

Communication with MD:

Change in Orders/Medication: Antibiotic 500mg/h / Hydrocortisone 100mg 5/5/10
3x day

1 MD Visit: Confirmed YES ☒ NO ☒ DATE 5/21/10 Pt Informed of changes YES ☒ NO ☒

Print Nurse Name: Shirley Etkin Nurse Signature: [Signature]

Supervisor: Cathy Taylor Date: 5/27/10 Patient Signature: Patricia Fore

Southwestern Homecare & Medical Services, Inc.

Skilled Visits

Patient Name: Patricia Fore Patient SSN: _____ Date: 5-25-10
 Visit Type: Initial Skill Nursing Evaluation Time In: 6:40 Time Out: 7:10

BP: 172/90 HR: 108 AP: 90 RP: 90 RESP: 22 TEMP: 97.4 ORA WT: _____

Neurological	Yes	No	Endocrine	Yes	No	Respiratory	Yes	No	Gastrointestinal	Yes	No	Muscular/Skeletal	Yes	No
Abnormal Pupils		☒	Diabetic		☒	ABN Sounds		☒	Right Abduction		☒	Assist Device		☒
Speech Defect		☒	Other		☒	Irregular Rate		☒	Pain		☒	Unsteady Gait		☒
Comatose		☒			☒	S.O.B.		☒	Distention		☒	Poor Balance		☒
Chvargic		☒	Cardiovascular		☒	Dyspnea		☒	Nausea		☒	Weakness		☒
Seizures		☒	Cyanosis		☒	Orthopnea		☒	Vomiting		☒	Pain		☒
Other		☒	Irregular Pulses		☒	Cough		☒	Melena		☒	Contractures		☒
MENTAL		☒	Bounding Pulses		☒	Productive		☒	Diarrhea		☒	Deformity		☒
Disoriented		☒	Thrready Pulses		☒	Non-productive		☒	Stool Incontinence		☒	Stiffness		☒
Forgetful		☒	JVD		☒	O2/LM		☒	ABN B.S.		☒	Paralysis		☒
Depression		☒	Edema		☒	Trach		☒	Hyper B.S.		☒	Decreased Coordina		☒
Other		☒	Chest Pain		☒	Other		☒	Hypo B.S.		☒	Other		☒
		☒	Numness		☒			☒	Hematemesis		☒			☒
EENT/ORAL		☒	Syncope		☒	SKIN		☒	Constipation		☒	GENITOURINARY		☒
Pain		☒	Dysrhythmia		☒	Rash/Lesions		☒	Inadequate PO Int		☒	Incontinent at times		☒
Discharge/Bleeding		☒	Dizziness		☒	Pressure Ulcer		☒	Fecal Impaction		☒	Frequency		☒
Lesions		☒	BREASTS		☒	Diabetic		☒	Feeding Tube(s)		☒	Urgency		☒
Dryness		☒	Discharge		☒	Petechia		☒	Anorexia		☒	Dysuria		☒
Tinnitus		☒	Pain		☒	Terting		☒	Other		☒	Nocturia		☒
Prosthesis/Aids		☒	Other		☒	Dry/Hot/Cold		☒	NAILS		☒	Hematuria		☒
Limited Vision		☒			☒	Pale/Flush		☒	Abnormalities		☒	Catheter		☒
HOH		☒			☒	Other		☒			☒	Other		☒
Other		☒			☒			☒			☒			☒

Homebound Status: Yes

Observations: Client sitting up watching TV - binder in place. Clear good resp. effort and non-labored. Graces to ambulation. Client uses walker to ambulation.

Skilled Interventions/Teachings: VS taken using field clear. Abd. soft - bowel sounds present x4. SPS: 140 bpm. Drg removed from back. Wound bed x4 - drg. Upper back soaked. NO drainage noted. 1, 3, 4 drs - Steri-strip in place. Drg. changed. Wound secured to tape. Client understood Goals: s/s resolved. Infection. Goal: Client will be free of infection throughout healing process.

