

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Hon. Alison R. Lee, Circuit Court Judge

Case No. 2011-CP-40-03561

RECEIVED

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SC Court of Appeals

Gertrude Shiver,.....Claimant, Appellant,

v.

Palmetto Health Richland, Employer,
Key Risk Management Services, Inc., TPA
Palmetto Hospital Trust Services, Carrier,
Trident Regional Medical Center, Employer,
Zurich American Insurance Company, Carrier,.....Respondents,

RECORD ON APPEAL
VOLUME IV

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INDEX

Index.....	1-8
------------	-----

ORDERS AND JUDGEMENTS

Order of Commissioner David W. Huffstetler, S. C. Workers' Compensation Commissioner, dated October 23, 2007.....	9-37
Order of The Full Commission of The S. C. Workers' Compensation Commission dated December 6, 2007.....	38-42
Decision and Order of the Appellate Panel Review, S. C. Workers' Compensation Commission, dated May 3, 2011.....	43-57
The Honorable L. Casey Manning, Judge of Fifth Judicial Circuit, dated July 9, 2010.....	58-59
Consent Order of Commissioner Bryan Lyndon, S. C. Workers' Compensation Commission, dated August 24, 1995.....	60-62
Order Relieving Counsel Thomas M. White as Counsel for Appellant dated November 14, 1995.....	63
Order of The Honorable Alison R. Lee, Judge of Fifth Judicial Circuit, dated March 25, 2013.....	64-73
Motion Order of Commissioner Roche dated June 20, 2014.....	74-77

PLEADINGS

Appellant's Complaint (W.C.C File No. 9503744) dated November 22, 1999.....	78-81
Appellant's Complaint (W. C. C. File No. 9503744) with attached sheet dated March 21, 2007.....	82-98
Appellant's Complaint (W.C. C. File No. 0126962) with attached sheet dated June 30, 2007.....	99-110

Appellant's Complaint (W.C. C. File No. 0217755) with attached sheet dated October 19, 2006.....	111-115
Appellant's Complaint (W.C.C. File No. 0227098) along with attached sheet dated July 9, 200.....	116-126
Appellant's Complaint (W.C.C. File No. 0322274) with attached sheet dated July 6, 2007.....	127-136
Appellant's Complaint (W.C.C. File No. 0321756) with attached sheet dated May 20, 2007.....	137-150
Appellant's Complaint (W.C.C. No. 0616756) with attached sheet dated May 29, 2007.....	151-158
Appellant's Appeal from The Full Commission of The Workers' Compensation Commission to The Circuit Court from the Denial of the Motion to Include Additional and New Evidence and Clarification of Order and The Dismissal of The Claim under The Concept of "With Prejudice" filed with The Fifth Circuit Clerk of Court on January 30, 2008.....	159-181
Appellant's Appeal in The Clerk's Office of The Fifth Judicial Circuit Court on June 1, 2011, from The Workers' Compensation Appellate Panel Full Commission Order rendered May 3, 2011.....	182-214

VOLUME II

Notice of Appeal from The Adverse Order of The Honorable Alison R. Lee dated April 19, 2013.....	215
Notice of Appeal filed April 26, 2013.....	216-217
Notice of Hearing before David W. Huffstetler, Commissioner, dated July 19, 2007.....	218-219
July 23, 2007 Form 50, Claimant's Request for Hearing (WCC Claim No. 9503744) (Documents Missing four pages).....	220-223
October 19, 2006 Form 50, Claimant's Request for Hearing (WCC Claim No. 0217755).....	224-226
October 18, 2006 Form 50, Claimant's Request for Hearing (WCC Claim No. 0126962).....	227-230

October 9, 2006 Form 50, Claimant's Request for Hearing (WCC Claim No. 0227098).....	231
October 7, 2006 Form 50 Claimant's Request for Hearing (WCC Claim No. 0322274).....	232-236
October 7, 2006 Form 50, Claimant's Request for Hearing (WCC Claim No. 0616756).....	237-240
October 18, 2005 Form 50, Claimant's Request for Hearing (WCC Claim No. 0321756).....	241-244
August 24, 2007 Form 51, Employer's Answer (WCC Claim No.9503744)	245
August 8, 2007 Form 51, Employer's Answer (WCC Claim No. 0126962).....	246
August 8, 2007 Form 51, Employer's Answer (WCC Claim No. 0217755).....	247
August 8, 2007 Form 51, Employer's Answer (WCC Claim No. 0227098).....	248
August 8, 2007 Form 51, Employer's Answer (WCC Claim No. 0322274).....	249
November 13, 2006 Form 51, Employer's Answer (WCC Claim No. 0616756).....	250
March 10, 2006 Form 51, Employer's Answer (WCC Claim No. 0321756) (1 page missing).....	251-252
Appellant's APA's:	
(WCC Claim No. 9503744).....	253-310
(WCC Claim No. 0126962).....	311-370
(WCC Claim No. 0217755.....	371-408
(WCC Claim No. 0227098.....	409-418

VOLUME III

(WCC Claim No. 0227098.....	419-443
(WCC Claim No. 0322274.....	444-461
(WCC Claim No. 0321756.....	462-546
(WCC Claim No. 0616756.....	547-571
APA 1.....	572-573
APA 2.....	574-577
APA.3.....	578
APA 4.....	579-580

APA 6.....	581-584
APA 10.....	585
APA 11.....	586-590
APA 14.....	591
APA 15.....	592-602
APA 16.....Volume 8, Book.....	1486-1565

Respondents Trident Regional Medical Center and Zurich American Insurance Company's APA:

(WCC Claim No. 9503744).....	603-614
------------------------------	---------

VOLUME IV

(WCC Claim No. 950374.....	615-642
----------------------------	---------

Respondents Palmetto Health Richland and Palmetto Hospital Trust Services' APA:

(WCC Claim No. 0126962).....	643-674
(WCC File No: 0217755).....	675-693
(WCC File No: 0227098).....	694-703
(WCC File No: 0322274).....	704-722

Respondents Palmetto Health Richland and Key Risk Management Services, Inc.'s APA:

(WCC Claim No. 0321756).....	723-827
------------------------------	---------

VOLUME V

(WCC Claim No. 0321756).....	828-1009
(WCC Claim No. 0616756).....	1010-1023

VOLUME VI

(WCC Claim No. 0616756.....	1024-1033
-----------------------------	-----------

TRANSCRIPTS OF RECORD

The Transcript of The hearing before David W. Huffstetler, S. C. Workers' Compensation Commission on September 4, 2007.....	1034-1120
---	-----------

The Transcript of The Hearing before The Honorable Alison R. Lee,

Circuit Judge for the Fifth Judicial Circuit on November 1, 2012.....	1121-1161
---	-----------

MOTIONS

Appellant's

Motion to Accept New Evidence To Include All Information in Folder, Addenda, and Attachments to Form 50, 58, my book which Commissioner Huffstetler has a copy, clarification of misinformation.....	1162-1190
--	-----------

Motion for Sanctions for Non-Compliance with Payment of Statutory Benefits (WCC Claim No. 0217755).....	1191-1192
---	-----------

Motion request dated 11/2/10.....	1193
-----------------------------------	------

Respondents'

Respondents' Motion to Dismiss The Interlocutory Appeal dated 3/30/10.....	1194 -1198
--	------------

Return to Claimant's Motion to submit additional evidence dated 11/12/10.....	1199-1201
---	-----------

Reply to Claimant's Motion for sanctions and/or Motion to Dismiss for Lack of Subject Matter Jurisdiction (WCC Claim No. 0217755) dated April 3, 2014.....	1202-1206
--	-----------

Motion For Continuance and Consolidation.....	1207-1208
---	-----------

Motion To Consolidate 6 Claims for 1 hearing.....	1209-1211
---	-----------

Motion To Postpone Hearing on Basis That Claimant was no-show for her Deposition/Motion To Compel Claimant to submit to Deposition filed by Defendant with Order and Deposition Resets.....	1212-1218
---	-----------

EXHIBIT

Appellant's

PHTS Claims Consultant offer of settlement dated March 1, 2007.....	1219
---	------

PHTS Senior Claims Consultant offer of settlement dated April 6, 2004.....	1220
--	------

PHTS Letter to Dr. Jones dated January 29, 2007.....	1221
--	------

Attorney E. Douglas Pratt-Thomas offer of settlement for Trident
Regional Medical Center dated April 20, 2000.....1222-1224

PHTS Claims Consultant offer of settlement for Palmetto Richland
Memorial Hospital dated January 2, 2007.....1225-1226

Form 58- South Carolina Workers' Compensation Commission dated
March 1, 1996.....1227

VOLUME VII

Deposition Transcript dated June 16, 2006 (along with errata sheets).....1228-1302
Errata Sheets, Volume V.....835-1009

Deposition of Appellant with Attorney Allison Carter dated August 24,
2007.....1303-1359

Deposition of Appellant dated May 31, 1995.....1360-1373

Letter from Robin Beaver, Claim Specialist denying Appellant
Workers' compensation dated February 14, 1995.....1374

Letter from Thomas M White to Robin Beaver, UCC unit dated
March 24, 1995.....1375

Letter from E. Douglas Pratt Thomas dated August 30, 1995.....1376

Letter from Thomas M. White to Commissioner Bryan Lyndon dated
August 11, 1995.....1377

Letter from Thomas M. White to E. Douglas Pratt-Thomas dated
June 6, 1995.....1378-1379

Letter from Thomas White to William E. Crouch, M.D dated
June 7, 1995.....1380

Letter from E. Douglas Pratt-Thomas to the Honorable Ann M. Mickel
dated April 20, 2000.....1381-1382

Letter from Felicia Lucas to Mike Kelly dated December 31, 2003.....1383

Letter from Attorney Paula M. Stewart to Jodi Starnes of PHTS.....1384-1385

Letter from Thomas M. White to Appellant dated March 8, 1995.....1386

Letter from Thomas M. White to Dr. William E. Crouch dated March 24, 1995.....	1387
Report by Dr. Robert H. Bowles dated January 19, 1995.....	1388-1390
Letter from Dr. William E. Crouch dated March 3, 1995.....	1391
Letter from Dr. William E. Crouch dated October 16, 1995.....	1392
Letter from Dr. William E. Crouch dated May 18, 1995.....	1393
Letter from Dr. Victor J. Weinstein dated July 31, 1995.....	1394
Letter from Dr. Victor J. Weinstein dated February 14, 1995.....	1395
Dr. James G. McCoy's medical report dated August 10, 1995.....	1396
Letter from Claimant re: new evidence motion, with attached motion dated November 5, 2007.....	1397-1423
Order Relieving Counsel of 11-14-1995.....	1424
MRI Report of 8-4-2002.....	1425-1426
Respondent's Trident Regional Medical Center And Zurich American Insurance Company	
Form 15, 8-22-95.....	1427
Form 17, 8-22-95.....	1428
Consent Order.....	1429-1431

MEDICAL RECORDS

EMG/ Nerve Conduction Study Physical Medicine and Rehabilitation Consultation dated 11/28/05.....	1432-1434
Care Alliance Health Services dated 9/12/2000.....	1435
Palmetto Health- The Center for Pain Management.....	1436-1442
Midlands Internal Medicine-Physical Examination dated 4/21/06.....	1443-1446

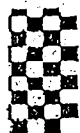
Healthworks Injury Treatment Report and Follow-up reports dated 5/3/02.....	1447-1449
Palmetto Imaging dated 2/15/05.....	1450
Internal Medicine and Cardiovascular disease visit of May 23, 1995.....	1451
Midlands Internal Medicine Associates office visit dated 10/29/02.....	1452-1453
Midlands Internal Medicine partial notes.....	1454-1454

VOLUME VIII

Midlands Internal Medicine partial notes.....	1455-1469
Charleston Spine and Physical Medicine dated July 1, 2003.....	1470
Sports Medicine and Rehabilitation Physical Therapy dated 1/30/95.....	1471
PHTS-Charleston Spine & Physical Medicine, PA dated 5/9/03.....	1472-1473
Charleston Spine & Physical Med. progress notes of 12/18/2000.....	1474-1475
HealthWorks Treatments dated 1/24/03.....	1476-1478
HPRC-Physical Therapy Initial Evaluation of 1/20/04.....	1479
Columbia Rehabilitation Clinic, Inc. Initial evaluation.....	1480-1482
Bon Secours-St. Francis Xavier Hospital Physical therapy Initial Evaluation.....	1483
Human Performance and Rehabilitation Center, Inc. Initial Evaluation 11/13/02.....	1484-1485

MISCELLANEOUS EXHIBIT

<i>The Fall of a Nurse: What Is Wrong With Gerly</i>	1486-1565
--	-----------



Carolina Medical Imaging

A new image for the Carolinas

PATIENT: Gertrude Shiver
DATE OF BIRTH: 05/19/54
REF PHYSICIAN: Dr. Hook
DATE OF EXAM: 02/26/03
PATIENT PH#: 803-353-9714

CT OF THE PELVIS

HISTORY: Abdominal pain, nausea, and vomiting.

TECHNIQUE: Pelvic CT images were performed with oral contrast material. I.V. contrast material was not administered.

FINDINGS: The pelvic structures and adnexal regions appear to be clear. The uterus and bladder appear unremarkable. The inguinal regions appear unremarkable.

IMPRESSION:

1. Normal pelvic CT scan with oral contrast material. I.V. contrast material was not administered.


G. Paul Forsyth, MD
Radiologist

GPF/dag

wofy

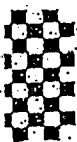
CT pelvis / 26d

completely
normal

pel

02/27/03

Wolfe
fb



Carolina Medical Imaging

A new image for the Carolinas

PATIENT: Gertrude Shiver
DATE OF BIRTH: 5/19/54
REF PHYSICIAN: Dr. Hook
DATE OF EXAM: 02/26/03
PATIENT PH#: 803-353-9714

CT OF THE ABDOMEN

HISTORY: Abdominal pain, nausea, and vomiting.

TECHNIQUE: CT scan of the abdomen was performed without I.V. contrast material and with oral contrast material.

FINDINGS: CT scan of the abdomen demonstrates that the hepatic parenchyma appears unremarkable. The spleen appears normal. The kidneys and adrenals appear to be unremarkable. The pancreas appears to be normal. The bowel gas pattern is non-diagnostic.

IMPRESSION:

1. Normal CT scan of the abdomen with oral contrast material. I.V. contrast material was not administered.

h. 2
G. Paul Forsyth, MD
Radiologist

GPF/dag

(616)

13

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for complete physical exam. The patient notes that she is continuing to have a moderate amount of neck discomfort, which somewhat radiates into her left shoulder. This all occurred after a chart from the hospital dropped on her shoulder region. She has undergone physical therapy with very little in the way of improvement. She otherwise has no major complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995

ALLERGIES:

1. Tetanus caused severe edema and induration with pain
2. CT dye gave her hives and palpitations.
3. PPD caused hives and palpitations as well.

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Mobic 7.5mg bid *Bevha*
4. Baby aspirin daily
5. Occasional Tylenol.
6. Skelaxin and Flexeril pm
7. Aciphex 20mg q day
8. Humibid LA bid

SOCIAL HISTORY: The patient does not smoke, nor does she use alcohol. She is not married and has no children. She is not sexually active. She is originally from Gaston and lived in Charleston but has been in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Richland Memorial Hospital and does note a moderate amount of stress.

(617)

14

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

PAGE 2 of 3

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90. She had diabetes, dementia, and actually had a stroke in the end as well. She denies any significant heart disease in the family but does note hypertension and strokes. She also notes diabetes as well as breast cancer. She had a sister in her 50's that was recently diagnosed with colon cancer. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is poor. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient continues to get occasional headaches. These, if anything have somewhat improved. She has her eyes checked regularly. She does note occasional mild dysphagia but this has improved with Aciphex and is not to the point where she needs repeat dilation. She notes occasional nauseated episodes but cannot give any further details in this regards. She denies any significant palpitations as of recent and has done well on her current regimen. She notes, again, diffuse pain in her neck and shoulder region as well as her lower back. She also continues to have some problems with abdominal discomfort but has had normal CT scan of the abdomen and pelvis as of recent. She notes a lesion on her left big toe that she would like to have removed. She really has no other major complaints, other than that of moderate fatigue. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light and accommodation. Extra-ocular movements intact. Fundoscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No lymphadenopathy. No thyromegaly. No bruits.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. There are no murmurs, rubs, or gallops.

ABDOMEN: Soft, nontender, nondistended. There are positive bowel sounds in all quadrants. There is no hepatosplenomegaly or mass.

BREASTS: No palpable masses. Mild fibrocystic changes. No nipple inversion. No skin dimpling.

(618)

15

**MIDLANDS INTERNAL MEDICINE
PHYSICAL EXAMINATION****NAME:** Gertrude Shiver**SS#:** 249-98-2546**DATE:** 04/08/03**PAGE 3 of 3****PHYSICAL EXAMINATION: (cont.)**

UROGENITAL: The patient has normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: No masses. Normal sphincter tone. Guaiac negative stool.

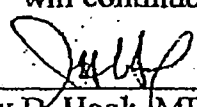
EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS: EKG was obtained and reveals a sinus bradycardia and nonspecific STT wave abnormalities, otherwise unchanged from prior tracings.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Extremely well controlled with current regimen, on Cardizem CD and Tenorin. Will continue with this regimen.
2. Reflux with overlapping stricture, status post dilation. Has improved with Aciphex. Will continue.
3. Adenomatous polyp. The patient had colonoscopy performed in May, 2002, which revealed a tubular adenoma. She will have repeat colonoscopy in two years.
4. Hoarseness. Had been a complaint. The patient went to see ENT, who basically claimed the patient had muscle tension dysphonia. She did have fiber optic exam, which basically was unremarkable. The patient was given speech therapy and Humibid LA. She claims that she was not completely satisfied with her evaluation.
5. Neck pain. Will send back to Charleston Spine Institute, which the patient has been followed there closely.
6. Chronic back pain. Again, followed by the Spine Institute. We will switch her Mobic over to Bextra, which hopefully will give her more relief.
7. Abdominal discomfort. The patient continues to have mild tenderness in the left upper and left lower quadrant, radiating to the suprapubic area. Again, there are no significant findings here. We will continue to follow. The patient was reassured in regards to a normal CT scan.
8. Lesion, left big toe. It appears that the patient has a small cyst on her left great toe tendon sheath. She was reassured.
9. Routine health maintenance. Have gotten the patient completely up to date. We will continue to follow closely.


Jeffrey D. Hook, MD

(619)

16

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/11/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for follow-up of her multiple medical problems. Since last being seen, the patient has gone to the Charleston Spine Institute and apparently has had questionable nerve block but definitely an epidural steroid injection in the neck region. She notes that this has been somewhat helpful for her. She also feels as though the Bextra has been better tolerated and has given her more relief. The patient also notes that she apparently had some Botox injections in the neck as well. She now notes that she is continuing to have problems with her left ankle. This has been somewhat long-standing and she has seen Neurology as well as Orthopedics for this. She is requesting a second opinion and has basically been set up with Dr. McBride at the University Clinics. Apparently, this ankle and foot has given her a tremendous amount of pain status post trauma and we have discussed the possibility of this perhaps being a reflex sympathetic dystrophy, even though I have told her that an orthopedist or a neurologist would need to make this absolute diagnosis. She really has no other major complaints and otherwise feels relatively well. She denies that she has had any palpitations and notes that her blood pressure has been well controlled. She has very little in the way of complaints at this time.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin and Flexeril prn
7. Aciphex 20mg q day
8. Ultram prn

(620)

17

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/11/03

PAGE 2 of 2

REVIEW OF SYSTEMS: The patient notes that the hoarseness that she had evaluated by ENT has completely resolved. She was taking Humibid LA short term. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac but regular.