Problem Identified: Wounds x4 & back

Communication with MD: NO

Change in Orders/Medication: NO

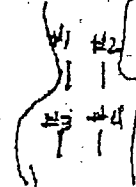
Next MD Visit: Confirmed YES ☒ NO ☐ DATE _____ Pt. Informed of changes YES ☐ NO ☐

Print Nurse Name: Patricia Fore Nurse Signature: Patricia Fore

Supervisor: Tracy Taylor Date: 5/27/10 Patient Signature: Patricia Fore

Physical Findings

Anterior Posterior



use cm measurement

	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Amount				
Character				
Tunneling				
Edema				
Odor				
Inflam				

Southwestern Homecare & Medical Services
Phone: (229) 889-1598 Fax: (229) 888-3558
Toll Free: (877) 889-1598

INITIAL NURSING ASSESSMENT AND VISIT RECORD

Patient Name: Patricia Gore Date: 5/24/10 Time: 5:30
Services Requested: W & PC/HHA Diagnosis: Comp. fusion of spine

CLINICAL BASELINE DATA		T: <u>98</u>	P: <u>87</u>	R: <u>22</u>	Ht: <u>6'11"</u>	Wt: <u>163</u>
☐ MALE	☒ FEMALE	BP Rt. Arm: <u>182/94</u>	BP Lt. Arm: <u>187/120</u>			
HISTORY of Current Illness: <u>injured back at work</u>						
ALLERGIES: <u>PCN</u>						
PAST MEDICAL HISTORY						
☐ Kidney Disease	☐ Heart Disease	☐ Hepatitis	☐ Blood Clots	☐ Fainting Episodes		
☐ Lung Disease	☐ GI/GU Disease	☐ Asthma	☐ Mental Illness	☐ Chemical Dependency		
☐ Liver Disease	☐ Stroke	☒ Diabetes	☐ Seizures	☐ Thyroid Disease		
☒ Hypertension	☐ Anemia	☐ Cancer	☐ Other: _____			
PSYCHO/SOCIAL ASSESSMENT						
HOUSING: ☒ Owns Home ☐ Rents ☐ Lives Alone ☐ Other: _____						
☐ Lives With: _____ Marital Status: _____						
Attends School/Program: ☐ Yes ☒ No ☐ N/A						
Literate: ☒ Yes ☐ No Primary Language (if other than English): _____						
Religion: <u>Papst</u>						
AFFECT: ☐ Angry ☐ Flat ☒ Calm ☐ Restless ☐ Depressed ☐ Withdrawn						
☐ Combative ☐ Anxious ☐ Agitated ☐ Lacks Motivation						
Availability of Caregiver: <u>Available and willing to assist</u>						
Other providers/agencies in the home: _____						
LEARNING CAPABILITIES		EXCELLENT	GOOD	FAIR	COMMENTS	
PATIENT		<u>✓</u>	_____	_____	_____	
CAREGIVER		<u>✓</u>	_____	_____	_____	

CLINICIAN INITIALS NO

Initial Nursing Assessment and Visit Record (continued):

HOME ENVIRONMENT				
	YES	NO		
Running Water	☒	☐	Electricity	☒
Adequate Refrigeration	☒	☐	Signs of Infestation	☒
Telephone	☒	☐	Accessible Toileting	☒
Adequate/Safe Heat	☒	☐	Adequate Outlets for Electricity	☒
Adequate/Safe Cooling	☒	☐	Functional Smoke Detectors	☒
Adequate Clean Storage Area	☒	☐	Smoking Precautions	☒
Adequate Clean Work Area	☒	☐	Stairs	☒
Pets: <u>cat</u>	☒	☐		
Safety Measures Needed: <u>safety & ambulation - keep area</u>				
<u>free of clutter.</u>				
Comments: _____				

SYSTEM REVIEW/ASSESSMENT

NEUROLOGICAL ☒ ALERT ☐ CONFUSED ☐ LETHARGIC ☐ COMATOSE ☐ IMPAIRED MEMORY ☐ VERBAL ☐ NON-VERBAL APHASIA: ☐ EXPRESSIVE ☐ SLURRED SPEECH ☐ RECEPTIVE ☐ RECENT NEURO/COGNITIVE CHANGE: DESCRIBE: _____ ORIENTED TO: ☒ TIME ☒ PLACE ☒ PERSON PARALYSIS: ☐ RUE ☐ LUE ☐ RLE ☐ LLE ☐ NO SIGNIFICANT PROBLEM NOTED	
HEENT HEAD: ☒ WNL ☐ VERTIGO ☐ HEADACHES ☐ OTHER: _____ EARS: ☒ WNL ☐ IMPAIRED HEARING: ☐ RT. ☐ LT. ☐ BOTH HEARING AIDS: ☐ RT. ☐ LT. ☐ BOTH EYES: ☒ WNL ☐ IMPAIRED VISION: ☐ GLASSES ☐ CATARACTS ☐ GLAUCOMA ☐ LEGALLY BLIND NOSE/THROAT: ☒ WNL ☐ EPISTAXIS ☐ DRAINAGE ☐ DIFFICULTY SWALLOWING ☐ HOARSENESS	
ORAL ☐ Pink and Moist ☐ Dry ☐ Tender ☐ White Patches ☐ Teeth/Chewing ☐ Other: _____ ☐ No significant problem noted	
RESPIRATORY ☐ SOB ☐ ORTHOPNEA, # OF PILLOWS _____ ☐ COUGH/PRODUCTIVE: _____ ☐ O2 RATE: _____ TYPE: _____ ☐ TRACHEOSTOMY ☐ SUCTION MACHINE ☐ NEBULIZER LUNG SOUNDS: RT. ☒ CLEAR ☐ CRACKLES ☐ WHEEZES ☐ DIMINISHED ☐ ABSENT LT. ☒ CLEAR ☐ CRACKLES ☐ WHEEZES ☐ DIMINISHED ☐ ABSENT ☐ OTHER: _____ ☐ No significant problem noted	
CARDIOVASCULAR ☐ PALPITATIONS ☐ SYNCOPE ☐ PACEMAKER ☐ DISCOMFORT/PAIN: LOC. _____ ☐ EDEMA: LOC. _____ RELIEVED BY: _____ ☐ NECK VEIN DISTENTION ☐ PERIPHERAL PULSES DIMINISHED ☐ OTHER: _____ ☒ NO SIGNIFICANT PROBLEM NOTED	

CLINICIAN INITIALS PD

Initial Nursing Assessment and Visit Record (continued)

GASTROINTESTINAL

☒ NO SIGNIFICANT PROBLEM NOTED

- ☐ NAUSEA ☐ VOMITING ☐ ANOREXIA ☐ ASCITES ☐ ABDOMINAL DISTENTION
☐ CHANGE IN APPETITE: _____ ☐ BOWEL SOUNDS: ☐ ACTIVE ☐ DIMINISHED
☐ PAIN ON PALPATION: LOC _____ ☐ STOOLS: ☐ WNL ☐ TARRY ☐ BLOODY
☐ DIARRHEA _____ ☐ CONSTIPATION: RELIEVED BY _____
☐ RECTAL BLEEDING ☐ CONTINENT ☐ INCONTINENT ☐ OSTOMY
 DIET: ☒ REGULAR ☐ SPECIAL ☐ PO ☐ FEEDING TUBE: TYPE _____
☐ BOLUS: AMOUNT _____ FREQUENCY _____ MANAGED BY: _____
 APPETITE: ☐ GOOD ☐ FAIR ☐ POOR ☐ DIETARY SUPPLEMENTS: _____
☐ FLUID RESTRICTIONS: _____ ☐ EATING DIFFICULTIES: _____

URINARY

☒ NO SIGNIFICANT PROBLEMS NOTED

- ☐ CONTINENT ☐ INCONTINENT ☐ RETENTION ☐ NOCTURIA ☐ URGENCY ☐ BURNING
☐ OSTOMY ☐ OTHER: _____ ☐ CATHETER: TYPE AND SIZE _____
☐ INCONTINENCE PADS/BRIEFS _____ MANAGED BY: _____

MUSCULOSKELETAL

☒ NO SIGNIFICANT PROBLEM NOTED

- IMPAIRED GROSS MOVEMENT: ☒ RUE ☒ LUE ☒ RLE ☒ LLE ☐ PAINFUL, SWOLLEN JOINTS
☐ CONTRACTURES ☐ AMPUTATION: _____ ☐ UNSTEADY GAIT
☒ REQUIRES ASSISTANCE WITH TRANSFER/AMBULATION ☐ CHAIR CONFINED
☐ BED CONFINED ☐ OTHER: _____ ☒ EQUIPMENT: Walker

NUTRITIONAL RISK ASSESSMENT

RISK FACTORS:

- ☐ STRICT MEDICALLY-PRESCRIBED DIET ☒ SIGNIFICANT NUTRITIONAL-RELATED
 PROBLEM OR NEED ☐ POOR SOCIAL SUPPORT SYSTEMS TO OBTAIN AND PREPARE FOOD
☐ OPEN WOUNDS LEVEL OF RISK: ☒ LOW ☐ MODERATE ☐ HIGH
 ***COUNSELING/TEACHING/REFERRAL (required for score of 3 or greater): _____