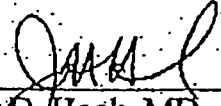
ABDOMEN: Benign.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will continue with this as the patient is asymptomatic.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex. Will continue.
3. Adenomatous polyp. The patient will have repeat colonoscopy in May of 2004.
4. Hoarseness. Completely resolved. She did use Humibid LA as needed.
5. Neck pain. Has improved with Botox injections as well as an epidural steroid injection, perhaps even a nerve block. Will follow at the Charleston Spine Institute.
6. Back pain. Again, followed by the Charleston Spine Institute. Continue Bextra and Ultram as needed.
7. Left ankle pain. Again, have encouraged her to obtain further work-up. Consider the diagnosis of reflex sympathetic dystrophy and she may actually see some improvement with Neurontin. We will hold off on this until further diagnosis is made.
8. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(621)

18

PATIENT: Gertrude Shiver
DATE OF BIRTH: 5-19-54
DATE OF VISIT: 8/14/03

This is concerning a fall.

SUBJECTIVE: Ms. Shiver is a patient of Dr. Hook's. She was at a hotel yesterday. She got up to take a break and she tripped over a chair. She caught her left foot on the chair and then she fell back on the floor. She said she hit her buttocks first and then her legs fell. She caught herself with her hands. She did not hit her head. She says she was able to get up and move around okay but as the days progress and yesterday she got progressively sore. She is just concerned. She says the Skelaxin and Ultram that she took did help her a little bit.

PHYSICAL EXAM: Weight: 185. Temp. 98.2. Pulse 76. Respiratory: 16. Blood pressure 100/74. HEENT: unremarkable. Neck: supple. Lungs: clear. Heart is S1/S2. No rubs, gallops or murmurs. Deep tendon reflexes are 2+. Peripheral pulses are 2+. Straight leg raising is negative. There is some tenderness to palpation in the lower legs especially on the left. A little bit of tenderness to palpation along the buttocks.

ASSESSMENT/PLAN:

1. contusions.

PLAN:

1. Reassurance.
2. She is going to continue on medication.
3. Plan on seeing her back in about a week or 10 days if she is not improved.
4. I have told her that she can try some heat and ice, that this may help.



Jean A. Massey, ANP, Ph.D. 

PPM-C/clong

(622)

19

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for worsening back pain status post fall on 08/13/03. The patient apparently "slipped" on carpet at a conference and landed quite violently on her buttocks. She claims that since that time, she has had a moderate amount of low back pain. She claims that she has recently begun to feel a "pop" in her back with torsion of the trunk and at times will feel a radiating pain down into her left lower extremity. She has had disc problems in the past and has been evaluated by The Spine Clinic in Charleston. She has had numerous falls and various traumas in the past and seems to be somewhat inclined to get injured relatively easily. She has gone through numerous Workman's Comp cases and again has a very low threshold for pain. She denies any change in her bowel or bladder and denies any lower extremity weakness or numbness. She has gone to The Brace and Boot Shop and she has had a back brace made for her, which she claims has helped. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day

REVIEW OF SYSTEMS: See History of Present Illness. The patient denies any palpitations, etc. All other systems reviewed at this time and negative.

(623)

20

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac and regular.

ABDOMEN: Benign.

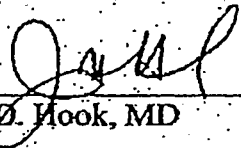
BACK: No significant spinous process tenderness. Straight leg raise is positive on the left.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Back pain status post fall. At this time, we will treat the patient with a Medrol dose pack. She may have a small herniated disc. If she sees no improvement, will obtain lumbosacral spine films, even though she has had numerous films performed in the past and has actually had an MRI of the lumbosacral spine within the year. We will follow closely. The patient was also given a few Lortab to take in place of her Ultram if absolutely needed. She was given Lortab 5mg, 50 with no refills. She can continue with Skelaxin and was encouraged to continue her back strengthening exercises.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex.
3. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will follow.
4. Left ankle pain. Will be seeing Dr. McBride. Again, it is felt that she may have a reflex sympathetic dystrophy.
5. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(624)

21



**Charleston Spine &
Physical Medicine, PA**

Gregory M. Jones, M.D.
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SHIVER, Gertrude

4559.

10 June 2002

CHIEF COMPLAINT: Low back pain after work injury.

HISTORY OF PRESENT ILLNESS: Ms. Shiver is a 48 year old female who in March of 2002, while at work, was picking up a pen which had dropped, when her chair rolled out from under her and the head portion of the chair hit her in the small of her low back. This occurred at 1:00 a.m. and was not witnessed by any other individuals. She went home that night, went to work, but because of low back pain, reported in to the emergency room the next day. X-rays, as reported to me by Ms. Shiver, were reported to be normal. Since that time, she has been treated by her primary physician. At this point in time, she has been given medications with some improvement in pain symptoms.

Initially her pain was 7-8/10 on the pain scale and she says that today it is 4/10 on the pain scale.

Currently, her pain is described as a burning sensation and a deep achy pain in the low back bilaterally with intermittent stabbing pain interchanged with burning and aching and then continuing with intermittent stabbing pain, left greater than right. Her symptoms are intermittent and wax and wane. The pain seems to be aggravated with bending and improved with lying down and medications that she is taking, including Mobic, Skelaxin, and Lortab. She denies any right leg pain but is reporting some paresthesias in the left lower leg that predate her injury. These initially presented at around November 15, 2001 and are being treated by a neurologist. Apparently, an electrodiagnostic evaluation was performed by that individual and it was reported to me today to be normal. I specifically asked Ms. Shiver if her symptoms in the left lower leg were worsened after the fall, and she states, "no". She stated that there has been no worsening of her symptomatology as far as the leg is concerned.

I asked Ms. Shiver if she had ever complained of low back pain before, and she said, "yes". She was initially seen at Charleston Spine and Physical Medicine on March 4, 1998, after a motor vehicle accident on April 20, 1997, when she was rear-ended by another motor vehicle. She was given a diagnosis of "partially discogenic" low back pain. In July of 1998, she was placed at MMI from that injury and was given a permanent impairment to the lumbosacral spine, DRE category II, 5% spinal impairment, translatable to 5% whole person impairment directly. She was then also involved in a motor vehicle accident on 11/25/2000, which apparently "flared" her low back pain. She was placed at MMI regarding injuries sustained to the lumbosacral spine from the 11/25/2000 MVA, on 5/07/2001. She was given a "DRE category I, 0% lumbosacral spine/whole person impairment" relating directly to the injury of 11/25/2000 and remained at her prior permanent impairment of 5% to the lumbosacral spine.

PAST MEDICAL HISTORY: "Heart conduction defect", previous neck and low back pain, history of headache.

PAST SURGICAL HISTORY: Myomectomy, 1995; breast reduction, 1997. She denies an previous spine surgeries, including neck or low back.

REVIEW OF SYSTEMS: As per the new patient questionnaire completed today as well as the history.

MEDICATIONS: Mobic, Skelaxin, Phenergan, Cardizem, Tenormin, aspirin.

ALLERGIES: Contrast dye causes a seizure; tetanus toxoid causes redness and swelling at the injection site and "TB tester" causes hives, increased heart rate and swelling.

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22

[Handwritten signature]
JUN 10 2002

SOCIAL HISTORY: Patient is single; works full-time in her current position of computer entry for approximately one year 8 months. She states she is a nonsmoker and nondrinker.

FAMILY HISTORY: As per the new patient questionnaire completed today.

PHYSICAL EXAMINATION: Height 5' 3-1/2". Weight 194 pounds. Respirations: 18.

Reveals a well developed well nourished female in a minimal to moderate amount of subjective pain. Grooming, nutrition, and body habitus are normal for her age. She is alert and oriented to time, place and person with normal mood and affect. Pedal pulses are palpable.

Gait and station is normal and non antalgic.

Inspection of the low back reveals no previous midline lumbar incisions. No muscle atrophy; no significant lumbar shift or step off in the lumbar spine. Forward flexion and extension of the lumbar spine is limited to less than 50% of normal today. Axial rotation with hands held to the side increases her low back pain, turning to each direction. There is some minimal to moderate tightness of the bilateral psoas, rectus femoris and hamstring muscles. PA mobilization of the lumbar spine in the prone position reveals tenderness to light touch and therefore throughout the entire lumbar spine and therefore Spring testing could not be performed today. On palpation of the PSIS bilaterally to light touch, there was increased pain. There is no tenderness over either greater trochanter or piriformis muscle belly. There were some palpable spasms noted in the lower lumbar regions bilaterally.

Neurologic examination, including motor strength and sensation, was intact in both lower extremities and torso, except for some spotty decreased sensation in non-radicular and non-myotomal pattern in the left lower extremity. She has negative neural tension signs in both legs in the seated slumped position. SLR testing increased her low back pain bilaterally at about 20°. Patrick's test was negative bilaterally. Prone hip hyperextension testing was negative today.

Examination of the thoracic spine reveals no thoracic paraspinal muscular spasms or tenderness and no tenderness over the spinous processes today.

DIAGNOSTIC TESTING: None new today.

DIAGNOSES:

1. New work injury with low back pain and moderate lumbar strain/contusion.
2. Pre-existing left calf paresthesias (not related to this recent work injury).
3. History of previous low back pain given diagnosis of lumbar disc discogenic pain (non-discogram proven).

PLAN: After reviewing Ms. Shiver's current clinical scenario and physical examination, it is my opinion with a reasonable degree of medical certainty that she has suffered a moderate lumbar strain/lumbar contusion based upon the mechanism of her injury and based upon her current symptomatology. The left lower extremity symptomatology has not worsened since that injury, and therefore, there is no aggravation of that preexisting condition with this most recent injury in March of 2002.

My recommendations are as follows:

1. She is going to continue with her independent exercise program at home as far as therapy is concerned, and remain on her current medication including Mobic and Skelaxin. The risks and benefits of those medications were again reviewed with her.
2. As far as the low back pain and spasm in the bilateral lower lumbar region, after reviewing the risks, benefits, alternative treatment options and prognosis with Ms. Shiver, she has agreed to go ahead with a trigger point injection today.

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23

SHIVER, Gertrude

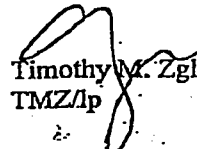
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Page 3

10 June 2002

The skin overlying the bilateral lower lumbar paraspinal musculature was prepped aseptically with alcohol. Next, a total solution of 2 cc containing 1 cc of 1% Lidocaine without epinephrine and 1 cc of 0.5% Bupivocaine was injected half into the right lower lumbar paraspinal musculature and the other half into the left lower lumbar paraspinal musculature after a negative aspirate for blood. The sites were then cleaned and dressed with Band-Aids. She tolerated the procedure well and I am going to discharge her to home after observation for an appropriate period of time after the procedure. She was instructed to look for signs of infection, including drainage, redness, fevers or chills.

3. From the standpoint of work, she may continue to work at this point in time.
4. She will be seen back in followup in approximately 1-2 weeks to reevaluate her neuromuscular status, monitor her medications, and see how she is progressing with the above treatment plan.


Timothy M. Zgleszewski, M.D.
TMZ/lp

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24

104
18 06/24/02

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

24 June 2002) Ms. Shiver presents today for follow up after her trigger point injection that was performed 6/10/02. She is reporting no relief of her pain symptomatology. She is continuing to complain of axial low back pain with her same paresthesias in the left calf. No new aggravating or alleviating factors.

Physical Examination: Unchanged from her previous visit. She is alert and oriented to time, place, and person. Gait and station is normal and non-antalgic.

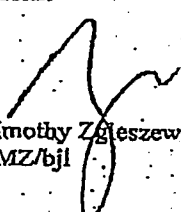
Inspection of the low back reveals no new surgical incisions, no new muscle atrophy, or lumbar shift. Forward flexion and extension of the lumbar spine remains limited to less than 50% of normal. There is some minimal to moderate tightness of the bilateral rectus femoris, psoas, and hamstring muscles.

PA mobilization of the lumbar spine in the prone position reveals tenderness to light touch. Again, spring testing could not be performed. PA mobilization of the PSIS also reproduced pain to light touch. She still has palpable spasms noted in the lower lumbar regions bilaterally.

Neurologic examination reveals intact and unchanged motor strength and sensation in both lower extremities and torso.

Diagnoses: 1. Low back pain.
2. Muscle imbalances.

Plan: After reviewing Ms. Shiver's clinical scenario, physical examination, and failure to improve with a trigger point injection, we are going to get her involved in a formal PT program to address her muscle imbalances and see if we can get good relief with that treatment modality. She will be seen back in follow up in approximately 3-4 weeks.


Timothy Zgleszewski, M.D.
TMZ/bjl

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICAL
PROGRESS NOTE

July 30, 2002 Gertie is seen in follow up. She was recently seen for 2 visits by Dr. Zgleszewski, initial visit primarily being consultation for recurrent low back pain secondary to work-related injury 3/23/02 where she fell back onto her lower lumbar region when her chair flipped backwards when she was trying to pick up a pen that she had dropped at work. This injury occurred on 3/23/02, had been at stable level in regard to low back symptoms since last seen in this office 11/20/01, until this new injury 3/23/02.

Patient complaining of fairly severe pain in low back, 7/10 pain level severity on average, sometimes worse, sometimes less. Patient has been doing well on oral medications, but only give temporary benefit at best. Patient estimates about 15% improvement with therapy regarding low back symptoms, accomplished therapy in Columbia at The Human Performance and Rehabilitation Center.

Medications: Patient currently on Skelaxin and Mobic, tolerating well, partial benefit as noted above.

ROS: Patient notes that she is not sure whether she has had significant change in leg symptoms since 3/23/02 back injury. Does state that she has some buttock and thigh pain, but most of her pain in LLE relates directly to separate injury to left Achilles tendon (contusion/stretch type injury described by patient today) occurred on the job 11/15/01, under care of separate physician.

Social History: Patient continues to work at Palmetto Richland Memorial Hospital, works in medical records, sedentary job primarily. Has lost about 2 weeks time from work relating to March 2002 work injury. Had been approved to receive treatment by Dr. Hooks, patient's primary physician (patient was told by ER physician to seek treatment with her primary doctor, although ER physician was aware that patient was injured on the job). We have not been approved for treatment relating to work injury 3/23/02 per carrier.

Past Spinal History: Reviewed by Dr. Z, see history of present illness and 6/10/02 IME/consult.

Physical Examination: Reveals marked tenderness bilateral L1-2, L3-4, L4-5, and L5-S1 lumbar facet regions, with significant left greater than right quadratus lumborum trigger points at originating fibers over iliac crests and also mid-belly of this muscle at L3 level 6 cm to left and right of midline respectively. Marked tenderness left side only over SI joint, with sciatic notch tenderness noted left greater than right side. No spinous process tenderness, no palpable step off, no CVA tenderness to percussion. Lower extremity exam reveals downgoing plantar responses; no clonus, negative SLRs bilaterally at 90 degrees sitting, no definite focal motor deficits, although there is give-way weakness gastroc-soleus complex on specific testing on left, with tenderness along Achilles tendon. Negative Homan's, negative crossed-SLR bilaterally, on increase in pain on internal and external rotation at either hip, reflexes 1+ and symmetric patellar and Achilles with Jendrassik maneuver.

Imaging: Prior imaging accomplished at Dr. Steven Macaruso's request at Palmetto Baptist Medical Center 3/24/02 lumbar spine AP and lateral views only with cone view lumbosacral junction shows no evidence of listhesis, no loss of disc space height of significance at any level, no scoliosis, 5 non-rib bearing lumbar vertebra, mild sclerosis bilateral SI joints, hip joints not well visualized, but appear normal (what is visualized). Minimal anterior osteophytes noted at L2-3 and to lesser extent L3-4 and L4-5 end-plate. Similar anterior osteophytes noted at superior endplates of T11 and T12 vertebral bodies.

Flexion/extension views accomplished today in office show no evidence of listhesis or instability in lumbar spine, although there is evidence of mild retrolisthesis T11 in respect to T12 vertebral body, 2-3 mm posterior displacement noted on extension only, with loss of disc space height at this level; however, on flexion views, no listhesis appreciable. Anterior osteophytes confirmed in lower thoracic levels as noted above, with most significant osteophytes in lumbar level noted anteriorly at L2 and L3 (and to a lesser extent L4) vertebral bodies.

Oblique views bilaterally lumbar spine accomplished today shows evidence of significant sclerosis with narrowing of bilateral L4-5 greater than bilateral L5-S1 facet joints. No definite stenosis appreciable, no spondylolysis noted at any level lumbar spine.

Impression: 1. Flared low back pain without significant definite radicular complaints, S/P recent/new work-related fall out of chair 3/23/02, rule out recurrent discogenic low back pain (vs. "new onset" lumbar facet syndrome/sacroiliitis (subacute lumbar strain syndrome).

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26

104
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SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDIC
PROGRESS NO.1

July 30, 2002\ Page 2

Impression(continued): 2. History of prior stable L4-5 disc protrusion/shallow HNP, flared S/P MVA 11/25/00, with history of pre-existent symptomatic L4-5 disc bulge secondary to initial work-related MVA 10/11/97).

Recommendations/Discussion: There is no change in assumption regarding impairment relating to 11/25/00 MVA, and injuries sustained to cervicothoracic spine relating to that accident, previously assessed on 8/13/01 in Charleston Spine progress notes.

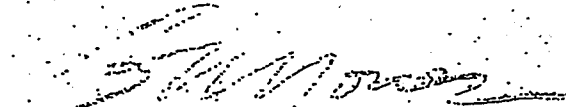
With new injury of 3/23/02, patient is not yet considered at MMI. Taking into account initial assessment by Dr. Zgleszewski, and recent follow up visit and lack of response to trial trigger point injection 6/24/02, and based on my review of x-rays from various sources as above, would suggest the following at this time:

1. Trial lumbar facet/focal injection therapy as accomplished today (see below).
2. Follow up in 1-2 weeks to assess response to above measures.
3. Continue Skelaxin and Mobic at current dosing.
4. Trial of stronger oral narcotic for more severe pain control.
5. Consideration for new MRI lumbar spine if no significant benefit or suboptimal benefit noted with lumbar facet/SI injections accomplished today on trial basis.
6. Monitor for any development of worsening leg symptoms. Patient feels that most of her symptoms in left leg distally relate to her prior Achilles tendon injury, under separate physician's care. Patient is to monitor for any more proximal symptoms or "new" symptoms; however, at this point, I seen no clear indication of radiculopathy relating to disc pathology in lumbar spine.
7. Patient should avoid any frequent or repetitive bending, stooping, or crawling activities, and also should avoid any lifting, pushing, or pulling greater than 20 pounds until further notice. As long as she can work within these restrictions, can continue to work at her current job. Patient placed out of work today and tomorrow post-lumbar facet/SI injections.

I have accomplished the following focal injections today:

1. Left L3-4, L4-5, and L5-S1 lumbar facet blocks, 5 mg methylprednisolone acetate per site, sterile technique, non-fluoroscopic, 25 gauge 5" spinal needle used at each site.
2. Left SI joint block, 5 mg Aristospan, sterile technique, non-fluoroscopic, 22 gauge 3.5" spinal needle used.
3. Left quadratus lumborum mid-belly trigger point injection (L3 level site as described above), 2.5 mg Aristospan, sterile technique, non-fluoroscopic, 25 gauge 3" spinal needle used.

The patient was prepped and draped in a sterile fashion in the prone position after informed consent was signed and patient questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).


Gregory M. Jones, M.D.

GMJ/bjl

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27

10/24
18 01/02/02

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDIC.
PROGRESS NO.

August 13, 2002 - Gertie is seen in follow up. Has only gotten about 20% improvement for the trial left sided lumbar facet and SI joint blocks accomplished 7/30/02. Still has the "deep-seated" low back pain. No change in this portion of symptoms. Pain at 7-8/10 level currently.

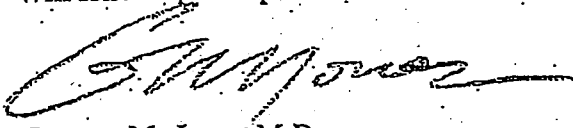
Medications: Patient tolerating Mobic, using Skelaxin for muscle spasm. Using MS Contin for more severe pain. Causes some drowsiness/hypersomnolence.