SKIN

☒ NO SIGNIFICANT PROBLEM NOTED

- COLOR: ☒ WNL ☐ PALE ☐ ASHEN ☐ FLUSHED ☐ JAUNDICED ☐ CYANOTIC
 TEMPERATURE: ☐ COOL ☐ DRY ☐ DIAPHORETIC ☒ WARM
 TURGOR: ☒ GOOD ☐ FAIR ☐ POOR ☐ RASH: LOC _____ DESCRIPTION: _____
☐ PRURITIS ☐ ALOPECIA ☐ PETECHIAE
☒ WOUND/INCISION/DECUBITI: ☒ INTACT MANAGED BY: JW #1 #2
☐ LOC: _____ ☐ WIDTH 1 cm ☐ DEPTH 0 ☐ LENGTH 3 mm 3 1/2 mm
☒ DRAINAGE Small amt ☐ OTHER ABNORMALITIES: _____ #3 #4
 BRANDON SCALE SCORE: 10 5 mm 5 1/2 mm

BEHAVIORAL ASSESSMENT

- ☐ CONVERSES MEANINGFULLY ☐ FORGETS SIGNIFICANT FACTS ☐ WANDERS
☐ DISTURBS OTHERS BY SHOUTING/YELLING ☐ THREATENS OTHERS VERBALLY
☐ HALLUCINATES ☐ CRIES WITHOUT OBSERVABLE CAUSE ☐ SLEEPING PROBLEMS
☐ EXHIBITS QUICK MOOD SHIFTS ☐ THINKS OTHERS ARE TRYING TO HARM HIM/HER
☒ ABLE TO FOLLOW DIRECTIONS ☐ OTHER: _____

CLINICIAN'S INITIALS JW

Patient Name Patricia Jive
Date 5/24/0

Pain Assessment Scale Score 8
Pharmacy Name Walgreen & Walmart
Number _____

Medications

Aspirin 60 bid.
Morphine 100 sliding scale as needed
Acetaminophen 15mg
Oxycodone 5/325
Butorphanol 25-50/1h.

Narrative or Summary Comments

46yr. old w/f up in home - ambulating
to use of walker. Binder in place
around waist. Oriented x4. Abd. soft -
bowel sounds present x4. Ambulating
slowly - grimacing to ambulation. Pt
took pain pill during visit. Discharge
to lower back - scarot drainage reddish
brown in color noted. Steri strips in
place x4. Discharge reappplied secured to tape.
ASBS = 118 mg/dl.

Care Plan Discussed and Approved by Patient/Caregiver ☒

[Signature]
Clinician Initials Signature

Southwestern Homecare & Medical Services, Inc.

Skilled Visits

Patient Name: Patricia Fore Patient SSN: _____ Date: 5-28-10
 Visit Type: Initial Skill Nursing Evaluation Time In: 6:40 Time Out: 7:10

BP: 178/88 FSBS: 148 AP: 90 RP: 90 RESP: 12 TEMP: 97.4 ORA WT: _____

Neurological	Yes	No	Endocrine	Yes	No	Respiratory	Yes	No	Gastrointestinal	Yes	No	Musculoskeletal	Yes	No
Abnormal Pupils		☒	Diabetic	☒		ABN Sounds	☒		Rigid Abdomen	☒		Assist. Device	☒	
Speech Defect		☒	Other			Irregular Rate	☒		Pain	☒		Unsteady Gait	☒	
Comatose		☒				S.O.B.	☒		Distention	☒		Poor Balance	☒	
Lethargic		☒	Cardiovascular	☒		Dyspnea	☒		Nausea	☒		Weakness	☒	
Seizures		☒	Cyanosis	☒		Orthopnea	☒		Vomiting	☒		Pain	☒	
Other			Irregular Pulses	☒		Cough	☒		Melena	☒		Contractures	☒	
MENTAL			Bounding Pulses	☒		Productive	☒		Diarrhea	☒		Deformity	☒	
Disoriented		☒	Thready Pulses	☒		Non-productive	☒		Stool Incontinence	☒		Stiffness	☒	
Forgetful		☒	JVD	☒		O2/LM	☒		ABN. B.S.	☒		Paralysis	☒	
Depression		☒	Edema	☒		Trach	☒		Hyper B.S.	☒		Decreased Coordination	☒	
Other			Chest Pain	☒		Other	☒		Hypo B.S.	☒		Other	☒	
			Numbness	☒					Hematemesis	☒				
EENT/ORAL			Syncope	☒		SKIN	☒		Constipation	☒		GENITOURINARY	☒	
Pain		☒	Dysrhythmia	☒		Rash/Lesions	☒		Inadequate PO int	☒		Incontinent at times	☒	
Discharge/Bleeding		☒	Dizziness	☒		Pressure Ulcer	☒		Fecal Impaction	☒		Frequency	☒	
Lesions		☒	BREASTS	☒		Diaphoretic	☒		Feeding Tube(s)	☒		Urgeacy	☒	
Dryness		☒	Discharge	☒		Petechia	☒		Anorexia	☒		Dysuria	☒	
Tinnitus		☒	Pain	☒		Tenting	☒		Other	☒		Nocturia	☒	
Prostheses/Aids		☒	Other	☒		Dry/Hot/Cold	☒		NAILS	☒		Hematuria	☒	
Limited Vision		☒				Pale/Flush	☒		Abnormalities	☒		Catheter	☒	
HOH		☒				Other	☒					Other	☒	
Other														

Homebound Status: Yes

Observations: Client sitting up watching TV - binder in place. Clear good resp. seen and non-labored. Graces to ambulation. Client uses walker to ambulation.

Skilled Interventions/Teachings: VS taken lung field clear. Abd. soft - bowel sounds present x4. SPS: 148/94. Dg removed from back. Wound tube x4 - dry. Upper back soaked. NO drainage noted. 1.5 x 4 dry - Steri-strips in place. Dg changed & dsgn. secured to tape. Client instructed Goals: Sp. w/d. infection. Goal: Client will be free of infection throughout healing process.

Problem Identified: Wounds x4 to back

Communication with MD: NO

Change in Orders/Medication: NO

MD Visit: Confirmed YES ☒ NO ☐ DATE _____ Pt. Informed of changes YES ☐ NO ☐

Print Nurse Name: Patricia Fore Nurse Signature: Patricia Fore

Supervisor: Chris Caffery Date: 5/28/10 Patient Signature: Patricia Fore

Physical Findings
Anterior Posterior



use cm measurement

	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Amount				
Character				
Tunneling				
Edema				
Odor				
Inflam				

Southwestern Homecare & Medical Services
Phone: (229) 889-1598 Fax: (229) 888-3558
Toll Free: (877) 889-1598

INITIAL NURSING ASSESSMENT AND VISIT RECORD

Patient Name: Patricia Gore Date: 5/24/10 Time: 3:30
Services Requested: W & PC/HHA Diagnosis: Compression of spine

CLINICAL BASELINE DATA		T: <u>98</u>	P: <u>87</u>	R: <u>22</u>	Ht: <u>67 in</u>	Wt: <u>163</u>
☐ MALE	☒ FEMALE	BP Rt. Arm: <u>182/94</u>		BP Lt. Arm: <u>187/110</u>		
HISTORY of Current Illness: <u>injured back at work</u>						
ALLERGIES: <u>PCN</u>						
PAST MEDICAL HISTORY						
☐ Kidney Disease	☐ Heart Disease	☐ Hepatitis	☐ Blood Clots	☐ Fainting Episodes		
☐ Lung Disease	☐ GI/GU Disease	☐ Asthma	☐ Mental Illness	☐ Chemical Dependency		
☐ Liver Disease	☐ Stroke	☒ Diabetes	☐ Seizures	☐ Thyroid Disease		
☒ Hypertension	☐ Anemia	☐ Cancer	☐ Other: _____			
PSYCHO/SOCIAL ASSESSMENT						
HOUSING: ☒ Owns Home ☐ Rents ☐ Lives Alone ☐ Other: _____						
☐ Lives With: _____ Marital Status: _____						
Attends School/Program: ☐ Yes ☒ No ☐ N/A						
Literate: ☒ Yes ☐ No Primary Language (if other than English): _____						
Religion: <u>Baptist</u>						
AFFECT: ☐ Angry ☐ Flat ☒ Calm ☐ Restless ☐ Depressed ☐ Withdrawn						
☐ Combative ☐ Anxious ☐ Agitated ☐ Lacks Motivation						
Availability of Caregiver: <u>Available and willing to assist</u>						
Other providers/agencies in the home: _____						
LEARNING CAPABILITIES		EXCELLENT	GOOD	FAIR	COMMENTS	
PATIENT		<u>✓</u>	_____	_____	_____	
CAREGIVER		<u>✓</u>	_____	_____	_____	

CLINICIAN INITIALS NO

Initial Nursing Assessment and Visit Record (continued):

HOME ENVIRONMENT				
	YES	NO		
Running Water	☒	☐	Electricity	☒ ☐
Adequate Refrigeration	☒	☐	Signs of Infestation	☐ ☒
Telephone	☒	☐	Accessible Toileting	☒ ☐
Adequate/Safe Heat	☒	☐	Adequate Outlets for Electricity	☒ ☐
Adequate/Safe Cooling	☒	☐	Functional Smoke Detectors	☒ ☐
Adequate Clean Storage Area	☒	☐	Smoking Precautions	☐ ☒
Adequate Clean Work Area	☒	☐	Stairs	☐ ☒
Pets: <u>Cat</u>	☒	☐		
Safety Measures Needed: <u>Safety & ambulation - keep area</u>				
<u>free of clutter.</u>				
Comments: _____				