Imaging: Prior imaging reviewed 7/30/02, including x-rays lumbar spine accomplished that date here in office.

Patient has had no recent MRI studies lumbar spine, and particularly none since fall 3/23/02. 3/14/98 MRI lumbar spine showed left paracentral L4-5 shallow herniation with annular tear, with no significant abnormalities at L5-S1 or L3-4 level.

Impression: 1. Persistent low back pain with partial lumbar facet syndrome/sacroiliitis (lumbar strain syndrome), S/P recent work-related fall from chair 3/23/02 (with history of prior stable L4-5 disc protrusion/shallow HNP left paracentral with annular tear), symptomatic S/P work-related MVA 10/11/97, significantly flared/worsened S/P MVA 11/25/00.

Recommendations/Discussion: This patient had problems with her disc relating particularly to the 11/25/00 injury. However, it may be reinjury to this disc level (or possibly to previously uninjured discs at L3-4 and/or L5-S1 levels) with fall on the job 3/23/02. Only way to determine this is with new MRI lumbar spine, which is ordered today. Will follow up with patient next week to review this study. No change in medications at this time.


Gregory M. Jones, M.D.

GMI/bjl

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28

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SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDIC
PROGRESS NO1

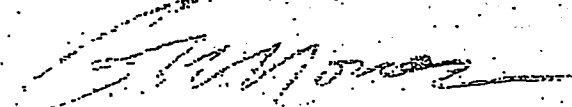
August 27, 2002 Gertie is seen in follow-up today for MRI review. Still complaining of back pain. Pain presently at 5-6/10 level when using MS Contin. More severe when off this medication. Tolerating well, gives over 12 hours of partial relief when taken. No change in other meds at this time.

Patient relates that still she only noted about 20% benefit from the trial left sided lumbar facet and SI joint-blocks accomplished 7/30/02. She is now one month out from those blocks, no change in pain character or severity.

Imaging: MRI lumbar spine shows evidence of disc bulge with no compressive sequelae at L3-4, with disc protrusion and annular tear at L4-5 impinging bilateral transiting L5 nerve roots, but no definite compromise of exiting L4 nerve roots on either side. Right paracentral and central disc protrusion noted at L5-S1 with contained herniation/annular tear noted, with displacement of transiting right S1 nerve root, but no compromise of exiting L5 nerve roots on either side. Incidental finding of right adnexal fullness consistent most probably with ovarian cyst noted (clinical correlation and/or pelvic-sonography via primary physician recommended).

Impression: 1. Persisting low back pain with probable worsened discogenic component, S/P recent work-related fall from chair 3/23/02, with partial lumbar facet syndrome/sacroiliitis (lumbar strain syndrome) concomitant.
2. L4-5 and L5-S1 annular tears/protrusions, rule out symptomatic disc lesion(s), S/P recent work-related fall 3/23/02 (with history of prior stable L4-5 disc protrusion/shallow HNP left paracentral with annular tear, symptomatic S/P work-related MVA 10/11/97, flared/worsened S/P MVA 11/25/00).

Recommendations/Discussion: Would suggest going ahead with series of blocks at L4-5 and/or L5-S1 level(s) based on findings noted on new MRI. Should hopefully be able to get Gertie back to her baseline pre-3/23/02 injury level of back pain and sciatica complaints. There is no change in assumptions regarding impairments relating to 11/25/00 MVA, and no change relating to cervicothoracic spine injuries sustained in that accident, previous injury assessed 8/13/01. Patient not yet at MMI regarding new injury to lumbar spine 3/23/02, as this does appear to be aggravation of underlying pre-existent conditions, with possible new-onset annular-tear/contained herniation at L5-S1 (and possibly new-onset symptomatic disc bulge L3-4).


Gregory M. Jones, M.D.

GMJ/bjl

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29

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

September 19, 2002 PROCEDURE NOTE

PROCEDURE: 1. Central L4-5 LESI.

DIAGNOSIS: 1. Discogenic low back pain with sciatica.

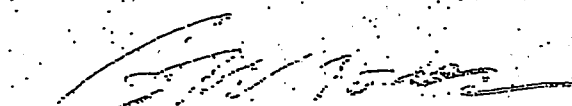
CLINICAL DATA: Patient has recently been injured 3/23/02 and has flared discogenic low back pain. This is an attempt to get discogenic pain under control non-surgically. This is first in series of three blocks.

PROCEDURE: Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to procedure per IV. Skin and subcutaneous tissue over central L4-5 interlaminar space identified and anesthetized using 8 cc 1% Xylocaine and 3 cc 0.5% Marcaine.

#18 gauge 3.5" Crawford needle was used to enter epidural space using loss of resistance to normal saline technique, confirmed by 2 cc 240 Omnipaque epidurogram on AP and lateral views (lateral epidurogram copy available in Charleston Spine chart for review).

90 mg DepoMedrol with 2 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) injected into epidural space; tolerated procedure well, needle was withdrawn. Patient went to recovery room in good condition.

The patient was prepped and draped in a sterile fashion in the prone position after informed consent was signed and patient questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).


Gregory M. Jones, M.D.

GMJ/bjl

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SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

October 17, 2002 PROCEDURE NOTE

PROCEDURE: 1. Left paracentral L5-S1 LESI.

DIAGNOSIS: 1. Recurrent discogenic low back pain with sciatica.

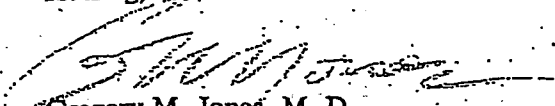
CLINICAL DATA: Patient is well known to this practice, has chronic discogenic low back pain, and has had recent injury via fall 3/23/02. This is an attempt to get flaring of discogenic pain under control non-surgically. Original injury sustained 11/25/00. Refer to Charleston Spine progress notes for details of prior work up and treatment.

PROCEDURE: Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to procedure per IV. Skin and subcutaneous tissue over left L5-S1 interlaminar space identified and anesthetized using 8 cc 1% Xylocaine.

#18 gauge 3.5" Crawford needle used to enter epidural space using loss of resistance to normal saline technique, confirmed by 2 cc 240 Omnipaque epidurogram on AP and lateral views. AP and lateral epidurogram copy available in Charleston Spine Chart for review.

90 mg DepoMedrol with 2 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) injected into epidural space, tolerated well, needle was withdrawn. Patient went to recovery room in good condition.

The patient was prepped and draped in a sterile fashion in the prone position after informed consent was signed and patient questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).


Gregory M. Jones, M. D.

GMI/bjl

NEW CLAIM
10-24-02

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31

10/24/02

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

November 14, 2002\ PROCEDURE NOTE

PROCEDURE: 1. Left paracentral L3-4 LESI.

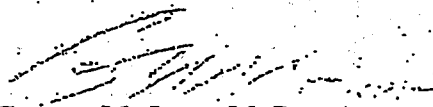
DIAGNOSIS: 1. Discogenic low-back with sciatica.

CLINICAL DATA: Refer to Charleston Spine progress notes for details of prior work up and treatment, as well as reasoning behind utilization of block procedure today.

PROCEDURE: Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to procedure per IV. Skin and subcutaneous tissue over left L3-4 interlaminar space near midline identified and anesthetized using 7 cc 1% Xylocaine and 2 cc 0.5% Marcaine.

#18 gauge 3.5" Crawford needle used to enter epidural space using loss of resistance to normal saline technique, confirmed by visualization on AP and lateral views of needle tip placement (patient allergic to contrast dye, no Omnipaque utilized for contrast visualization for this reason).

90 mg DepoMedrol with 1.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) injected into epidural space, tolerated well, needle was withdrawn. Patient went to recovery room in good condition.


Gregory M. Jones, M. D.

GMJ/bjl

Addendum: Pre-block assessment and discussion with patient accomplished today. Patient notes the following:

1. Patient noted no significant relief from 9/19/02 L4-5 LESI.
2. Patient noted very good relief following 10/17/02 left paracentral L5-S1 LESI.
3. Patient states that she was involved in a new injury at work on 10/24/02, apparently injuring her neck. Patient states that she is currently under care of Dr. Jeff Hook, who has started patient on physical therapy. Dr. Hook has suggested that if patient's symptoms do not abate with conservative measures, he may want to consult this practice for further care if specialty care becomes necessary for this new injury.

(635)

32



If you need anything



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SHIVER, Gertrude #4559

May 9, 2003

CHIEF COMPLAINT: Left sided neck and shoulder pain; throat discomfort with voice change.

HISTORY OF PRESENT ILLNESS: Patient is a 48 year old female who is well known to this practice, who is complaining of persistent left sided neck and shoulder pain since injury occurring on the job 10/24/02.

Patient states that she was at her job, her supervisor accidentally dropped a thick chart, chart striking the left side of patient's neck and shoulder, this occurring 10/24/02. Patient states that she has been under care of Dr. Hook since that time, but pain has not returned to "baseline" level. Patient initially noted primarily stabbing and burning pain left side of neck and shoulder, flared from baseline level, but then beginning approximately 12/25/02, patient notes that she has had problems with her voice, volume decreased, unable to talk in more than whisper, unable to sing. Patient notes that during this time, she has had excessive secretions in back of throat and nasally, and although her voice and throat problems have not clear completely she did have most of her voice come back in mid-February. Patient has had anterior throat pain associated with her increased throat and nasopharyngeal secretions and voice abnormalities. Patient has continued to work since injury to neck and shoulder. Patient unsure as to whether throat and voice problems related to 10/24/02 work injury. No prior history of similar condition. Has had four sessions of PT in formal PT, now on home exercise program.

PAST MEDICAL HISTORY: Past medical history significant. Surgical history is quite significant as well. This history includes a heart conduction defect with myomectomy 1995, breast reduction surgery 1997, no prior spine surgeries, but patient has multiple injury histories to spine. Patient was initially seen in this practice 3/4/98 for low back symptoms due to MYA 4/20/97, with flaring of these symptoms following work-related lifting injury 10/11/97.

Patient underwent conservative treatment, was placed at MMI July 1998, assessed DRE Category II impairment to cervicothoracic spine for chronic cervical strain syndrome, and DRE Category II impairment to lumbosacral spine for symptomatic disc bulge with partial myofascial low back pain components.

Patient was then involved in MYA 11/25/00. This caused major problems in regard to low back symptoms, and patient developed thereafter bilateral sciatica complaints. Patient's treatment in this practice began on 12/18/00 relating to MYA 11/25/00, and patient remained under our care for symptomatic disc pathology in lumbar spine and recurrent/flared cervicothoracic pain through 2001. Patient was assumed at MMI 5/7/01 for lumbar injuries sustained 11/25/00, assessed no additional impairment at that time as patient's disc lesion at L4-5 had stabilized symptomatically. However, patient did have significant worsening/aggravation of cervicothoracic injuries sustained 11/25/00, and additional 3% impairment assessed for additional injuries to cervical spine in 11/25/00 MYA on date of MMI for cervical injuries 8/13/01. Patient has required intermittent even since assessment of MMI, and this has included occasional use of cervical facet/focal injections, with last visit occurring 11/20/01 relating directly to that accident of 11/25/00.

Patient was unfortunately involved in another work injury on 3/22/02, injured low back when chair flipped backward when she fell, and treatment from 6/10/02 initial assessment through follow ups and a set of three epidural blocks in fall of 2002 relates to the patient's lumbar spine condition and flaring of low back pain from work injury 3/22/02. Patient was last seen 11/14/02 for pre-block assessment, and had the last block on 11/14/02 in series of three.

REVIEW OF SYSTEMS: Patient has history of palpitations relating to her cardiac disease. Currently on medication for this. Also hypertension controlled with Cardizem. Takes one baby aspirin daily, no other blood thinners. Has history of IBS with intermittent problems with constipation. Also has prior history of bone and joint/spinal pain, see PMH above. Has history of headaches, difficulty sleeping. Otherwise noncontributory, no sexual dysfunction, no immune or blood disorders, no depression or psychiatric history, no diabetes or cancer history, no fibromyalgia history, no weight change.

MEDICATIONS: Ultram 50 mg 1 po q6h prn pain. Other medications include Bextra 20 mg po q daily (both given by Dr. Jeff Hook, patient's primary physician). Other medications include 1 baby aspirin q daily, Humibid 600 mg LA 1 tablet q12h, Tenormin 25 mg 1 bid, Cardizem 120 mg tablet q daily, and Skelaxin 400 mg q8h prn muscle spasm.

ALLERGIES: Contrast dye ("seizure-like activity"), tuberculin skin test (palpitations, itching, rash with wheals on body). Also tetanus toxoid (hematoma formation at injection site).

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FROM-CHAS SPINE

14:11 05-22-03

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33



PHYSICIAN MANAGEMENT SERVICES

page 2

May 9, 2003



If you need a history of patient's file, no children, works full time at Palmetto Richland Memorial Hospital in Columbia for past 2 1/2 years, work as a health information management specialist, inputs data into computer, also pulls records, files, makes charts, analyzes and assembles records. Does require some lifting, usually not heavy. Long sitting required. Nonsmoker, no alcohol use. Lives in Gadsden, SC. Dr. Jeff Hook is patient's primary and referring physician regarding this consult today.

FAMILY HISTORY: Positive for diabetes in sisters and one brother. Also history of colon cancer in one sister.

PHYSICAL EXAMINATION: Reveals a pleasant cooperative female, familiar to me from previous treatment, height 5' 3 1/2", weight 194 pounds. Upper extremity exam reveals negative Hoffman's, negative Spurling's, negative foraminal compression test, but both of the latter tests cause an increase in left sided neck pain (basically on any motion of the cervical spine side to side or with extension pain noted in left neck and left upper shoulder), no focal sensory deficits in dermatomal pattern either upper limb, reflexes are 1+ in triceps, 2+ in biceps, and trace, but symmetric in brachioradialis bilaterally. No definite focal motor deficits or atrophy either upper limb in myotomal pattern, no impingement at either shoulder, no subacromial or AC joint tenderness on either side. Marked trigger points noted left upper trapezius, left levator scapulae, and left supraspinatus, with similar findings noted left anterior and posterior scalene muscles mid-bellies, and left sternocleidomastoid as well as digastric, with most marked trigger points noted left splenius capitis and left splenius cervicis. Marked tenderness also noted over cervical facets at almost all levels from C2-3 down to cervicothoracic junction to varying degrees, with only moderate tenderness noted over greater occipital nerve route, none noted on right side. Moderate tenderness also noted over right cervical facets at C3-4 to C5-6 levels to moderate extent. Although there are minimal trigger points right upper shoulder and right lateral neck muscles in same region as on left side; these are no where near as tender or as large as the ones on left side. Cervical range is significantly limited, but particularly lateral bending and extension most difficult for patient. No CVA tenderness to percussion, no scapulohumeral motion deficits or scapular winging. HENT exam deferred.

IMAGING: Cervical spine plain radiographs accomplished today reviewed. Mild inferior endplate osteophytes noted at C4 and C6, more significant at C5, with earlier osteophyte superior endplate at C7 level. I can appreciate no definite loss of disc space height at any level on lateral views, and there is no evidence of listhesis or abnormal motion on flexion/extension views, other than limited extension. Standard neutral lateral views show reversal of normal cervical lordosis. Bilateral oblique views show no significant neuroforaminal narrowing at any level on either side. AP views show evidence of mild atherosclerosis both carotids, no lateral subluxations or acute injuries noted. Odontoid views normal with normal symmetry.

IMPRESSION: 1. History of contusion/blow to left lateral neck and left proximal/upper shoulder region 10/24/02 while on the job, with persistent left sided neck and upper shoulder pain in spite of prior conservative measures.
2. History of chronic cervicothoracic myofascial and facet-generated pain, previously stable, now likely flared/recurrent, S/P most recent work-related injury 10/24/02, no evidence of cervical radiculopathy clinically either upper limb.
3. History of chronic L4-S and L5-S1 symptomatic disc lesions with associated low back pain and bilateral sciatica, with history of recent flaring of discogenic and non-discogenic pain components following work-related fall from chair 3/22/02 (previously stable S/P MVA 11/25/00, with history of prior initial injury 10/11/97).

RECOMMENDATIONS/DISCUSSION: Fortunately, patient appears to have been stabilized in regard to the injuries sustained on the job 3/22/02. This patient received treatment 6/10/02 through 11/14/02, and since we have completed the series of three epidural blocks 9/19/02, 10/17/02, and 11/14/02, patient has achieved a return to "baseline" level in relation to the flaring of low back and leg/buttock symptoms following work-related fall out of chair onto lower back 3/22/02. It is my opinion that patient can be considered at MMI regarding injuries sustained on the job to lumbar spine 3/22/02, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, patient has likely suffered no additional impairment to lumbar spine relating to those injuries; to a reasonable degree of medical certainty. It appears that this patient suffered most problems with the accident of 11/25/00, this was the most significant injury suffered in this "egg-shell" patient, and extensive care was necessary to stabilize her condition relating to that injury event. Patient has been assessed at MMI previously for that specific injury event as well.

In regard to this new injury of 10/24/02, patient is not yet considered at MMI. It is my opinion that patient would likely benefit from treatment directed toward the trigger points and cervical facets. Patient is to come in with driver 5/13/03, can go ahead with focal injection therapies, will hopefully be able to get patient back to "baseline" level in regard to cervical injuries sustained 10/24/02 without use of cervical epidural block.

In regard to the complaints of voice change, increased nasopharyngeal/oropharyngeal secretions, and throat soreness/pain, this appears to have begun approximately 2 months after contusion to left side of neck and shoulder 10/24/02. I would suggest that patient seek care with Dr. Hook, and if he feels that it is appropriate (if not already accomplished), patient may benefit from evaluation and treatment with otolaryngologist. I cannot clearly relate the ENT symptoms to the work injury of 10/24/02, to a reasonable degree of medical certainty; would defer to otolaryngologist for determination of relationship of this condition to any specific injury event.

Gregory M. Jones, M.D.
GMI/bjl

cc: Sandy Saukas, RN

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FROM-CHAS SPINE

1411 05-22-03

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SHEVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

June 4, 2003 Patient is seen in follow up, we had completed the treatment yesterday regarding left cervical facet injections. Patient is here today for the trial of Myobloc injections that we had previously discussed. Patient has had chronic myofascial pain component, this has been flared recently by work injury 10/24/02, but we had also discussed possible utilization of trigger point injections and/or chemodenervation of recalcitrant trigger points relating to MVC 4/20/97, but particularly since patient has had significant flaring of neck and shoulder girdle myofascial pain since MVA 11/25/00. Therefore, this treatment today relates not only to the significant flaring of myofascial pain component in these two regions following MVA 11/25/00, but also to the significant flaring and even worsening of any myofascial pain present since work injury and contusion to left shoulder and neck region 10/24/02.

ROS: Patient currently experiencing no significant left arm pain.

PMH: No significant change in symptoms since left sided cervical facet injections accomplished yesterday, too soon to tell what type of benefit will be achieved.

Physical Examination: Reveals significant trigger points at typical locations in this patient, and this includes left upper trapezius mid-belly, left levator scapulae, and left supraspinatus mid-belly. I have not treated any of the rhomboid, infraspinatus, or middle or lower trapezial trigger points, and no treatment accomplished on right side today, using this side as "control." Patient has significant recalcitrant/chronic trigger points at usual locations left lateral neck, including splenius capitis, splenius cervicis, posterior scalene, and anterior scalene. These are in usual locations within these muscles, but there is also significant residual tenderness left greater occipital nerve route, and still tenderness noted over cervical facets treated yesterday. No evidence of erythema or local swelling noted over sites treated yesterday. Significant trigger point also noted left sternocleidomastoid muscle at clavicular head, 2 cm above clavicle.