SYSTEM REVIEW/ASSESSMENT

NEUROLOGICAL ☒ ALERT ☐ CONFUSED ☐ LETHARGIC ☐ COMATOSE ☐ IMPAIRED MEMORY ☐ VERBAL ☐ NON-VERBAL APHASIA: ☐ EXPRESSIVE ☐ SLURRED SPEECH ☐ RECEPTIVE RECENT NEURO/COGNITIVE CHANGE: DESCRIBE: _____ ORIENTED TO: ☒ TIME ☒ PLACE ☒ PERSON PARALYSIS: ☐ RUE ☐ LUE ☐ RLE ☐ LLE ☐ NO SIGNIFICANT PROBLEM NOTED	
HEENT HEAD: ☒ WNL ☐ VERTIGO ☐ HEADACHES ☐ OTHER: _____ EARS: ☒ WNL ☐ IMPAIRED HEARING: ☐ RT. ☐ LT. ☐ BOTH HEARING AIDS: ☐ RT. ☐ LT. ☐ BOTH EYES: ☒ WNL ☐ IMPAIRED VISION: ☐ GLASSES ☐ CATARACTS ☐ GLAUCOMA ☐ LEGALLY BLIND NOSE/THROAT: ☒ WNL ☐ EPISTAXIS ☐ DRAINAGE ☐ DIFFICULTY SWALLOWING ☐ HOARSENESS	
ORAL ☒ Pink and Moist ☐ Dry ☐ Tender ☐ White Patches ☐ Teeth/Chewing ☐ Other: _____ ☐ No significant problem noted	
RESPIRATORY ☐ SOB ☐ ORTHOPNEA, # OF PILLOWS _____ ☐ COUGH/PRODUCTIVE: _____ ☐ O2 RATE: _____ TYPE: _____ ☐ TRACHEOSTOMY ☐ SUCTION MACHINE ☐ NEBULIZER LUNG SOUNDS: RT. ☒ CLEAR ☐ CRACKLES ☐ WHEEZES ☐ DIMINISHED ☐ ABSENT LT. ☒ CLEAR ☐ CRACKLES ☐ WHEEZES ☐ DIMINISHED ☐ ABSENT ☐ OTHER: _____ ☐ No significant problem noted	
CARDIOVASCULAR ☐ PALPITATIONS ☐ SYNCOPE ☐ PACEMAKER ☐ DISCOMFORT/PAIN: LOC. _____ ☐ EDEMA: LOC. _____ RELIEVED BY: _____ ☐ NECK VEIN DISTENTION ☐ PERIPHERAL PULSES DIMINISHED ☐ OTHER: _____ ☒ NO SIGNIFICANT PROBLEM NOTED	

CLINICIAN INITIALS NO

Initial Nursing Assessment and Visit Record (continued)

GASTROINTESTINAL

☒ NO SIGNIFICANT PROBLEM NOTED

- ☐ NAUSEA ☐ VOMITING ☐ ANOREXIA ☐ ASCITES ☐ ABDOMINAL DISTENTION
☐ CHANGE IN APPETITE: _____ ☐ BOWEL SOUNDS: ☐ ACTIVE ☐ DIMINISHED
☐ PAIN ON PALPATION: LOC _____ ☐ STOOLS: ☐ WNL ☐ TARRY ☐ BLOODY
☐ DIARRHEA _____ ☐ CONSTIPATION: RELIEVED BY _____
☐ RECTAL BLEEDING ☐ CONTINENT ☐ INCONTINENT ☐ OSTOMY
 DIET: ☒ REGULAR ☐ SPECIAL ☐ PO ☐ FEEDING TUBE: TYPE _____
☐ BOLUS: AMOUNT _____ FREQUENCY _____ MANAGED BY: _____
 APPETITE: ☐ GOOD ☐ FAIR ☐ POOR ☐ DIETARY SUPPLEMENTS: _____
☐ FLUID RESTRICTIONS: _____ ☐ EATING DIFFICULTIES: _____

URINARY

☒ NO SIGNIFICANT PROBLEMS NOTED

- ☐ CONTINENT ☐ INCONTINENT ☐ RETENTION ☐ NOCTURIA ☐ URGENCY ☐ BURNING
☐ OSTOMY ☐ OTHER: _____ ☐ CATHETER: TYPE AND SIZE _____
☐ INCONTINENCE PADS/BRIEFS _____ MANAGED BY: _____