Impression:

1. Severe flared left sided cervicothoracic myofascial and facet-generated pain (left sided superimposed acute and underlying chronic cervical and upper shoulder girdle strain syndrome), significantly flared since most recent work-related contusion to left neck and shoulder region 10/24/02 (unresponsive to prior conservative measures, Dr. Hook), initially symptomatic S/P MVA 4/20/97 and work injury 10/11/97 (with history of severe flaring following more recent MVA 11/25/00, with development of chronic myofascial pain thereafter).
2. Known underlying/pre-existent multilevel cervical spondylosis, worse at C4-5 and C5-6 levels, rule out spondylitic (vs. discogenic) cervical pain component with left shoulder, but no current significant upper extremity complaints.
3. Chronic, but currently stable, multifactorial low back pain with discogenic (symptomatic L4-5 and L5-S1 annular tear/protrusions), multilevel facet-generated, and myofascial pain components, one or more of these components significantly flared/symptomatic S/P work-related fall from chair 3/23/02 (this flare now stable following recent series of lumbar epidural blocks), symptoms initially present in low back following work-related MVA 10/11/07, significantly flared/worsened, S/P MVA 11/25/00.

Recommendations/Discussion: In regard to patient's pathology, patient is considered at MMI as of today's date, relating to lumbar injuries and flaring of multifactorial low back pain following work-related fall from chair 3/23/02. Patient has already been assessed for impairment relating to the most severe injury of this region, specifically the MVA 11/25/00. There is no change in assumptions regarding impairments relating to this injury. Based on fact that we have no indication of a "new" injury to lumbar spine with work injury of 3/23/02, this was primarily a flaring/aggravation of underlying pre-existent multifactorial pain generators in lumbar spine.

Although there is possibility that the annular tear/contained herniation at L5-S1 or the bulge at L3-4 could be related to work injury of 3/23/02, I would suggest that no additional impairment rating is necessary relating to that injury of 3/23/02, considering fact that patient is now stable in lumbar spine, has had no significant flaring since completion of epidural blocks, and has no definite clinical evidence of worsening or true "aggravation" per *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* definition, based on current understanding of patient's chronic low back pain problems.

Therefore, patient is assessed at MMI for work injuries sustained 3/23/02 to lumbar spine, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, patient is assessed DRE Category I, 0% lumbar spine/0% whole person additional impairment relating to accident of 3/23/02 on the job. This assumption of no additional impairment is making an assumption, i.e., that patient will not require more aggressive treatment than that already necessary to maintain stability of patient's lumbar spine pathologies, those treatments being accomplished on prn basis relating to permanent impairment and injuries sustained 11/25/00. It should be noted that some of treatments post-injury 3/23/02 actually would have been necessary for ongoing care of patient relating to chronic low back pain, and this can (at least partially) be related

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SHIVER, Gertrude
#4559CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

May 13, 2003 Patient is seen in follow up has failed to show any significant benefit to the PT and appropriate medications given by Dr. Hook. Dr. Hook has now discontinued Mobic and has started patient on Bextra on trial basis, pending further treatment here. See medication section for other details.

Patient has come in today for consideration for possible trigger point/focal injections left neck/shoulder.

Medications: Patient is currently taking alprazolam (Xanax 0.5 mg) prn for anxiety, this prescribed by Dr. Hook. Patient recently started on Bextra, no change in pain as yet with this new medication.

Physical Examination: Reveals significant trigger points left supraspinatus mid-belly, left levator scapulae, and left upper trapezius, but also significant trigger points left posterior and anterior scalene and left splenius cervicis as well as capitis muscles usual sites. Marked tenderness also noted over left C2-3 through C6-7 cervical facets to varying degrees, most significant tenderness at upper four cervical levels. Left greater than right greater occipital nerve route tenderness also noted.

- Impression:**
1. Flared/recurrent cervicothoracic myofascial and/or facer-generated pain (left-sided cervical and upper shoulder strain syndrome (S/P work-related neck and shoulder contusion, unresponsive to prior conservative measures (Dr. Hook).
 2. Persistent left sided cervical facet syndrome with significant myofascial pain component, symptomatic/flared S/P work-related contusion to left neck and shoulder 10/24/02 by history (with history of chronic myofascial/facet-generated pain and underlying/pre-existent C4-5/C5-6 cervical spondylosis, initially symptomatic S/P MVA 4/20/97, flared with work injury 10/11/97, also flared more recently with significant recurrence following MVA 11/25/00).
 3. Chronic (but currently stable) low back pain with underlying discogenic, facer-generated, and myofascial pain components, recently flared/symptomatic S/P work-related fall from chair 3/23/02, stable following recent series of blocks (with known L4-5 and L5-S1 symptomatic annular tear/protrusions, previously stable, initially symptomatic S/P work-related MVA 10/11/97, flared/worsened S/P MVA 11/25/00).

Recommendations/Discussion: Patient is candidate for focal injection therapy left shoulder and neck region. She is really the classic "egg-shell" patient in that she has had multiple injuries in past, and even minor injuries to these regions can cause fairly significant flares in this patient. It is not atypical for these patient's to fail to respond to more conservative measures such as PT and medications (those measures that may be effective in less compromised patients), with this in mind, I have accomplished the following today:

1. Left C3-4 and C4-5 cervical facer blocks, 5 mg methylprednisolone acetate per site, sterile technique, non-fluoroscopic, 25 gauge 2" spinal needles used at each site.
2. Left lateral neck trigger point injections, left posterior scalene and left splenius cervicis muscles, 2.5 mg Aristospan per site, non-fluoroscopic, 27 gauge 1 1/4" spinal needle used at each site.
3. Left shoulder girdle trigger point injections, 2 sites (left supraspinatus and levator scapulae muscles), 2.5 mg Aristospan per site, sterile technique, non-fluoroscopic, 27 gauge 1 1/4" spinal needles used.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Follow up will be accomplished in several weeks. I have discussed option regarding use of further cervical facer injections (if necessary), based on response to two levels treated today, for any residual cervical symptoms relating to this underlying pathology. I have also discussed option regarding treatment of recalcitrant trigger points with Myobloc (botulinum toxin type B) if necessary.

At this point, patient remains neurologically stable, as assessed 4/23/03 regarding upper limbs. No need for any specific restrictions regarding vocational and/or avocational pursuits at this time, relating to cervical injuries sustained 10/24/02, to a reasonable degree of medical certainty.

Patient not yet considered at MMI regarding injuries sustained 10/24/02 on the job to left cervical and upper shoulder girdle region.

Gregory M. Jones, M. D.

GMJ/bjl

(639)

36

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

June 4, 2003\ page 2

Recommendations/Discussion (continued): to MVC of 11/25/00, to a reasonable degree of medical certainty.

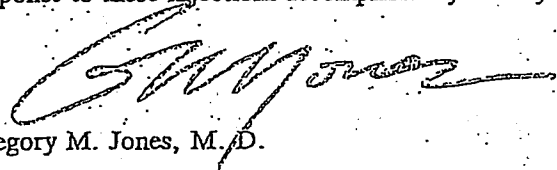
It is noted by history that patient was involved in work-related fall in January 2003, has had significant leg and hip symptoms since that fall, and also left flank and left inguinal pain. This appears to be a separate injury from the stable low back and buttock/sciatica symptoms relating to the lumbar pathologies noted above. Patient is currently under care of separate physician for these injuries sustained on the job January 2003, and any additional or new impairments relating to this injury should be addressed by current treating physician(s), once patient at MMI. I have not addressed any additional impairments that may be related to that specific injury January 2003 on the job, to lumbar spine, as I have not been involved in the patient's care of these new injuries.

Patient is not yet considered at MMI regarding most recent injuries sustained to cervical spine, particularly in relation to work injury 10/24/02. There is no change in assessment of prior impairments or MMI relating to cervicothoracic spine injuries sustained 11/25/00 in MVC, assessed date of MMI 8/13/01. However, since patient is not yet at MMI relating to flaring/worsening of left sided neck and shoulder symptoms since work-related contusion to left neck and shoulder 10/24/02, I cannot address issues regarding MMI or any additional impairment rating (if this becomes appropriate/necessary) until patient is maximized regarding non-surgical measures available to her. It should be noted that the treatments accomplished today (see below) relate to ongoing care regarding MVC 11/25/00, as we had already discussed these options previously (Myobloc injections for recalcitrant trigger points due to chronic myofascial pain components present/flared since MVA 11/25/00), and the injury of 10/24/02 to left neck and shoulder has aggravated this portion of patient's pain in shoulder/neck region to point to where it is necessary to go ahead with the chemodenervation trial as follows:

1. Left shoulder girdle chemodenervation at supraspinatus, levator scapulae, and upper trapezius sites, three sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.
2. Left lateral neck chemodenervation of scalene and splenius trigger sites, four sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Patient is placed out of work as of yesterday through 6/5/03. Patient is to follow up in 3-5 weeks to assess response to cervical facet injections and Myobloc chemodenervation trial. I do not see any reason to consider new MRI cervical spine. If patient gets adequate relief to these two sets of injections accomplished yesterday and today, no need to consider cervical epidural. Should be able to determine best options available to patient for future medical care for flaring, based on response to these injections accomplished yesterday and today.


Gregory M. Jones, M.D.

GMI/bjl

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37

SHIYER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

July 1, 2003 Patient is seen in follow up. Has fortunately seen good benefit with the injections accomplished in series 6/3/03 (left cervical facet injections, 5 levels) and 6/4/03 (left shoulder girdle and left lateral neck Myobloc chemodenervation). Patient estimates overall about 80% relief. Still feels that she has persisting pain in left anterior chest wall (upper aspect) and left anterior shoulder region which is "new" and related to most recent injury on the job when a group of charts fell onto her neck and shoulder on left side.

- Impression:**
1. Flared left sided cervicothoracic and shoulder girdle myofascial pain (with flared cervical facer-generated pain concomitant) secondary to work-related contusion to left neck and shoulder region 10/24/02, good relief noted with recent focal injection therapies, now considered at MMI.
 2. History of chronic multifactorial cervicalgia, worse on left, initially symptomatic following injuries 4/20/97 (MVA) and 10/11/97 (work injury) with 5% DRE Category II impairment assessed 7/29/98, followed by additional aggravation of particularly cervical facet injuries in 11/25/00 MVA, with additional 3% impairment assessed 8/13/01, date of MMI.
 3. Chronic, currently stable multifactorial low back pain.

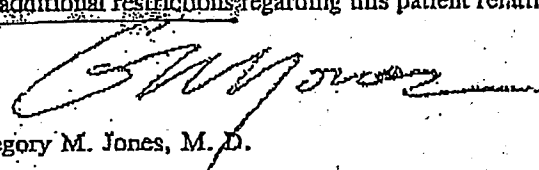
Recommendations/Discussion: There is no change regarding impairment assessed for lumbar pathology in past. Refer to 6/4/03 progress note for details.

As of today's date, we can likely assume Gertrude at MMI regarding injuries sustained on the job 10/24/02 due to contusion to left neck and shoulder region with charts. Patient appears to have had flaring of primarily myofascial pain, but also had flaring of cervical facet-generated pain components on left side. Fortunately, patient has gotten significant benefit with treatment directed toward these injuries.

Assuming MMI as of today's date for work injury sustained 3/23/02 to cervical spine and left shoulder girdle, and based on AMA Guides to the Evaluation of Permanent Impairment, 5th edition, I can assess no additional impairment for this injury, as previous impairments have been assessed for both myofascial and cervical facer-generated pain, which was present in this patient to great extent even prior to 10/24/02 injury on the job. Although patient does have residual anterior shoulder and left upper chest wall pain and discomfort which has appeared as "new" myofascial injury following 10/24/02 accident on the job, this would require assessment for myofascial pain, and based on recommendations per AMA Guides to the Evaluation of Permanent Impairment, 5th edition interpretation, it is inappropriate to add further impairments for this type of injury, particularly when impairments have addressed myofascial injuries in this region previously.

Patient had majority of injuries that have resulted in additional impairment cervical spine occurring on 11/25/00. This not only flared neck pain (particularly cervical facer-generated pain component), but also significantly flared multifactorial low back symptoms. Assessments for impairments (where necessary) have already been addressed in regard to these various injuries sustained 11/25/00.

Although patient is released today from active care regarding injuries sustained 10/24/02, patient is candidate for intermittent use of cervical facer and/or trigger point management with focal injections for flares. I can address issues regarding future medical care via Life Care Plan if this becomes necessary. Patient to continue with home exercise protocol life-long. Patient would also benefit from regular aerobic activity at least 3x weekly. Patient is allowed to continue with usual duties, as her work site requirements are primarily for sedentary work at desk/computer, where she is in health information management, working in Columbia for Palmetto Richland Memorial Hospital. There have been no additional restrictions regarding this patient relating to work injury 10/24/02. Follow up hereafter prn.


Gregory M. Jones, M.D.

GMJ/bjl

cc: Palmetto Health Trust
Attn: Lori Sharpe

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LOWCOUNTRYORTHOPAEDIC
ASSOCIATES, PA
James J. McCoy, M.D.

WC File # 9503744
Carrier File # 47893
Carrier Code - 253
Employer - 57060961

PATIENT: Gertrude Shiver
CHART NO. 61047

PAGE One

8/10/95: Chief complaint is pain in her right shoulder. It is a complicated hx and it also includes pain in the right ankle and the left ankles and both knees. She dates a lot of the problems back to a fall she took over a chair at work in 9/94. Sounds like she was able to get up under her own power and was not knocked unconscious. She was evaluated, x-rayed and had a second fall "I don't know why or how I fell" while she was going over to the employees office at the Trident Hospital. She had a 3rd fall again at work in 1/95. She has been taking some Tylox from her family physician for the discomfort and occasionally takes NSAID. She says that she cannot lift and move her arm like she used to before the falls.

PHYSICAL EXAMINATION: Reveals a somewhat overweight 41 year old black female who with coaxing has good FROM in both upper extremities and no obvious crepitus or popping in the right shoulder. No obvious muscle atrophy. No obvious swelling. Both knees show no effusion and good ROM. Stable. Both ankles do not appear to have gross swelling and have good ROM and good clinical stability.

X-RAYS: In her jacket show a multitude of films but do include x-rays of the right shoulder and both ankles that do not show any acute or chronic bone pathology.

IMPRESSION: Resolving sprains right shoulder and both ankles.

In general the pt's subjective complaints far outweigh the objective findings. We see no reason that she should not be able to work and carry out the duties of her job. We don't see anything that would lead us to believe that she has any permanent impairment here. We have no suggestions for further evaluations or for any specific treatments. We are discharging her from our care. JJM/la (8/14)

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COUNTY OF RICHLAND

Claimant,

VS.

Employer,

and

Carrier,

Defendants.

BEFORE THE
SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC Number 0126962

**NOTICE OF WITNESSES,
WRITTEN REPORTS, OR OTHER
EVIDENCE TO BE INTRODUCED
ON BEHALF OF THE DEFENDANTS**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
AND MS. GERTRUDE SHIVER, ATTORNEY FOR CLAIMANT:

YOU ARE HEREBY NOTIFIED THAT THE Employer, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following reports/physician or other evidence on behalf of the Employer to wit:

<u>NAMES OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE</u>		<u>DATE OF REPORT(S)</u>	<u>NUMBER OF PAGES</u>
1.	Dr. Martin Durkin/Healthworks	11/15/01-7/25/02	1-24
2.	Dr. Angus McBryde, Jr.	9/4/03, 11/10/03	25-28
3.	Dr. Robert Belding	2/14/02	29-30

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purpose of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina

(643)

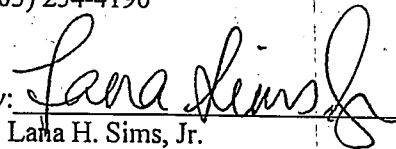
Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Employer.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Employer: None.

Respectfully submitted,

ELLIS, LAWHORNE & SIMS, P.A.
Post Office Box 2285
1501 Main Street, 5th Floor
Columbia, South Carolina 29202
(803) 254-4190

By:



Lana H. Sims, Jr.
Attorney for Employer

Columbia, South Carolina

August 20, 2007

(644)

HEALTHWORKS
POST-INJURY HEALTH QUESTIONNAIRE

Name: Gertrude Shiver

Date: 11-15-01

Do you now have or have you ever had the following? (Please circle "yes" or "no" for each item)

If "yes," please explain or describe

Allergies (to medicines, latex, etc.)

no

☒ yes

At dye Scan dye

Bleeding tendency

☒ no

yes

Diabetes ("sugar")

☒ no

yes

Heart problem embolism defect

no

☒ yes

Has SVT

High blood pressure

no

☒ yes

Trouble breathing or shortness of breath

☒ no

yes

HIV infection or AIDS

☒ no

yes

Ulcer or other stomach problem

no

☒ yes

Gerd

Any other serious or chronic disease

☒ no

yes

For women:

Are you pregnant?

☒ no

yes

When was your last menstrual period?

About 2 weeks ago

Do you smoke?

☒ no

yes

If yes, how many each day? _____

When was your last tetanus immunization?

within the last 10 years

Have you ever injured this part of your body before?

☒ no

yes

When? _____

Have you had any infection or illness in the last 3 months

☒ no

yes

Have you been hospitalized in the last three years?

☒ no

yes

Are you under a doctor's care for any illness now?

no

yes Problems c neck muscles
typical leg

Please list all medications you have taken in the last month

Skatol
10 mg, Ispirin 100 mg per day, Arthrolex, tenormin, vitamin tabs
1 tab v. codin 400 mg & 100 mg night

What pain medications have you taken in the past?

Tylox, v. codin, Darvocet, Tylenol #3
Another similar to v. codin.

Signature: Gertrude Shiver

987 77 126/66

Started
Nov 2001
Dr. Gregory Owen
Spinal specialist

(645)

HealthWorks

Injury Treatment Report

Date of Report: 11/16/01

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg

Co. Status:
Clinic Status:
File Status: OPEN
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on:

TREATMENTS

11/15/01 03:30 Pract : Barbara Griffin, RN
Treatment : see f 3 memo
Restrictions:

Ambulated without difficulty to HW. States her left heel is sore. No swelling/discoloration of heel. Very small, very superficial abrasion noted to area. It doesn't not extend through the full skin thickness. Asked if she feels it needs to be xrayed or she needs to be seen and she declines. States her supervisor said she had to come over to complete the report. Given ice/heat pack. Elevate foot, apply ice 20 minutes every 2 hours for 2 days and then may use warm compresses. Can take otc meds if needed for pain. Will recheck tomorrow as she comes in to work.

11-16-01 8:45am Received a call from Gertrude stating that her heel was still sore. She was going down steps and she fell for no apparent reason. Will come in this pm to be seen.

(646)

HealthWorks

Injury Treatment Report

Date of Report: 11/16/01

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg
Co. Status:
Clinic Status:
File Status: CLOSED
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 11/16/01

TREATMENTS

11/16/01 15:10 Pract : Coleen Collins, NP
Treatment : See F3
Restrictions: See F3

Hx: Ms. Shiver returns for F/U of left heel contusion. States her heel is still sore. She hurt her foot again falling down steps at home today.

PE: Ambulating, slightly favoring left foot. Left heel is without discoloration or edema. There is tenderness in the Achille's region. Able to bear full weight on left foot, but c/o pain when does so. The foot has FROM with nl sensation and strength; good stability.

Assess: Contusion Left Heel

Plan: Continue routine meds and ice. Elevate. F/U one week; sooner, prn.

C. Collins FN

(647)

HealthWorks

Injury Treatment Report

Date of Report: 11/19/01

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg
Co. Status:
Clinic Status: Returned To Work as of: 11/16/01
File Status: CLOSED
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 11/16/01

TREATMENTS

11/19/01 14:30 Pract : Barbara Griffin, RN
Treatment : see f 3 memo
Restrictions:

Came to HW after calling to say her ankle is hurting her and she has decided that she did want an xray. States she had been offered an xray several times but had declined. Now she feels liked she needs one. Also wants something in writing that she shouldn't be doing overhead work or squatting. Given note to that effect...except it said tip toeing. She will return on Wednesday for her xray report and to see how she is doing.

(648)

Palmetto Richland Memorial Hospital
Columbia, SC 29223

Address
1026 CONGAREE CH RD

SS# MR#
249-98-2546 R009952117

ST Zip Code
SC 29052

CPT: 73650LT

Account#
R0132301024

Chk-in D/T
11/19/01 1541

DOB
05/19/54

Age Sex Room#
47Y F DIS - OPR

Pat Type Release D/T
OPR 11/20/01 1528

Ordering Physician
DURKIN, MARTIN W
1333 TAYLOR STREET
SUITE 3-H
COLUMBIA SC 29201

Admitting Physician
DURKIN, MARTIN W

Chk-in # Order Exam
3042490 0002 00775 XR OS CALCIS HEEL L
Ord Diag: 924.20-CONTUSION OF FOOT

CALCANEUM:

There is no evidence for fracture, sclerotic, or destructive lesions of bone. There is no evidence for significant spur formation at the plantar or Achilles insertions on the calcaneus. The visualized aspects of the remainder of the hindfoot and ankle are normal.

IMPRESSION: NORMAL LEFT CALCANEUM.

/READ BY/ PARESH P SHAH, M.D.
/Released By/ PARESH P SHAH, M.D.

11/20/01 1528
HJO

C. Collins
11/24/01
FNP

FINAL DUPLICATE

(649)
=> PRMH EMP HEALTH

, TEL=803 434 3587

11/21/01 16:08 5

Injury Treatment Report

Date of Report: 11/21/01

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg

Status:
Clinical Status: Returned To Work as of: 11/16/01
Wound Status: OPEN
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 11/21/01

TREATMENTS

11/21/01 15:00 Pract : Coleen Collins, NP
Treatment : See F3
Restrictions: See F3

Hx: Ms. Shiver presents for F/U of left heel contusion. States she's still feeling some pain, but admits the left heel has improved.

PE: Ambulating better today than when last seen. Xray left heel is negative. Left heel is NT with FROM and good stability. No discoloration, edema, or heat.

Assess: Contusion left heel

Plan: Continue routine meds. Continue Ice/Heat applications
prn. Continue Modified duty. F/U Monday.

CC Collins FNP

(650)

FOLLOW-UP CARE STATEMENT

COMPLETED BY EMPLOYEE:

Employee: Gertrude Shiver
Date of Birth: 5-19-54
Title: HR Specialist

SSN: 249-98-2546
Date of illness/injury: 11-15-01
Employer: PRM H

TO BE COMPLETED BY PROVIDER:

Visit date: 11-26-01 Visit time: 1500 Diagnosis rev. (L) ankle
Treatment / Findings: _____

Work Status

Return to regular duty immediately.

Return to modified duty on (date) today:

Restrictions:

- ☐ Patient is unable to lift greater than _____ pounds
☒ Limitations of motion: No twisting or squatting
☐ Patient must avoid contact with _____
☐ Patient must keep sutures clean and dry
☐ Other _____

These restrictions apply until (date) _____, at that time:

☐ restrictions will be reassessed OR ☐ patient may return to full duty.

Patient is unable to work at this time.

Instructions

Medications: Continue routine med.
Other: Continue ice/heat applications

Follow-up appointment (Date / Time) one week Mon Dec 3 @ 2:30

Provider's signature: O. Gellms FNB Visit Time Out: 1515

(651)

Injury Treatment Report

Date of Report: 12/03/01

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg

o. Status:
Clinic Status: Light Duty as of: 11/21/01
File Status: CLOSED
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 11/26/01

TREATMENTS

12/03/01 14:30 Pract : Coleen Collins, NP
Treatment : See F3
Restrictions: See F3

Hx: Ms. Shiver returns for F/U of contusion left heel. States she continues to improve. Still using ice/heat and Epsom salts. Able to walk much better.

PE: Ambulating without difficulty. Left heel without edema, discoloration, or tenderness. Reflexes and sensation wnl. Able to tiptoe much better with better ability to bear weight without losing balance. No real problems squatting.

Assess: Contusion left heel resolving.

Plan: Continue ice;heat and Epsom salt tx prn. Will keep on modified duty one more week. F/U one week.

Coleen Collins

(652)

FOLLOW-UP CARE STATEMENT

COMPLETED BY EMPLOYEE:

Name: Buttrick Shivers
Date of Birth: 5-19-54
Title: HRM Specialist

SSN: 249-98-2546
Date of illness/injury: 11-15-01
Employer: PRM H

TO BE COMPLETED BY PROVIDER:

Visit date: 12-3-01 Visit time: 2:30 PM Diagnosis: rev. (L) heel
Treatment / Findings: _____

Work Status

Return to regular duty immediately.

Return to modified duty on (date) Tuesday:

Restrictions:

- ☐ Patient is unable to lift greater than _____ pounds.
- ☒ Limitations of motion: Avoid typing or squattng
- ☐ Patient must avoid contact with _____
- ☐ Patient must keep sutures clean and dry
- ☐ Other _____

These restrictions apply until (date) _____, at that time:
_____ restrictions will be reassessed OR _____ patient may return to full duty.

Patient is unable to work at this time.

Instructions

Medications: Continue routine med
Other: Continue Ice/Heat prn

Follow-up appointment (Date / Time) ONE week, Dec 10th 3:15

Provider's signature: C. Collins MD Visit Time Out: 2:47

(653)

Injury Treatment Report

Date of Report: 12/11/01

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg

o. Status:
Clinic Status: Light Duty as of: 11/21/01
File Status: CLOSED
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 12/03/01

TREATMENTS

12/11/01 15:30 Pract : Coleen Collins, NP
Treatment : See F3
Restrictions: See F3

Hx: Ms. Shiver returns for F/U contusion left heel. States she's much better. Has no problems tiptoeing or squatting, so should be able to return to full duty. Occ has heel pain when walks long distances, but takes routine meds and uses Epsom salts with relief.

PE: Ambulating without difficulty. Left heel is without tenderness, discoloration, or edema. Able to tip-toe and squat without trouble. Reflexes left foot wnl with nl sensation and strength 5/5.

Assess: Contusion left heel

Plan: Will release without work limitations. Will limit long walks for now, but self manage treatment if takes long walks. Will RTC if symptoms persist or worsen.

CCollins FNP

(654)

FOLLOW-UP CARE STATEMENT

COMPLETED BY EMPLOYEE:

Employee: Gertmae Shiver
Date of Birth: 5-19-54
Title: HIM Specialist

SSN: 249-98-7546

Date of illness/injury: _____

Employer: PKM-H

COMPLETED BY PROVIDER:

Date: 12/11/01 Visit time: 330 pm Diagnosis: Contusion (heel)
Treatment / Findings: _____

Work Status

Return to regular duty immediately.

Return to modified duty on (date) _____:

Restrictions:

☐ Patient is unable to lift greater than _____ pounds

☐ Limitations of motion: _____

☐ Patient must avoid contact with _____

☐ Patient must keep sutures clean and dry

☐ Other _____

These restrictions apply until (date) _____, at that time:

☐ restrictions will be reassessed OR ☐ patient may return to full duty.

Patient is unable to work at this time.

Instructions

Medications: _____

Other: Released to limitation

Follow-up appointment (Date / Time) prn

Provider's signature: [Signature] Visit Time Out: 1545

(655)

HealthWorks

Injury Treatment Report

Date of Report: 12/21/01

INJURY

ame: Shiver, Gertrude Injury ID: 1
mp ID: 249-98-2546 Injury Date: 11/15/01
njury: Contusion, leg
o. Status:
linic Status: Returned To Work as of: 12/11/01
ile Status: OPEN
ompany: Richland Memorial Hospital Days Lost:
ns. Co.: PHT Services, Ltd. Days Lt Duty:
laim No: Estimated on: 12/19/01

TREATMENTS

12/19/01 Pract : Martin Durkin, MD
Treatment : SEE F-3
Restrictions: SEE F-3

PATIENT: Gertrude Shiver
SSN: 249-98-2546
DATE OF VISIT: 12/19/01

FOLLOW-UP WORKER'S COMPENSATION NOTE

HISTORY:

Ms. Shiver is seen in follow up for her left heel. She says that on 11/15/01, while at work, a supply cart struck her in the left heel. She was seen in HealthWorks that day and given First Aid. The next morning, while at home, she was walking up some steps and fell striking her left elbow but said that she did not injure her left foot or ankle. She now has stinging and numbness in the left heel since about 12/16/01.

Her past history indicates that she has low back pain since 1997 and has been found to have the left L4/5 herniated nucleus pulposis on MRI.

PHYSICAL EXAMINATION:

On examination today, there is some tenderness at the insertion of

(656)

Shiver

12
12/24

Date of Report: 12/21/01

Shiver, Gertrude
249-98-2546Injury ID: 1
Date of Visit: 12/19/01

Page 2

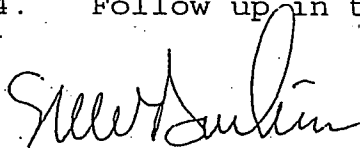
the left Achilles tendon. There is some mild medial ankle tenderness as well. There is no swelling. She has good plantar flexion of the left foot both actively and passively. The ankle is stable. There is no Tinel's sign over the posterior tibial nerve in the region of the tarsal tunnel. There is some decreased light touch in an area about 3 cm in diameter on the posterior aspect of the left heel. Straight leg raising produces some left posterior thigh pain on the left, it is negative on the right. The deep tendon reflexes are 2+ and symmetrical at the knees and ankles.

DIAGNOSIS:

Contusion of the left heel. I did suggest the possibility that the numbness could be on the basis of her lower back problem but particularly given the delay in those symptoms after the supply cart hit her heel. The patient was not particularly accepting of that explanation. In any event, we will evaluate and treat the situation. She does have a previously x-ray of the left calcaneus.

PLAN:

1. Full duty.
2. Continue her medications.
3. PT to the left ankle.
4. Follow up in three weeks.



Martin W. Durkin, M.D.

rta30337-79401

(657)

13
MAY 1 2002

HealthWorks

Injury Treatment Report

Date of Report: 01/07/02

INJURY

Name:	Shiver, Gertrude	Injury ID:	1
Emp ID:	249-98-2546	Injury Date:	11/15/01
Injury:	Contusion, leg		
Co. Status:			
Clinic Status:	Returned To Work as of: 12/11/01		
File Status:	OPEN		
Company:	Richland Memorial Hospital	Days Lost:	
Ins. Co.:	PHT Services, Ltd.	Days Lt Duty:	
Claim No:		Estimated on:	01/02/02

TREATMENTS

01/07/02 Pract : Barbara Griffin, RN
Treatment : call from Melody, is doing better
Restrictions: swelling and rom are improving,wants to do 2 more tx

(658)

Date of Report: 01/11/02

Name: Shiver, Gertrude
SS#: 249-98-2546Injury ID: 1
Date of Visit: 01/10/02

Page 2

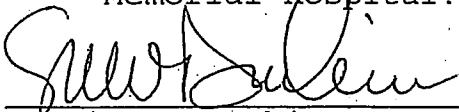
Bilateral tibial motor nerve conductions were done and were within normal limits with no evidence of a tarsal tunnel syndrome. EMG of the left lower extremity and left lumbar paraspinal muscles reveals some positive sharp waves in the left lumbar paraspinal musculature. She does have a past history of a herniated disc that involved the left lower extremity.

DIAGNOSIS:

Left lower extremity pain and numbness.

PLAN:

1. Regular duty.
2. We are going to get some x-rays of the left ankle and left lower leg. She has previously had x-ray of the left calcaneus.
3. She is to continue her physical therapy.
4. She does need to be able to elevate that left leg at work as needed. She has been using a stool or bench, but it has not been too comfortable, so we will try to find something more comfortable for her.
4. We will plan to see her back in three weeks at Richland Memorial Hospital.


Martin W. Durkin, M.D.

TrUSA31030-80616

(659)

EMG / Nerve Conduction Report **HealthWorks – Palmetto Health**

□ 1333 Taylor St., Suite 3-H Columbia, SC 29220 (803) 296-3500 Fax (803) 296-3965
X 3000 Northeast Medical Park, Suite 111 Columbia, SC (803) 434-3362 Fax (803) 434-3389

Patient Name Gertrude Shiver SSN 249-98-2546 DOB 5/19/54 Date 1/10/02

Brief History: This lady was hit in the left heel by a cart on 11/15/01. She now has distal left lower leg and ankle pain, as well as numbness of the left heel. She has a past history of a herniated lumbar disk affecting the left leg.

Motor Nerve Conduction Studies

Nerve	Segment	Latency, msec	Latency Difference, msec	Distance, cm.	Conduction Velocity, m/sec	Amplitude, mV
R. Tibial	Ankle - AH	4.80	-----	8.0	-----	11
	Pop - Ankle	13.40	8.60	35.0	40.7	3
	Ankle - FDMB	5.20	-----	Stimulus site same as for AH	-----	3
L. Tibial	Ankle - AH	4.60	-----	8.0	-----	14
	Pop - Ankle	13.40	8.80	33.5	38.1	1.5
	Ankle - FDMB	4.60	-----	Stimulus site same as for AH	-----	3

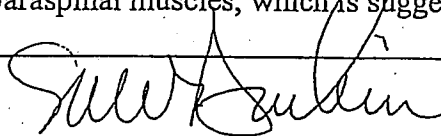
Monopolar Needle Electromyography

Muscle	Insertional Activity	Spontaneous Activity			Motor Units	Interference Pattern
		PSWs	Fibs	Other		
L. Rectus Femoris	Normal	None	None	None	Normal	Full
L. Tibialis Anterior	Normal	None	None	None	Normal	Full
L. Extensor Hall. Longus	Normal	None	None	None	Normal	25%, inc. effort
L. Gastrocnemius	Normal	None	None	None	Normal	Full
L. Semitendinosus	Normal	None	None	None	Normal	Full
L. Lumbar Paraspinals	Normal	1+	None	None	-----	-----

Interpretation:

1. No evidence of tarsal tunnel syndrome on bilateral tibial motor studies.
2. Positive sharp waves in left lumbar paraspinal muscles, which is suggestive of left lumbar radiculopathy but is not localizing.

Martin W. Durkin, MD Neurologist



(660)

Margaret McKechnie, MS, APRN, BC
CSC 18748



HealthWorks
Palmetto Health Alliance
Taylor at Marion Street
Columbia, SC 29220
(803) 296-3500

Martin Durkin, MD
SCL# 12692

DATE 1/10/02 NAME Gertrude Shiver ADDRESS _____

Rx	(Please Label Contents)	Mg.	No.	SIG.	REFILL
1.	Xrays of Lower leg and ankle			Reg Blunt trauma	
2.	11/15/01. Complaints of heel numbness & ankle & distal lower leg pain.				
Dispense as Written		MD / MS, APRN, BC		<u>MW Durkin</u>	MD / MS, APRN, B
				Substitution Permitted	

(661)

Date of Report: 02/05/02

Name: Shiver, Gertrude
SS#: 249-98-2546

Injury ID: 1
Date of Visit: 01/31/02

Page 2

TREATMENTS

01/31/02 Pract : Martin Durkin, MD
Treatment : SEE F-3
Restrictions: SEE F-3

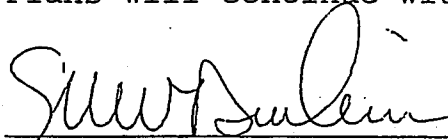
PATIENT: Gertrude Shiver
SSN: 249-98-2546
DATE OF VISIT: 01/31/02

FOLLOW-UP WORKERS' COMPENSATION NOTE

HISTORY:

Ms. Shiver is seen in follow-up of her left foot numbness and pain. Bilateral tibial medial and lateral plantar sensory studies were done and do not show any evidence of tarsal tunnel syndrome. Bilateral sural nerve conduction studies are normal. EMG of the right gastrocnemius muscle is normal.

Plans will continue with orthopaedic referral.



Martin W. Durkin, M.D.

TrUSA31030-82140

(662)

HealthWorks

Injury Treatment Report

Date of Report: 05/03/02

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg
Status:
Clinic Status: Returned To Work as of: 12/11/01
File Status: OPEN
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 05/02/02

TREATMENTS

05/01/02 Pract : Martin Durkin, MD
Treatment : SEE F-3
Restrictions: SEE F-3

SSN: 249-98-2546 DATE: 05/01/02
FOLLOW UP WORKER'S COMPENSATION NOTE
(Palmetto Richland Hospital)

HISTORY:

Gertrude Shiver returns in follow up of her left Achilles pain. She notes pain in the region of the Achilles insertion as well as some posterior plantar heel pain and some gastrocnemius pain on the left. She also has some numbness that comes and goes and involves "whole foot" that is increased by walking. In general, the numbness is less than previous. Intermittently she has swelling of "the whole foot". In March of this year she had swelling of both legs and feet but it is now better.

To review the situation, on 11/15/01, she was hit with a metal cart in the region of the left heel. Since then, we have done an EMG of both gastrocnemius muscles and the left lower extremity. Bilateral tibial motor and sensory nerve conductions have been normal. X-rays of the left ankle and left calcaneum and left lower leg have been normal. She has been seen in consultation by Dr. Belding. We tried various nonsteroidal antiinflammatory medications. Her private physician has placed her on Mobic 7.5 mg daily and that seems to do the best.

(663)

SWW

Date of Report: 05/03/02

Name: Shiver, Gertrude
SS#: 249-98-2546Injury ID: 1
Date of Visit: 05/01/02

Page 2

PHYSICAL EXAMINATION:

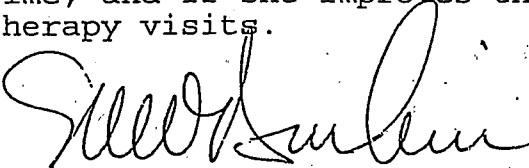
On examination of the feet, the right first metatarsal phalangeal joints is 10 degrees of valgus and is flexible, the left is in 14 degrees of valgus and is flexible. There is no bunion on the right and a minimal bunion on the left. She has prominent fifth metatarsal phalangeal joints but no evidence of inflammation, corns, or calluses in that area. She has fixed hammertoes of the fifth toes bilaterally. There are no corns or calluses throughout. The skin of both feet is normal although the heels are dry bilaterally. The toenails are dark and mildly thickened bilaterally. The plantar fascia is nontender. Toe extension does not particularly cause her any difficulty. Dorsalis pedis pulses are normal bilaterally. Vibratory sensation is normal in both feet. Pinprick is diminished along the left lateral plantar foot and heel to about 80% of that on the left. There is no Tinel's sign posterior to the medial malleolus on either side. She is able to achieve 30 degrees of varus on inversion at both the talar joints and 10 degrees of valgus bilaterally. There is some tenderness over the distal Achilles tendon on the left and where it inserts into the calcaneus. The medial longitudinal arch and the arch both appear normal nonweightbearing but there is decrease in the arch on the right with weightbearing. In a standing position the Achilles alignment shows some eversion on the right. Bilateral heel rise test results in no inversion on the right and mild inversion on the left.

DIAGNOSIS:

Left Achilles pain.

PLAN:

1. Regular duty.
2. I have given her a prescription for Mobic 7.5 mg #30, 2 p.o. daily with 1 refill.
3. We will plan to see her back in five weeks.
4. I did offer another orthopaedic opinion but the patient would rather continue the medication and give it a little more time, and if she improves then go back for a few more physical therapy visits.



Martin W. Durkin, M.D.

TrUSA30337-89137

(664)

HealthWorks

Injury Treatment Report

Date of Report: 07/01/02

INJURY

me: Shiver, Gertrude Injury ID: 1
p ID: 249-98-2546 Injury Date: 11/15/01
jury: Contusion, leg
Status:
in Status: Returned To Work as of: 12/11/01
le Status: OPEN
mpany: Richland Memorial Hospital Days Lost:
s. Co.: PHT Services, Ltd. Days Lt Duty:
aim No: Estimated on: 06/11/02

TREATMENTS

6/05/02 Pract : Martin Durkin, MD
Treatment : SEE F-3
Restrictions: SEE F-3

SSN: 249-90-2546 DATE: 06/05/02 FOLLOW UP WORKER'S
COMPENSATION NOTE

HISTORY:

Gertrude Shiver returns in follow up of her left heel pain.
Things are about the same. She seems to deriving benefit from
Mobic.