MUSCULOSKELETAL

☒ NO SIGNIFICANT PROBLEM NOTED

- IMPAIRED GROSS MOVEMENT: ☒ RUE ☒ LUE ☒ RLE ☒ LLE ☐ PAINFUL, SWOLLEN JOINTS
☐ CONTRACTURES ☐ AMPUTATION: _____ ☐ UNSTEADY GAIT
☒ REQUIRES ASSISTANCE WITH TRANSFER/AMBULATION ☐ CHAIR CONFINED
☐ BED CONFINED ☐ OTHER: _____ ☒ EQUIPMENT: 1. 940 Ken

NUTRITIONAL RISK ASSESSMENT

RISK FACTORS:

- ☐ STRICT MEDICALLY-PRESCRIBED DIET ☒ SIGNIFICANT NUTRITIONAL-RELATED PROBLEM OR NEED
☐ POOR SOCIAL SUPPORT SYSTEMS TO OBTAIN AND PREPARE FOOD
☐ OPEN WOUNDS LEVEL OF RISK: ☒ LOW ☐ MODERATE ☐ HIGH
 ***COUNSELING/TEACHING/REFERRAL (required for score of 3 or greater): _____

SKIN

☒ NO SIGNIFICANT PROBLEM NOTED

- COLOR: ☒ WNL ☐ PALE ☐ ASHEN ☐ FLUSHED ☐ JAUNDICED ☐ CYANOTIC
 TEMPERATURE: ☐ COOL ☐ DRY ☐ DIAPHORETIC ☒ WARM
 TURGOR: ☒ GOOD ☐ FAIR ☐ POOR ☐ RASH: LOC _____ DESCRIPTION: _____
☐ PRURITIS ☐ ALOPECIA ☐ PETECHIAE
☒ WOUND/INCISION/DECUBITI: ☒ INTACT MANAGED BY: JW
☐ LOC: _____ ☐ WIDTH 1.5 cm ☐ DEPTH 0 ☐ LENGTH 3mm
☒ DRAINAGE Small amt ☐ OTHER ABNORMALITIES: _____
 BRANDON SCALE SCORE: 10

BEHAVIORAL ASSESSMENT

- ☒ CONVERSES MEANINGFULLY ☐ FORGETS SIGNIFICANT FACTS ☐ WANDERS
☐ DISTURBS OTHERS BY SHOUTING/YELLING ☐ THREATENS OTHERS VERBALLY
☐ HALLUCINATES ☐ CRIES WITHOUT OBSERVABLE CAUSE ☐ SLEEPING PROBLEMS
☐ EXHIBITS QUICK MOOD SHIFTS ☐ THINKS OTHERS ARE TRYING TO HARM HIM/HER
☒ ABLE TO FOLLOW DIRECTIONS ☐ OTHER: _____

CLINICIAN'S INITIALS JW

Patient Name Patricia Fox
Date 5/24/10

Pain Assessment Scale Score 8
Pharmacy Name Walgreens & Walmart
Number _____

Medications

Lorazepam 60 bid.
Hydrocodone 10mg sliding scale as needed
Oxycodone 15mg
Oxycodone 5/325
Paracetamol 25mg/15

Narrative or Summary Comments

46yr. old w/f up in home - ambulating
to use of walker. Binder in place
around waist. Oriented x4. Abd. soft -
bowel sounds present x4. Ambulating
slowly - grimacing to ambulation. Pt
took pain pill during visit. Discharge
to lower back - scarot drainage reddish
brown in color noted. Steri strip in
place x4. Discharge re-applied secured to tape.
SBS = 118 mg/dl.

Care Plan Discussed and Approved by Patient/Caregiver ☒

Tommy Taylor
Clinician Initials Signature

RECEIVED AUG 24 2010

WCG

To Whom It May Concern:

My name is Thad Griffin. I am the President of Griffco of Wampee, Inc. Ms. Patricia Fore worked for me as a meat cutter before the most recent date of accident of 2/24/08. I knew through general conversations with her that she had diabetes before 2/24/08 injury to her lumbar spine and hip.