PHYSICAL EXAMINATION:

On examination today, her foot and ankle are diffusely tender
although the heel squeeze seems to give her a bit more trouble
than other maneuvers. There is no Tinel's sign over the tarsal
tunnel. Her gait is fairly normal.

DIAGNOSIS:

Left foot and ankle pain.

PLAN:

1. Regular duty.
2. She is given a prescription for Mobic 7.5 mg #100, 1 p.o.
b.i.d., no refill.
3. PT to the left foot and ankle, 4 visits.
4. Follow up in 6 weeks. Hopefully she will be released at
that point.

Shiver

(665)



Downtown: 1333 Taylor St., Suite 100 Columbia, SC 29220 (803) 296-3500
Fax (803) 296-3965

Northeast: 3000 Medical park, Suite 111 Columbia, SC 29223 (803) 434-3362
Fax (803) 434-3389

FOLLOW-UP CARE STATEMENT

BE COMPLETED BY EMPLOYEE:

Employee: Gertrude Shiver
Date of Birth: 5-11-54
Title: Health Information
Specialist

SSN: 241-98-2546

Date of illness/injury: Nov. 2001

Employer: PKMTH

BE COMPLETED BY PROVIDER:

Visit date: 6/5/02 Visit time: 11:00 AM Diagnosis: ② foot/ankle pain
Treatment / Findings: _____

Work Status

Return to regular duty immediately.

Return to modified duty on (date) _____:

Restrictions:

___ Patient is unable to lift greater than _____ pounds

___ Limitations of motion: _____

___ Patient must avoid contact with _____

___ Patient must keep sutures clean and dry

___ Other _____

These restrictions apply until (date) _____, at that time:

___ restrictions will be reassessed OR ___ patient may return to full duty.

Patient is unable to work at this time.

Instructions

Medications: PK Mobic 7.5mg BID

Other: PT to ② foot/ankle x 4 visits. appt 6/13 @ 1000

Follow-up appointment (Date / Time) 6 weeks. July 26, 2002 @ 1015

Provider's signature: [Signature] Visit Time Out: 11:30 AM

(666)

HealthWorks

Injury Treatment Report

Date of Report: 08/02/02

INJURY

Name: Shiver, Gertrude
Emp ID: 249-98-2546
Injury: Contusion, leg
Injury ID: 1
Injury Date: 11/15/01
Status:
Clinic Status: Returned To Work as of: 12/11/01
File Status: OPEN
Company: Richland Memorial Hospital
Ins. Co.: PHT Services, Ltd.
Claim No:
Days Lost:
Days Lt Duty:
Estimated on: 07/26/02

TREATMENTS

07/25/02 Pract : Martin Durkin, MD
Treatment : SEE F-3
Restrictions: SEE F-3

SSN: 249-98-2546 DATE: 07/24/02 FOLLOW UP WORKER'S
COMPENSATION NOTE

HISTORY:

Gertrude Shiver returns having completed Physical Therapy. She may be a bit better. She still complains of pain in the region of the insertion of the left Achilles tendon as well as somewhat anteromedial to that in the direction of the medial malleolus. She complains of tingling in her left foot, particularly with walking.

PHYSICAL EXAMINATION:

On examination today, there is some mild tenderness to palpation over the insertion of the left Achilles tendon. She thinks that her calf has increased in diameter on the left and I have remeasured them. Ten cm below the inferior patella the right calf circumference is 35.5 cm and on the left 38 cm. Fifteen cm below the inferior patella, the calf circumference is 34.5 cm on the right and 36 cm on the left. I really do not detect any difference in pinprick between the two feet. There is really no Tinel's sign over the posterior tibial nerve in the region of the tarsal tunnel on the left. Her gait is fairly normal.

(667)

Date of Report: 08/02/02

Name: Shiver, Gertrude
SS#: 249-98-2546

Injury ID: 1
Date of Visit: 07/25/02

Page 2

DIAGNOSIS:

Left Achilles tendinitis.

PLAN:

1. Regular duty.
2. I have given her another prescription for Mobic 7.5 mg #30, 1 p.o. b.i.d. with no refill.
3. I really do not have anything more to offer this lady. I do not detect any definite permanent impairment. She has had one consultation from a foot specialist. I would not object to her seeing Dr. Bethea. This could be arranged by PHTS if they wish.

Martin W. Durkin, M.D.

TrUSA30337-94722

(668)

24



UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

UNIVERSITY SPECIALTY CLINICS

SEPTEMBER 4, 2003

RE: GERTRUDE SHIVER #63682

ORTHOPAEDIC EVALUATION

HISTORY OF PRESENT ILLNESS: Ms. Shiver is seen for a second opinion related to a long standing problem in her left foot. She describes pain and tingling sensation in the left leg with a tender Achilles and entire hindfoot. It is difficult to put a handle on exactly where this originates. Her symptoms sound neuropathic in nature in that she keeps saying "burning", "shocking sensation", etc. She also has occasional foot swelling. That is particularly true when she is in Sunday shoes. Her Achilles gets tight. Standing increases her symptoms.

I have a note from Geneva Andrews PHT Services Limited, fax number 803-731-2849, regarding this second opinion.

I also have a sheath of notes dating back to November 16, 2001 at which time she was seen by Coleen Collins at Richland Memorial for follow-up of a left heel contusion following a fall down the steps at home. That would seem to have been a fairly simple problem. Those are continued symptoms and a left os calcis x-ray was taken on November 20, 2001 which was normal. Dr. Durkin saw her initially on December 21, 2001 roughly six weeks after her injury and nothing specific could be found. She described for him several times the original injury on November 15, 2001 which is also described for me now as an incident at work in which a supply cart struck her in the left heel. That was the same day that she was seen initially by Coleen Collins per above. On December 19, 2001, she described the home injury walking up some steps as the next morning that would have been November 16, 2001. Pain continued in the left lower extremity with some numbness and the symptoms noted above through January. Her pain was worse at night. She had x-rays of her left ankle and leg. Dr. Durkin ordered these. Because of the neuro-type description she underwent nerve conduction studies by Dr. Durkin, a neurologist, on January 10, 2002 at which time no foot abnormality was found either in nerve conduction or EMG. She was discharged from physical therapy on December 27, 2001.

Dr. Robert Belding of Midlands Orthopaedic Clinic, 1910 Blanding Street, Columbia, SC 29201 saw her on February 14, 2002 and could find no evidence of a significant problem and with that no evidence of a permanent problem at all.

By May, which was almost seven months after her November 15, 2001 injury, Dr. Durkin noted more Achilles with more peritendinous description. Mobic could help somewhat. She was given more therapy, i.e., strengthening, stretching and modalities.

Ms. Shiver is 49-years-old.

(669)

USC SPORTS MEDICINE CENTER
Two Medical Park, Suite 404, Columbia, SC 29203
803-434-7689, FAX 803-434-7306

25

25

PAGE TWO

RE: GERTRUDE SHIVER #63682

SEPTEMBER 4, 2003

CURRENT MEDICATIONS: She takes Cardizem, a Bayer aspirin, Tenormin, Alprazolam, Skelaxin, Aciphex and Bextra along with Ultram as necessary.

PAST SURGICAL HISTORY: She has had a myomectomy in the past, also bilateral breast reductions.

DRUG ALLERGIES: DYE, TETANUS TOXOID.
Not allergic to latex.

FAMILY HISTORY: Cancer of the colon in the sister. Strokes in the mother and father. Diabetes in mother, brother, sister and aunt. Hypertension in the mother and father. Father is deceased.

SOCIAL HISTORY: She is a medical records specialist. I have seen her there. She drives. She does not drink, smoke or do drugs.

REVIEW OF SYSTEMS: Positive in several areas. A positive note is that she has lost about 41 pounds. She does have occasional dizziness. She has occasional dysphagia with some GI symptoms. These are not progressive. Known hypertension treated with the medications per above. Occasional cough with bronchitis (remember does not smoke). She has some backache and has been worked-up for that in the past. Dr. Durkin notes that. January 2003, she had a urinary tract infection and the disc problem as noted previously.

PHYSICAL EXAMINATION: Blood pressure: 140/70. Pulse: 72. Weight: 188 pounds. There is symmetry. She moves off and on the table and up from the chair reasonably. She has a straight spine and a level pelvis. Her hips and knees move well. No adenopathy, no calf tenderness, no popliteal cyst. Her reflexes are okay. There is no malangulation or malrotation of the legs. Examination of her uninvolved right foot is very similar to the left. There is a reasonable leg/heel and heel/forefoot alignment with some minimal rear foot valgus. Her peroneals and posterior tibs are both strong. On the left with repeated examinations compared to the right, she does have about a half grade weakness. There also seems to be some very minimal fullness in the submalleolar area over the posterior tibial tendon sheath and between it and its insertion on the navicular. There is some mild pain with upward pressure on the navicular. Tinel's sign, posterior impingement testing and medial/lateral compression of the os calcis are basically negative for suggestion of pathology. There is some mild tenderness at the os calcis exostosis but not in the bursa. There is no frank peritendinitis, there is no crepitus. There is no decrease in calf circumference. She is awkward but can get up on her toes and

(670)

26

PAGE THREE
RE: GERTRUDE SHIVER #63682
SEPTEMBER 4, 2003

heels. Sensation is intact with medial and plantar nerve sensation functioning. The serial nerve is okay. Stability tests of the ankle are negative.

SUMMARY: This injury which she in detail describes as occurring when she got off of the elevator and a cart (medical) hit her left Achilles was the injury. That is almost two years. There has been no finding of abnormal x-rays, abnormal physical examination and she has had a normal EMG and excellent evaluations both by Dr. Durkin on an ongoing basis and by Dr. Belding at least twice.

PLAN: Unquestionably she needs an MRI of her hindfoot to look at A) Achilles tendon insertion. B) Posterior tibial tendon itself. C) The anatomy in and around the hindfoot, i.e., possible impingement, possible old stress fracture, etc.

If her MRI is completely normal then we know her diagnosis, we know her ongoing charge for treatment and no further diagnostic tests, no further physical therapy and no limitation of activity should be done.

She will, in that case, indefinitely need to strengthen, stretch and ice her hindfoot area to keep symptoms under control perhaps along with Mobic, Bextra, etc., but realizing that at some point it should become relatively asymptomatic and a minor problem. I, like Dr. Belding, do not see any permanent impairment from her original injury and for that matter from her home injury the next morning, November 16, 2001.

If, on the other hand, there is something to be found on the MRI I would like to see her again for clinical correlation.

WORKING DIAGNOSIS: Until I see the MRI, 1.) Mild possible posterior tibial tendinitis without tendinopathy, left hindfoot/midfoot. 2.) Possible tendinopathy at insertion of the Achilles tendon or within the Achilles itself proximal to its insertion (MRI can determine this, not found clinically).

(671)

DRAFT

#0126962

NOVEMBER 10, 2003

RE: GERTRUDE SHIVER #63682

Gertrude is back for a self requested visit following discharge. Her MRI was read as an abnormality about the flexor hallucis longus. Review of that MRI and particularly when correlated clinically with her symptoms physically with her findings and with the time interval and course of the present illness, it is clear that this is not a surgical situation, that this is not a posttraumatic problem, and that there is no further diagnostic or procedural study and/or treatment that needs to be done.

My previous notes related to her final diagnosis and lack of permanent impairment stand.

DIAGNOSIS: Her final diagnosis is: Resolved contusion, left hindfoot at retrocalcaneal area with residual pain.

DISPOSITION: Continue strengthening, continue occasional icing indefinitely. Stretching remains important and of course, heel counters in her left (or for that matter right) heel situation should not be used.

She is not particularly happy with the specifics of the diagnosis, of the specifics of treatment, and the ongoing pain, but I have nothing else to add. I am delighted to see her if other problems arise.

DRAFT

Angus M. McBryde, Jr., M.D.

TrUSA192

C: Geneva Andrews, Suite 402, Converse Building, 250 Berryhill Road, P.O. Box 21099, Columbia, SC 29221-1099

C: Gertrude Shiver, 1026 Congaree Church Road, Gaston, SC 29052

(672)

28

NAME: GERTURDE SHIVER
DOB: 05/19/54

ACCOUNT #: 250380
SSN: 249 98 2546

2-14-02

CHIEF COMPLAINT: Leg Pain

PRESENT ILLNESS: The patient is a 47-year-old black female referred by Worker's Compensation for evaluation of an injury that occurred on 11/15/01 at Richland Hospital. The patient states that she was hit on the back of the foot with a cart and that caused pain. She was seen at the Health Care Center there. Her foot was treated with ice to get rid of the swelling. She has been through physical therapy with ionophoresis. She has had a EMG/NCS which was normal. She has had normal x-rays. She has continued to work but continues to complain of pain including pain around the foot and ankle area and pain radiating up to the calf. There is numbness in the heel and foot. She has difficulty with standing or bearing weight.

PAST HISTORY:

Allergies: Sulfa
Medications: Aciphex, Tenormin, Cardizem CD, Arthrotec, Skelaxin
Surgeries: Breast reduction, hysterectomy
Illnesses: Acid reflux and HBP

SOCIAL HISTORY: Patient does not smoke or drink alcohol. She is single.

FAMILY HISTORY: Positive for arthritis, diabetes, HBP, stroke and cancer.

REVIEW OF SYSTEMS:

General Health: Non-contributory
EENT : Non-contributory
Respiratory : Non-contributory
Cardiac : Occasional palpitations
Skin : Non-contributory
GI : Non-contributory
Urinary : Non-contributory
Neurological : Occasional headaches
Hematologic : Non-contributory

PHYSICAL EXAMINATION: She is a well-developed black female who walks in the office with a normal gait. She has no evidence of atrophy. Anterior tib, posterior tib and peroneal functions normally. Subtalar joint and ankle joint motion are normal and symmetrical with the opposite side. She has a negative Tinel's

(673)



MIDLANDS ORTHOPEDICS, PA
1910 BLANDING STREET
COLUMBIA, SC 29201

Page 2

NAME: GERTURDE SHIVER
DOB: 05/19/54

ACCOUNT #: 250380
SSN: 249 98 2546

at any one spot although she complains on each spot that I touch her toe. There is no erythema. There is no local heat. There is no instability of the ankle.

RADIOGRAPHS: review of radiographs show no evidence of fracture, subluxation or other abnormality.

DIAGNOSIS: 1. CONTUSION OF THE FOOT, SLOWLY HEALING.

DISPOSITION & RECOMMENDATIONS: I think that the patient has been thoroughly evaluated. I find no permanent physical impairment. I think there is no other treatment needed at this point and she can be at full activity. I do think that it may take more time for her symptoms of pain to resolve.

RETURN APPOINTMENT: PRN.

Robert H. Belding, M.D.

RHB/agw

(674)

Defendants.

Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Employer.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Employer: None.

Respectfully submitted,

ELLIS, LAWHORNE & SIMS, P.A.
Post Office Box 2285
1501 Main Street, 5th Floor
Columbia, South Carolina 29202
(803) 254-4190

By: Lana H. Sims, Jr.
Lana H. Sims, Jr.
Attorney for Employer

Columbia, South Carolina

August 20, 2007

(676)

Control #	Check #	Trans Date	Type	Clr.	Void	Status	Payee	Check Amount	From/To Date	Invoice #	Transaction Type	Detail Amount	User	Check Date
0388879	574872	8/7/2002	Payment	No	No	P	Pitts Radiological Associ	\$18.00	3/24/2002 - 3/24/2002	8208300003	Radiology	\$18.00	gandre	8/8/2002
0386884	0	8/7/2002	Payment	No	No	P	Intracorp Hospital Bill R	\$3.53	3/24/2002 - 3/24/2002	2306095015	Intracorp/Bill Review	\$3.53	gandre	8/7/2002
0388370	575674	8/21/2002	Payment	No	No	P	Palmetto Baptist Medical	\$488.00	3/24/2002 - 3/24/2002	b0208300003	Hospital/Institution	\$488.00	wkelle	8/22/2002
0388371	0	8/21/2002	Payment	No	No	P	Intracorp Hospital Bill R	\$3.53	3/24/2002 - 3/24/2002	2306098552	Intracorp/Bill Review	\$3.53	wkelle	8/21/2002
0437798	598909	5/10/2003	Payment	No	No	P	CHARLESTON SPINE & PHYS M	\$1,068.00	6/10/2002 - 7/30/2002	4559-12	Doctor	\$1,068.00	CSC	11/5/14/2003
0437799	0	5/10/2003	Payment	No	No	P	Intracorp Hospital Bill R	\$23.63	6/10/2002 - 7/30/2002	2307418793	Intracorp/Bill Review	\$23.63	CSC	11/5/10/2003
0437800	598910	5/10/2003	Payment	No	No	P	CHARLESTON SPINE & PHYS M	\$622.78	7/30/2002 - 11/14/2002	4559-10	Doctor	\$622.78	CSC	11/5/10/2003
0437801	0	5/10/2003	Payment	No	No	P	Intracorp Hospital Bill R	\$46.85	7/30/2002 - 11/14/2002	2307418818	Intracorp/Bill Review	\$46.85	CSC	11/5/10/2003
0438526	599235	5/15/2003	Payment	No	No	P	CHARLESTON SPINE & PHYS M	\$1,537.00	8/27/2002 - 11/14/2002	4559-10	Doctor	\$1,537.00	CSC	11/5/19/2003
0438527	0	5/15/2003	Payment	No	No	P	Intracorp Hospital Bill R	\$105.92	8/27/2002 - 11/14/2002	2307436340	Intracorp/Bill Review	\$105.92	CSC	11/5/15/2003
0459407	0	9/19/2003	Payment	No	No	P	PHT Services, Ltd.	\$22.00	5/1/2003 - 5/31/2003	0501-0531-2003	Managed Care	\$22.00	dlee	9/19/2003
0444771	602106	6/24/2003	Payment	No	No	P	CHARLESTON SPINE & PHYS M	\$105.60	5/13/2003 - 5/13/2003	455913	Physical Therapy	\$105.60	CSC	11/6/27/2003
0444772	0	6/24/2003	Payment	No	No	P	Intracorp Hospital Bill R	\$14.17	5/13/2003 - 5/13/2003	2307575760	Intracorp/Bill Review	\$14.17	CSC	11/6/24/2003
0467878	612208	11/3/2003	Payment	No	No	P	PALMETTO RICHLAND	\$902.40	9/8/2003 - 9/8/2003	R0325100081	Radiology	\$902.40	CSC	11/11/5/2003
0467879	0	11/3/2003	Payment	No	No	P	PALMETTO RICHLAND	\$500.00	9/8/2003 - 9/8/2003	R0325100081	Deductible Applied	\$500.00	CSC	11/11/3/2003
0467880	0	11/3/2003	Payment	No	No	P	Intracorp Hospital Bill R	\$47.83	9/8/2003 - 9/8/2003	2308002682	Intracorp/Bill Review	\$47.83	CSC	11/11/3/2003
0540246	661407	3/8/2005	Payment	No	No	P	Reimbursement Consultants	\$41.07	1/24/2005 - 1/24/2005	1106593461	SIF Recovery Fees & Expen	\$41.07	lsmith	9/7/2005
0538524	0	2/22/2005	Collection	No	No	R	Second Injury Fund	(\$410.69)	2/4/2005 - 2/4/2005	126331483	Second Injury Fund Recove	(\$410.69)	Lcurtis	2/22/2005
0610336	692082	1/17/2007	Payment	No	No	P	Garber Reporting Service	\$60.00	12/20/2006 - 12/20/2006	12-06-247	Court Reporting Fees	\$60.00	ahartin	1/17/2007

Over all Total: \$5,199.62

Payments: \$5,610.31

Collections: \$410.69

Voids: \$0.00

Note:

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3.22.02

(677)



**Charleston Spine &
Physical Medicine, PA**

Gregory M. Jones, M.D.
1930 Charlie Hall Boulevard
Charleston, SC 29414

Office (843) 402-0111
FAX (843) 402-9010
Toll Free (800) 393-7008

SHIVER, Gertrude

4559

10 June 2002

CHIEF COMPLAINT: Low back pain after work injury.

HISTORY OF PRESENT ILLNESS: Ms. Shiver is a 48 year old female who in March of 2002, while at work, was picking up a pen which had dropped, when her chair rolled out from under her and the head portion of the chair hit her in the small of her low back. This occurred at 1:00 a.m. and was not witnessed by any other individuals. She went home that night, went to work, but because of low back pain, reported in to the emergency room the next day. X-rays, as reported to me by Ms. Shiver, were reported to be normal. Since that time, she has been treated by her primary physician. At this point in time, she has been given medications with some improvement in pain symptoms.

Initially her pain was 7-8/10 on the pain scale and she says that today it is 4/10 on the pain scale.

Currently, her pain is described as a burning sensation and a deep achy pain in the low back bilaterally with intermittent stabbing pain interchanged with burning and aching and then continuing with intermittent stabbing pain, left greater than right. Her symptoms are intermittent and wax and wane. The pain seems to be aggravated with bending and improved with lying down and medications that she is taking, including Mobic, Skelaxin, and Lortab. She denies any right leg pain but is reporting some paresthesias in the left lower leg that predate her injury. These initially presented at around November 15, 2001 and are being treated by a neurologist. Apparently, an electrodiagnostic evaluation was performed by that individual and it was reported to me today to be normal. I specifically asked Ms. Shiver if her symptoms in the left lower leg were worsened after the fall, and she states, "no". She stated that there has been no worsening of her symptomatology as far as the leg is concerned.

I asked Ms. Shiver if she had ever complained of low back pain before, and she said, "yes". She was initially seen at Charleston Spine and Physical Medicine on March 4, 1998, after a motor vehicle accident on April 20, 1997, when she was rear-ended by another motor vehicle. She was given a diagnosis of "partially discogenic" low back pain. In July of 1998, she was placed at MMI from that injury and was given a permanent impairment to the lumbosacral spine, DRE category II, 5% spinal impairment, translatable to 5% whole person impairment directly. She was then also involved in a motor vehicle accident on 11/25/2000, which apparently "flared" her low back pain. She was placed at MMI regarding injuries sustained to the lumbosacral spine from the 11/25/2000 MVA, on 5/07/2001. She was given a "DRE category I, 0% lumbosacral spine/whole person impairment" relating directly to the injury of 11/25/2000 and remained at her prior permanent impairment of 5% to the lumbosacral spine.

PAST MEDICAL HISTORY: "Heart conduction defect", previous neck and low back pain, history of headache.

PAST SURGICAL HISTORY: Myomectomy, 1995; breast reduction, 1997. She denies an previous spine surgeries, including neck or low back.

REVIEW OF SYSTEMS: As per the new patient questionnaire completed today as well as the history.

MEDICATIONS: Mobic, Skelaxin, Phenergan, Cardizem, Tenormin, aspirin.

ALLERGIES: Contrast dye causes a seizure; tetanus toxoid causes redness and swelling at the injection site and "TB tester" causes hives, increased heart rate and swelling.

(678)

[Handwritten signature]
2

SOCIAL HISTORY: Patient is single; works full-time in her current position of computer entry for approximately one year 8 months. She states she is a nonsmoker and nondrinker.

FAMILY HISTORY: As per the new patient questionnaire completed today.

PHYSICAL EXAMINATION: Height 5' 3-1/2". Weight 194 pounds. Respirations: 18.

Reveals a well developed well nourished female in a minimal to moderate amount of subjective pain. Grooming, nutrition, and body habitus are normal for her age. She is alert and oriented to time, place and person with normal mood and affect. Pedal pulses are palpable.

Gait and station is normal and non antalgic.

Inspection of the low back reveals no previous midline lumbar incisions. No muscle atrophy, no significant lumbar shift or step off in the lumbar spine. Forward flexion and extension of the lumbar spine is limited to less than 50% of normal today. Axial rotation with hands held to the side increases her low back pain, turning to each direction. There is some minimal to moderate tightness of the bilateral psoas, rectus femoris and hamstring muscles. PA mobilization of the lumbar spine in the prone position reveals tenderness to light touch and therefore throughout the entire lumbar spine and therefore Spring testing could not be performed today. On palpation of the PSIS bilaterally to light touch, there was increased pain. There is no tenderness over either greater trochanter or piriformis muscle belly. There were some palpable spasms noted in the lower lumbar regions bilaterally.

Neurologic examination, including motor strength and sensation, was intact in both lower extremities and torso, except for some spotty decreased sensation in non-radicular and non-myotomal pattern in the left lower extremity. She has negative neural tension signs in both legs in the seated slumped position. SLR testing increased her low back pain bilaterally at about 20°. Patrick's test was negative bilaterally. Prone hip hyperextension testing was negative today.

Examination of the thoracic spine reveals no thoracic paraspinal muscular spasms or tenderness and no tenderness over the spinous processes today.

DIAGNOSTIC TESTING: None new today.

DIAGNOSES:

1. New work injury with low back pain and moderate lumbar strain/contusion.
2. Pre-existing left calf paresthesias (not related to this recent work injury).
3. History of previous low back pain given diagnosis of lumbar disc discogenic pain (non-discogram proven).

PLAN: After reviewing Ms. Shiver's current clinical scenario and physical examination, it is my opinion with a reasonable degree of medical certainty that she has suffered a moderate lumbar strain/lumbar contusion based upon the mechanism of her injury and based upon her current symptomatology. The left lower extremity symptomatology has not worsened since that injury, and therefore, there is no aggravation of that preexisting condition with this most recent injury in March of 2002.

My recommendations are as follows:

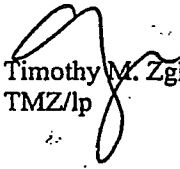
1. She is going to continue with her independent exercise program at home as far as therapy is concerned, and remain on her current medication including Mobic and Skelaxin. The risks and benefits of those medications were again reviewed with her.
2. As far as the low back pain and spasms in the bilateral lower lumbar region, after reviewing the risks, benefits, alternative treatment options and prognosis with Ms. Shiver, she has agreed to go ahead with a trigger point injection today.

(679)

10/23/02
18 05/02/02

The skin overlying the bilateral lower lumbar paraspinal musculature was prepped aseptically with alcohol. Next, a total solution of 2 cc containing 1 cc of 1% Lidocaine without epinephrine and 1 cc of 0.5% Bupivocaine was injected half into the right lower lumbar paraspinal musculature and the other half into the left lower lumbar paraspinal musculature after a negative aspirate for blood. The sites were then cleaned and dressed with Band-Aids. She tolerated the procedure well and I am going to discharge her to home after observation for an appropriate period of time after the procedure. She was instructed to look for signs of infection, including drainage, redness, fevers or chills.

3. From the standpoint of work, she may continue to work at this point in time.
4. She will be seen back in followup in approximately 1-2 weeks to reevaluate her neuromuscular status, monitor her medications, and see how she is progressing with the above treatment plan.


Timothy M. Zgleszewski, M.D.
TMZ/lp

(680)

104
4
104
104

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

24 June 2002 Ms. Shiver presents today for follow up after her trigger point injection that was performed 6/10/02. She is reporting no relief of her pain symptomatology. She is continuing to complain of axial low back pain with her same paresthesias in the left calf. No new aggravating or alleviating factors.

Physical Examination: Unchanged from her previous visit. She is alert and oriented to time, place, and person. Gait and station is normal and non-analgesic.

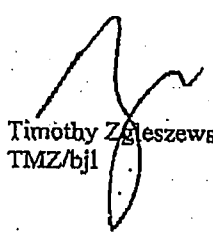
Inspection of the low back reveals no new surgical incisions, no new muscle atrophy, or lumbar shift. Forward flexion and extension of the lumbar spine remains limited to less than 50% of normal. There is some minimal to moderate tightness of the bilateral rectus femoris, psoas, and hamstring muscles.

PA mobilization of the lumbar spine in the prone position reveals tenderness to light touch. Again, spring testing could not be performed. PA mobilization of the PSIS also reproduced pain to light touch. She still has palpable spasms noted in the lower lumbar regions bilaterally.

Neurologic examination reveals intact and unchanged motor strength and sensation in both lower extremities and torso.

Diagnoses: 1. Low back pain.
2. Muscle imbalances.

Plan: After reviewing Ms. Shiver's clinical scenario, physical examination, and failure to improve with a trigger point injection, we are going to get her involved in a formal PT program to address her muscle imbalances and see if we can get good relief with that treatment modality. She will be seen back in follow up in approximately 3-4 weeks.


Timothy Zgleszewski, M.D.
TMZ/bjl

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

July 30, 2002 Gertie is seen in follow up. She was recently seen for 2 visits by Dr. Zgleszewski, initial visit primarily being consultation for recurrent low back pain secondary to work-related injury 3/23/02 where she fell back onto her lower lumbar region when her chair flipped backwards when she was trying to pick up a pen that she had dropped at work. This injury occurred on 3/23/02, had been at stable level in regard to low back symptoms since last seen in this office 11/20/01, until this new injury 3/23/02.

Patient complaining of fairly severe pain in low back, 7/10 pain level severity on average, sometimes worse, sometimes less. Patient has been doing well on oral medications, but only give temporary benefit at best. Patient estimates about 15% improvement with therapy regarding low back symptoms, accomplished therapy in Columbia at The Human Performance and Rehabilitation Center.

Medications: Patient currently on Skelaxin and Mobic, tolerating well, partial benefit as noted above.

ROS: Patient notes that she is not sure whether she has had significant change in leg symptoms since 3/23/02 back injury. Does state that she has some buttock and thigh pain, but most of her pain in LLE relates directly to separate injury to left Achilles tendon (contusion/stretch type injury described by patient today) occurred on the job 11/15/01, under care of separate physician.

Social History: Patient continues to work at Palmetto Richland Memorial Hospital, works in medical records, sedentary job primarily. Has lost about 2 weeks time from work relating to March 2002 work injury. Had been approved to receive treatment by Dr. Hooks, patient's primary physician (patient was told by ER physician to seek treatment with her primary doctor, although ER physician was aware that patient was injured on the job). We have not been approved for treatment relating to work injury 3/23/02 per carrier.

Past Spinal History: Reviewed by Dr. Z, see history of present illness and 6/10/02 IME/consult.

Physical Examination: Reveals marked tenderness bilateral L1-2, L3-4, L4-5, and L5-S1 lumbar facet regions, with significant left greater than right quadratus lumborum trigger points at originating fibers over iliac crests and also mid-belly of this muscle at L3 level 6 cm to left and right of midline respectively. Marked tenderness left side only over SI joint, with sciatic notch tenderness noted left greater than right side. No spinous process tenderness, no palpable step off, no CVA tenderness to percussion. Lower extremity exam reveals downgoing plantar responses, no clonus, negative SLRs bilaterally at 90 degrees sitting, no definite focal motor deficits, although there is give-way weakness gastroc-soleus complex on specific testing on left, with tenderness along Achilles tendon. Negative Homan's, negative crossed-SLR bilaterally, on increase in pain on internal and external rotation at either hip, reflexes 1+ and symmetric patellar and Achilles with Jendrassik maneuver.

Imaging: Prior imaging accomplished at Dr. Steven Macaruso's request at Palmetto Baptist Medical Center 3/24/02 lumbar spine AP and lateral views only with cone view lumbosacral junction shows no evidence of listhesis, no loss of disc space height of significance at any level, no scoliosis, 5 non-rib bearing lumbar vertebra, mild sclerosis bilateral SI joints, hip joints not well visualized, but appear normal (what is visualized). Minimal anterior osteophytes noted at L2-3 and to lesser extent L3-4 and L4-5 end-plate. Similar anterior osteophytes noted at superior endplates of T11 and T12 vertebral bodies.

Flexion/extension views accomplished today in office show no evidence of listhesis or instability in lumbar spine, although there is evidence of mild retrolisthesis T11 in respect to T12 vertebral body, 2-3 mm posterior displacement noted on extension only, with loss of disc space height at this level; however, on flexion views, no listhesis appreciable. Anterior osteophytes confirmed in lower thoracic levels as noted above, with most significant osteophytes in lumbar level noted anteriorly at L2 and L3 (and to a lesser extent L4) vertebral bodies.

Oblique views bilaterally lumbar spine accomplished today shows evidence of significant sclerosis with narrowing of bilateral L4-5 greater than bilateral L5-S1 facet joints. No definite stenosis appreciable, no spondylolysis noted at any level lumbar spine.

Impression: 1. Flared low back pain without significant definite radicular complaints, S/P recent/new work-related fall out of chair 3/23/02, rule out recurrent discogenic low back pain (vs. "new onset" lumbar facet syndrome/sacroiliitis (subacute lumbar strain syndrome).

(682)

6
10/18/02

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDIC.
PROGRESS NO. 1

July 30, 2002\ Page 2

Impression(continued): 2. History of prior stable L4-5 disc protrusion/shallow HNP, flared S/P MVA 11/25/00, with history of pre-existent symptomatic L4-5 disc bulge secondary to initial work-related MVA 10/11/97).

Recommendations/Discussion: There is no change in assumption regarding impairment relating to 11/25/00 MVA, and injuries sustained to cervicothoracic spine relating to that accident, previously assessed on 8/13/01 in Charleston Spine progress notes.

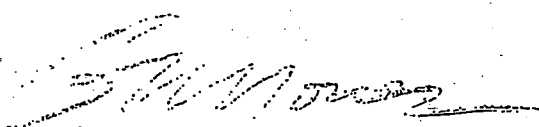
With new injury of 3/23/02, patient is not yet considered at MMI. Taking into account initial assessment by Dr. Zgleszewski, and recent follow up visit and lack of response to trial trigger point injection 6/24/02, and based on my review of x-rays from various sources as above, would suggest the following at this time:

1. Trial lumbar facet/focal injection therapy as accomplished today (see below).
2. Follow up in 1-2 weeks to assess response to above measures.
3. Continue Skelaxin and Mobic at current dosing.
4. Trial of stronger oral narcotic for more severe pain control.
5. Consideration for new MRI lumbar spine if no significant benefit or suboptimal benefit noted with lumbar facet/SI injections accomplished today on trial basis.
6. Monitor for any development of worsening leg symptoms. Patient feels that most of her symptoms in left leg distally relate to her prior Achilles tendon injury, under separate physician's care. Patient is to monitor for any more proximal symptoms or "new" symptoms; however, at this point, I seen no clear indication of radiculopathy relating to disc pathology in lumbar spine.
7. Patient should avoid any frequent or repetitive bending, stooping, or crawling activities, and also should avoid any lifting, pushing, or pulling greater than 20 pounds until further notice. As long as she can work within these restrictions, can continue to work at her current job. Patient placed out of work today and tomorrow post-lumbar facet/SI injections.

I have accomplished the following focal injections today:

1. Left L3-4, L4-5, and L5-S1 lumbar facet blocks, 5 mg methylprednisolone acetate per site, sterile technique, non-fluoroscopic, 25 gauge 5" spinal needle used at each site.
2. Left SI joint block, 5 mg Aristospan, sterile technique, non-fluoroscopic, 22 gauge 3.5" spinal needle used.
3. Left quadratus lumborum mid-belly trigger point injection (L3 level site as described above), 2.5 mg Aristospan, sterile technique, non-fluoroscopic, 25 gauge 3" spinal needle used.

The patient was prepped and draped in a sterile fashion in the prone position after informed consent was signed and patient questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).


Gregory M. Jones, M.D.

GMI/bjl

(683)

104
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SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDIC.
PROGRESS NO. 1

August 13, 2002 Gertie is seen in follow up. Has only gotten about 20% improvement for the trial left sided lumbar facet and SI joint blocks accomplished 7/30/02. Still has the "deep-seated" low back pain. No change in this portion of symptoms. Pain at 7-8/10 level currently.

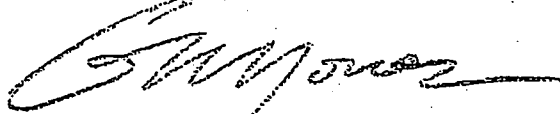
Medications: Patient tolerating Mobic, using Skelaxin for muscle spasm. Using MS Contin for more severe pain. Causes some drowsiness/hypersomnolence.

Imaging: Prior imaging reviewed 7/30/02, including x-rays lumbar spine accomplished that date here in office.

Patient has had no recent MRI studies lumbar spine, and particularly none since fall 3/23/02. 3/14/98 MRI lumbar spine showed left paracentral L4-5 shallow herniation with annular tear, with no significant abnormalities at L5-S1 or L3-4 level.

Impression: 1. Persistent low back pain with partial lumbar facet syndrome/sacroiliitis (lumbar strain syndrome), S/P recent work-related fall from chair 3/23/02 (with history of prior stable L4-5 disc protrusion/shallow HNP left paracentral with annular tear), symptomatic S/P work-related MVA 10/11/97, significantly flared/worsened S/P MVA 11/25/00.

Recommendations/Discussion: This patient had problems with her disc relating particularly to the 11/25/00 injury. However, it may be reinjury to this disc level (or possibly to previously uninjured discs at L3-4 and/or L5-S1 levels) with fall on the job 3/23/02. Only way to determine this is with new MRI lumbar spine, which is ordered today. Will follow up with patient next week to review this study. No change in medications at this time.



Gregory M. Jones, M.D.

GMJ/bjl

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SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDIC.
PROGRESS NO. 1

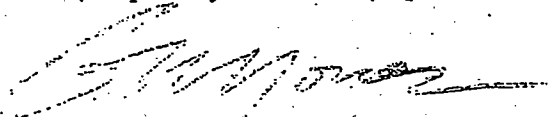
August 27, 2002 Gertie is seen in follow up today for MRI review. Still complaining of back pain. Pain presently at 5-6/10 level when using MS Contin. More severe when off this medication. Tolerating well, gives over 12 hours of partial relief when taken. No change in other meds at this time.

Patient relates that still she only noted about 20% benefit from the trial left sided lumbar facet and SI joint blocks accomplished 7/30/02. She is now one month out from those blocks, no change in pain character or severity.

Imaging: MRI lumbar spine shows evidence of disc bulge with no compressive sequelae at L3-4, with disc protrusion and annular tear at L4-5 impinging bilateral transiting L5 nerve roots, but no definite compromise of exiting L4 nerve roots on either side. Right paracentral and central disc protrusion noted at L5-S1 with contained herniation/annular tear noted, with displacement of transiting right S1 nerve root, but no compromise of exiting L5 nerve roots on either side. Incidental finding of right adnexal fullness consistent most probably with ovarian cyst noted (clinical correlation and/or pelvic sonography via primary physician recommended).

- Impression:**
1. Persisting low back pain with probable worsened discogenic component, S/P recent work-related fall from chair 3/23/02, with partial lumbar facet syndrome/sacroiliitis (lumbar strain syndrome) concomitant.
 2. L4-5 and L5-S1 annular tears/protrusions, rule out symptomatic disc lesion(s), S/P recent work-related fall 3/23/02 (with history of prior stable L4-5 disc protrusion/shallow HNP left paracentral with annular tear, symptomatic S/P work-related MVA 10/11/97, flared/worsened S/P MVA 11/25/00).

Recommendations/Discussion: Would suggest going ahead with series of blocks at L4-5 and/or L5-S1 level(s) based on findings noted on new MRI. Should hopefully be able to get Gertie back to her baseline pre- 3/23/02 injury level of back pain and sciatica complaints. There is no change in assumptions regarding impairments relating to 11/25/00 MVA, and no change relating to cervicothoracic spine injuries sustained in that accident, previous injury assessed 8/13/01. Patient not yet at MMI regarding new injury to lumbar spine 3/23/02, as this does appear to be aggravation of underlying pre-existent conditions, with possible new-onset annular tear/contained herniation at L5-S1 (and possibly new-onset symptomatic disc bulge L3-4).