Signature and Title

8-16-10
Date



ATTORNEYS AT LAW

Reply To
JAMES H. LICHTY
Direct Dial: (803) 227-2288
jlichty@mgclaw.com
COLUMBIA

October 2, 2009

Mr. William E. Gunn, Director
S.C. SECOND INJURY FUND
100 Executive Center Drive, Suite 101
Columbia, South Carolina 29210

RE: Patricia Fore v. Griffco of Wampee, Inc. and Commerce & Industry Insurance Company c/o
Chartis Claims, Inc.
Date of Accident: February 24, 2008 and February 21, 2008
WCC File No.: 0810152 and WCC IC File No***
Our File No.: 2094.08282
Claim No.: 709-659592
Document Label: LEGAL - OTHER COURT DOCUMENTS

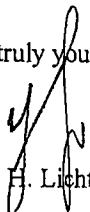
Dear Mr. Gunn:

This firm represents the Employer and Carrier. The Claimant, Patricia Fore, alleges that she sustained injury or injuries arising out of and in the course of employment. Our investigation indicates that she had a pre-existing condition which may have combined with or been aggravated by this work injury. Please accept this letter as notification of a potential claim for reimbursement benefits from the South Carolina Second Injury Fund. Pursuant to S.C. Code Ann. Section 42-9-400, we are providing the following required information:

Employer Name:	Griffco of Wampee, Inc.
Employer Address:	8729 Highway 90 Longs, South Carolina 29568
Carrier Name:	Commerce & Industry Insurance Company c/o Chartis Claims, Inc.
Carrier Address:	AIG Domestic Claims Post Office Box 4230 Alpharetta, Georgia 30023
Carrier Policy No.:	Unknown
Policy Effective Dates:	Unknown
NCCI Code No.:	Unknown
County Where Accident Occurred:	Horry

Kindly forward the appropriate documents to me so that we may complete this filing.

Very truly yours,


James H. Lichty

JHL/smg

cc: George Hinson, Chartis Claims, Inc.
Eric Brown, Griffco of Wampee, Inc.
South Carolina Workers' Compensation Commission

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

RECEIVED
FEB 10 2014
SC Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Case No. 2013-001814

South Carolina Second Injury Fund,.....Appellant,

v.

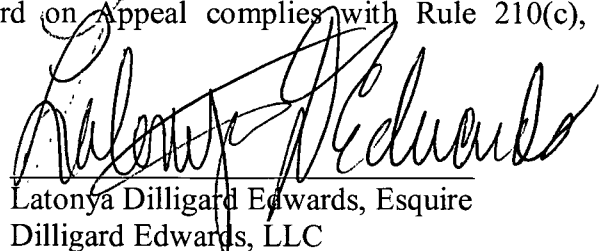
Griffco of Wampee, Inc., Employer, and
Commerce & Industry Insurance Company, Carrier,..... Respondents.

In re:
Patricia Fore, Employee, Claimant.

CERTIFICATE OF COUNSEL

The undersigned certified that this Record on Appeal complies with Rule 210(c),
SCACR.

February 7, 2014



Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
S.C. Bar #: 14593
(803) 750-2214 (telephone)
(803) 750-2377 (facsimile)

ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Case No. 2013-001814

RECEIVED
FEB 10 2014
SC Court of Appeals

South Carolina Second Injury Fund,.....Appellant,

v.

Griffco of Wampee, Inc., Employer, and
Commerce & Industry Insurance Company, Carrier,..... Respondents.

In re:
Patricia Fore, Employee, Claimant.

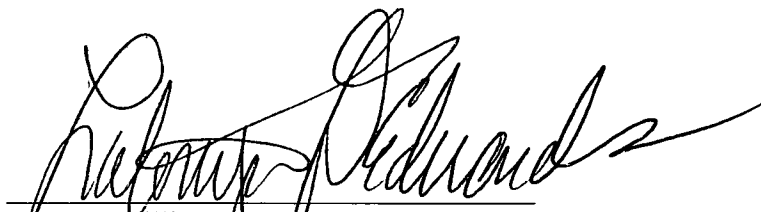
PROOF OF SERVICE

The undersigned employee of Dilligard Edwards, LLC, Attorney for the Appellant, does hereby certify that service of the **Final Brief of Appellant, Record on Appeal**, and, **Certificates of Counsel** to the South Carolina Court of Appeals in the above-captioned matter was made upon counsel of record for Respondents Griffco of Wampee, Inc., Employer, and Commerce & Industry Insurance Company, Carrier, and the South Carolina Workers' Compensation Commission, by placing same in the United States Mail, first class postage prepaid, at the below listed address clearly indicated on said envelope on this 10th day of February, 2014, addressed as follows:

Weston Adams, III, Esquire
Helen F. Hiser, Esquire
James H. Lichty, Esquire

McAngus Goudelock & Courie, LLC
Post Office Box 12519
Columbia, South Carolina 29211

The Honorable Virginia Crocker, Judicial Director
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715



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3790 Fernandina Road, Suite 103
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(803) 750-2214 (telephone)
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ATTORNEY FOR APPELLANT