Gregory M. Jones, M.D.

GMJ/bjl

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SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

September 19, 2002 PROCEDURE NOTE

PROCEDURE: 1. Central L4-5 LESI.

DIAGNOSIS: 1. Discogenic low back pain with sciatica.

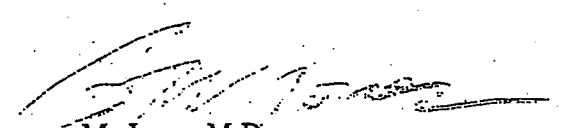
CLINICAL DATA: Patient has recently been injured 3/23/02 and has flared discogenic low back pain. This is an attempt to get discogenic pain under control non-surgically. This is first in series of three blocks.

PROCEDURE: Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to procedure per IV. Skin and subcutaneous tissue over central L4-5 interlaminar space identified and anesthetized using 8 cc 1% Xylocaine and 3 cc 0.5% Marcaine.

#18 gauge 3.5" Crawford needle was used to enter epidural space using loss of resistance to normal saline technique, confirmed by 2 cc 240 Omnipaque epidurogram on AP and lateral views (lateral epidurogram copy available in Charleston Spine chart for review).

90 mg DepoMedrol with 2 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) injected into epidural space; tolerated procedure well, needle was withdrawn. Patient went to recovery room in good condition.

The patient was prepped and draped in a sterile fashion in the prone position after informed consent was signed and patient questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).


Gregory M. Jones, M.D.

GMJ/bjl

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10

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

October 17, 2002 PROCEDURE NOTE

PROCEDURE: 1. Left paracentral L5-S1 LESI.

DIAGNOSIS: 1. Recurrent discogenic low back pain with sciatica.

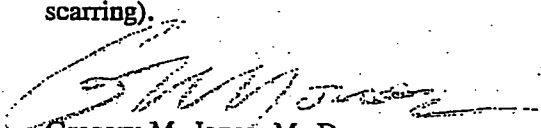
CLINICAL DATA: Patient is well known to this practice, has chronic discogenic low back pain, and has had recent injury via fall 3/23/02. This is an attempt to get flaring of discogenic pain under control non-surgically. Original injury sustained 11/25/00. Refer to Charleston Spine progress notes for details of prior work up and treatment.

PROCEDURE: Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to procedure per IV. Skin and subcutaneous tissue over left L5-S1 interlaminar space identified and anesthetized using 8 cc 1% Xylocaine.

#18 gauge 3.5" Crawford needle used to enter epidural space using loss of resistance to normal saline technique, confirmed by 2 cc 240 Omnipaque epidurogram on AP and lateral views. AP and lateral epidurogram copy available in Charleston Spine Chart for review.

90 mg DepoMedrol with 2 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) injected into epidural space, tolerated well, needle was withdrawn. Patient went to recovery room in good condition.

The patient was prepped and draped in a sterile fashion in the prone position after informed consent was signed and patient questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).


Gregory M. Jones, M. D.

GMJ/bjl

NEW CLAIM
10-24-02

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10/24/02

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

November 14, 2002 PROCEDURE NOTE

PROCEDURE: 1. Left paracentral L3-4 LESI.

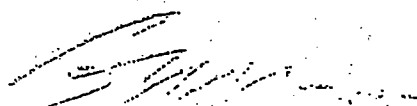
DIAGNOSIS: 1. Discogenic low back with sciatica.

CLINICAL DATA: Refer to Charleston Spine progress notes for details of prior work up and treatment, as well as reasoning behind utilization of block procedure today.

PROCEDURE: Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to procedure per IV. Skin and subcutaneous tissue over left L3-4 interlaminar space near midline identified and anesthetized using 7 cc 1% Xylocaine and 2 cc 0.5% Marcaine.

#18 gauge 3.5" Crawford needle used to enter epidural space using loss of resistance to normal saline technique, confirmed by visualization on AP and lateral views of needle tip placement (patient allergic to contrast dye, no Omnipaque utilized for contrast visualization for this reason).

90 mg DepoMedrol with 1.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) injected into epidural space, tolerated well, needle was withdrawn. Patient went to recovery room in good condition.


Gregory M. Jones, M. D.

GMJ/bjl

Addendum: Pre-block assessment and discussion with patient accomplished today. Patient notes the following:

1. Patient noted no significant relief from 9/19/02 L4-5 LESI.
2. Patient noted very good relief following 10/17/02 left paracentral L5-S1 LESI.
3. Patient states that she was involved in a new injury at work on 10/24/02, apparently injuring her neck. Patient states that she is currently under care of Dr. Jeff Hook, who has started patient on physical therapy. Dr. Hook has suggested that if patient's symptoms do not abate with conservative measures, he may want to consult this practice for further care if specialty care becomes necessary for this new injury.

(688)

10/14/02
12



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SHIVER, Gertrude #4559

May 9, 2003

CHIEF COMPLAINT: Left sided neck and shoulder pain; throat discomfort with voice change.

HISTORY OF PRESENT ILLNESS: Patient is a 48 year old female who is well known to this practice, who is complaining of persistent left sided neck and shoulder pain since injury occurring on the job 10/24/02.

Patient states that she was at her job, her supervisor accidentally dropped a thick chart, chart striking the left side of patient's neck and shoulder, this occurring 10/24/02. Patient states that she has been under care of Dr. Hook since that time, but pain has not returned to "baseline" level. Patient initially noted primarily stabbing and burning pain left side of neck and shoulder, flared from baseline level, but then beginning approximately 12/25/02, patient notes that she has had problems with her voice, volume decreased, unable to talk in more than whisper, unable to sing. Patient notes that during this time, she has had excessive secretions in back of throat and nasally, and although her voice and throat problems have not clear completely she did have most of her voice come back in mid-February. Patient has had anterior throat pain associated with her increased throat and nasopharyngeal secretions and voice abnormalities. Patient has continued to work since injury to neck and shoulder. Patient unsure as to whether throat and voice problems related to 10/24/02 work injury. No prior history of similar condition. Has had four sessions of PT in formal PT, now on home exercise program.

PAST MEDICAL HISTORY: Past medical history significant. Surgical history is quite significant as well. This history includes a heart conduction defect with myomectomy 1995, breast reduction surgery 1997, no prior spine surgeries, but patient has multiple injury histories to spine. Patient was initially seen in this practice 3/4/98 for low back symptoms due to MVA 4/20/97, with flaring of these symptoms following work-related lifting injury 10/11/97.

Patient underwent conservative treatment, was placed at MMI July 1998, assessed DRE Category II impairment to cervicothoracic spine for chronic cervical strain syndrome, and DRE Category II impairment to lumbosacral spine for symptomatic disc bulge with partial myofascial low back pain components.

Patient was then involved in MVA 11/25/00. This caused major problems in regard to low back symptoms, and patient developed thereafter bilateral sciatica complaints. Patient's treatment in this practice began on 12/18/00 relating to MVA 11/25/00, and patient remained under our care for symptomatic disc pathology in lumbar spine and recurrent/flared cervicothoracic pain through 2001. Patient was assessed at MMI 5/7/01 for lumbar injuries sustained 11/25/00, assessed no additional impairment at that time as patient's disc lesion at L4-5 had stabilized symptomatically. However, patient did have significant worsening/aggravation of cervicothoracic injuries sustained 11/25/00, and additional 3% impairment assessed for additional injuries to cervical spine in 11/25/00 MVA on date of MMI for cervical injuries 8/13/01. Patient has required intermittent even since assessment of MMI, and this has included occasional use of cervical facet/focal injections, with last visit occurring 11/20/01 relating directly to that accident of 11/25/00.

Patient was unfortunately involved in another work injury on 3/22/02, injured low back when chair flipped backward when she fell, and treatment from 6/10/02 initial assessment through follow ups and a set of three epidural blocks in fall of 2002 relates to the patient's lumbar spine condition and flaring of low back pain from work injury 3/22/02. Patient was last seen 11/14/02 for pre-block assessment, and had the last block on 11/14/02 in series of three.

REVIEW OF SYSTEMS: Patient has history of palpitations relating to her cardiac disease. Currently on medication for this. Also hypertension controlled with Cardizem. Takes one baby aspirin daily, no other blood thinners. Has history of IBS with intermittent problems with constipation. Also has prior history of bone and joint/spinal pain, see PMH above. Has history of headaches, difficulty sleeping. Otherwise noncontributory, no sexual dysfunction, no immune or blood disorders, no depression or psychiatric history, no diabetes or cancer history, no fibromyalgia history, no weight change.

MEDICATIONS: Ultram 50 mg 1 po q6h prn pain. Other medications include Bextra 20 mg po q daily (both given by Dr. Jeff Hook, patient's primary physician). Other medications include 1 baby aspirin q daily. Humibid 600 mg LA 1 tablet q12h, Tenormin 25 mg 1 bid, Cardizem 120 mg tablet q daily, and Skelaxin 400 mg q8h prn muscle spasm.

ALLERGIES: Contrast dye ("seizure-like activity"), tuberculin skin test (palpitations, itching, rash with wheals on body). Also tetanus toxoid (hematoma formation at injection site).

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FROM-CHAS SPINE

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Suite 402, Converse Building • 250 Berryhill Road • P.O. Box 21099 • Columbia, SC 29221-1099

P 803 731 5300. 800 848 9010. F 803 731 3040

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If you need a history of patient's file, no children, works full time at Palmetto Richland Memorial Hospital in Columbia for past 2 1/2 years, worked as a health information management specialist, inputs data into computer, also pulls records, files, makes charts, analyzes and assembles records. Does require some lifting, usually not heavy. Long sitting required. Nonsmoker, no alcohol use. Lives in Gadsden, SC. Dr. Jeff Hook is patient's primary and referring physician regarding this consult today.

FAMILY HISTORY: Positive for diabetes in sisters and one brother. Also history of colon cancer in one sister.

PHYSICAL EXAMINATION: Reveals a pleasant cooperative female, familiar to me from previous treatment, height 5' 3 1/2", weight 194 pounds. Upper extremity exam reveals negative Hoffman's, negative Spurling's, negative foraminal compression test, but both of the latter tests cause an increase in left sided neck pain (basically on any motion of the cervical spine side to side or with extension pain noted in left neck and left upper shoulder). no focal sensory deficits in dermatomal pattern either upper limb, reflexes are 1+ in triceps, 2+ in biceps, and trace, but symmetric in brachioradialis bilaterally. No definite focal motor deficits or atrophy either upper limb in myotomal pattern, no impingement at either shoulder, no subacromial or AC joint tenderness on either side. Marked trigger points noted left upper trapezius, left levator scapulae, and left supraspinatus, with similar findings noted left anterior and posterior scalene muscles mid-bellies, and left sternocleidomastoid as well as digastric, with most marked trigger points noted left splenius capitis and left splenius cervicis. Marked tenderness also noted over cervical facets at almost all levels from C2-3 down to cervicothoracic junction to varying degrees, with only moderate tenderness noted over greater occipital nerve route, none noted on right side. Moderate tenderness also noted over right cervical facets at C3-4 to C5-6 levels to moderate extent. Although there are minimal trigger points right upper shoulder and right lateral neck muscles in same region as on left side, these are no where near as tender or as large as the ones on left side. Cervical range is significantly limited, but particularly lateral bending and extension most difficult for patient. No CVA tenderness to percussion, no scapulohumeral motion deficits or scapular winging. HENT exam deferred.

IMAGING: Cervical spine plain radiographs accomplished today reviewed. Mild inferior endplate osteophytes noted at C4 and C6, more significant at C5, with earlier osteophyte superior endplate at C7 level. I can appreciate no definite loss of disc space height at any level on lateral views, and there is no evidence of listhesis or abnormal motion on flexion/extension views, other than limited extension. Standard neutral lateral views show reversal of normal cervical lordosis. Bilateral oblique views show no significant neuroforaminal narrowing at any level on either side. AP views show evidence of mild atherosclerosis both carotids, no lateral subluxations or acute injuries noted. Odontoid views normal with normal symmetry.

IMPRESSION: 1. History of contusion/blow to left lateral neck and left proximal/upper shoulder region 10/24/02 while on the job, with persistent left sided neck and upper shoulder pain in spite of prior conservative measures.
2. History of chronic cervicothoracic myofascial and facet-generated pain, previously stable, now likely flared/recurrent, S/P most recent work-related injury 10/24/02, no evidence of cervical radiculopathy clinically either upper limb.
3. History of chronic L4-5 and L5-S1 symptomatic disc lesions with associated low back pain and bilateral sciatica, with history of recent flaring of discogenic and non-discogenic pain components following work-related fall from chair 3/22/02 (previously stable S/P MVA 11/25/00, with history of prior initial injury 10/11/97).

RECOMMENDATIONS/DISCUSSION: Fortunately, patient appears to have been stabilized in regard to the injuries sustained on the job 3/22/02. This patient received treatment 6/10/02 through 11/14/02, and since we have completed the series of three epidural blocks 9/19/02, 10/17/02, and 11/14/02, patient has achieved a return to "baseline" level in relation to the flaring of low back and leg/buttock symptoms following work-related fall out of chair onto lower back 3/22/02. It is my opinion that patient can be considered at MMI regarding injuries sustained on the job to lumbar spine 3/22/02, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, patient has likely suffered no additional impairment to lumbar spine relating to those injuries, to a reasonable degree of medical certainty. It appears that this patient suffered most problems with the accident of 11/25/00, this was the most significant injury suffered in this "egg-shell" patient, and extensive care was necessary to stabilize her condition relating to that injury event. Patient has been assessed at MMI previously for that specific injury event as well.

In regard to this new injury of 10/24/02, patient is not yet considered at MMI. It is my opinion that patient would likely benefit from treatment directed toward the trigger points and cervical facets. Patient is to come in with driver 5/13/03, can go ahead with focal injection therapies, will hopefully be able to get patient back to "baseline" level in regard to cervical injuries sustained 10/24/02 without use of cervical epidural block.

In regard to the complaints of voice change, increased nasopharyngeal/oropharyngeal secretions, and throat soreness/pain, this appears to have begun approximately 2 months after contusion to left side of neck and shoulder 10/24/02. I would suggest that patient seek care with Dr. Hook, and if he feels that it is appropriate (if not already accomplished), patient may benefit from evaluation and treatment with otolaryngologist. I cannot clearly relate the ENT symptoms to the work injury of 10/24/02, to a reasonable degree of medical certainty; would defer to otolaryngologist for determination of relatedness of this condition to any specific injury event.

Gregory M. Jones, M.D.
GMJ/bjl

cc: Sandy Saukas, RN

(690)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

June 4, 2003 Patient is seen in follow up, we had completed the treatment yesterday regarding left cervical facet injections. Patient is here today for the trial of Myobloc injections that we had previously discussed. Patient has had chronic myofascial pain component, this has been flared recently by work injury 10/24/02, but we had also discussed possible utilization of trigger point injections and/or chemodenervation of recalcitrant trigger points relating to MVC 4/20/97, but particularly since patient has had significant flaring of neck and shoulder girdle myofascial pain since MVA 11/25/00. Therefore, this treatment today relates not only to the significant flaring of myofascial pain component in these two regions following MVA 11/25/00, but also to the significant flaring and even worsening of any myofascial pain present since work injury and contusion to left shoulder and neck region 10/24/02.

ROS: Patient currently experiencing no significant left arm pain.

PMH: No significant change in symptoms since left sided cervical facet injections accomplished yesterday, too soon to tell what type of benefit will be achieved.

Physical Examination: Reveals significant trigger points at typical locations in this patient, and this includes left upper trapezius mid-belly, left levator scapulae, and left supraspinatus mid-belly. I have not treated any of the rhomboid, infraspinatus, or middle or lower trapezial trigger points, and no treatment accomplished on right side today, using this side as "control." Patient has significant recalcitrant/chronic trigger points at usual locations left lateral neck, including splenius capitis, splenius cervicis, posterior scalene, and anterior scalene. These are in usual locations within these muscles, but there is also significant residual tenderness left greater occipital nerve route, and still tenderness noted over cervical facets treated yesterday. No evidence of erythema or local swelling noted over sites treated yesterday. Significant trigger point also noted left sternocleidomastoid muscle at clavicular head, 2 cm above clavicle.

Impression:

1. Severe flared left sided cervicothoracic myofascial and facet-generated pain (left sided superimposed acute and underlying chronic cervical and upper shoulder girdle strain syndrome), significantly flared since most recent work-related contusion to left neck and shoulder region 10/24/02 (unresponsive to prior conservative measures, Dr. Hook), initially symptomatic S/P MVA 4/20/97 and work injury 10/11/97 (with history of severe flaring following more recent MVA 11/25/00, with development of chronic myofascial pain thereafter).
2. Known underlying/pre-existent multilevel cervical spondylosis, worse at C4-5 and C5-6 levels, rule out spondylitic (vs. discogenic) cervical pain component with left shoulder, but no current significant upper extremity complaints.
3. Chronic, but currently stable, multifactorial low back pain with discogenic (symptomatic L4-5 and L5-S1 annular tear/protrusions), multilevel facet-generated, and myofascial pain components, one or more of these components significantly flared/symptomatic S/P work-related fall from chair 3/23/02 (this flare now stable following recent series of lumbar epidural blocks), symptoms initially present in low back following work-related MVA 10/11/07, significantly flared/worsened, S/P MVA 11/25/00.

Recommendations/Discussion: In regard to patient's pathology, patient is considered at MMI as of today's date, relating to lumbar injuries and flaring of multifactorial low back pain following work-related fall from chair 3/23/02. Patient has already been assessed for impairment relating to the most severe injury of this region, specifically the MVA 11/25/00. There is no change in assumptions regarding impairments relating to this injury. Based on fact that we have no indication of a "new" injury to lumbar spine with work injury of 3/23/02, this was primarily a flaring/aggravation of underlying pre-existent multifactorial pain generators in lumbar spine.

Although there is possibility that the annular tear/contained herniation at L5-S1 or the bulge at L3-4 could be related to work injury of 3/23/02, I would suggest that no additional impairment rating is necessary relating to that injury of 3/23/02, considering fact that patient is now stable in lumbar spine, has had no significant flaring since completion of epidural blocks, and has no definite clinical evidence of worsening or true "aggravation" per *AMA Guides to the Evaluation of Permanent Impairment, 5th edition* definition, based on current understanding of patient's chronic low back pain problems.

Therefore, patient is assessed at MMI for work injuries sustained 3/23/02 to lumbar spine, and based on *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*, patient is assessed DRE Category I, 0% lumbar spine/0% whole person *additional* impairment relating to accident of 3/23/02 on the job. This assumption of no *additional* impairment is making an assumption, i.e., that patient will not require more aggressive treatment than that already necessary to maintain stability of patient's lumbar spine pathologies, those treatments being accomplished on prn basis relating to permanent impairment and injuries sustained 11/25/00. It should be noted that some of treatments post-injury 3/23/02 actually would have been necessary for ongoing care of patient relating to chronic low back pain, and this can (at least partially) be related

(691)

15

HealthWorks

Injury Treatment Report

Date of Report: 03/27/02

INJURY

Name: Shiver, Gertrude Injury ID: 1
Emp ID: 249-98-2546 Injury Date: 11/15/01
Injury: Contusion, leg
Co. Status: 2ND JOB DEPT. 7140.
Clinic Status: Returned To Work as of: 12/11/01
File Status: OPEN
Company: Richland Memorial Hospital Days Lost:
Ins. Co.: PHT Services, Ltd. Days Lt Duty:
Claim No: Estimated on: 03/26/02

TREATMENTS

03/26/02 10:30 Pract : Inez Pempleton
Treatment : SEE F3
Restrictions: SEE F3

SPOKE WITH MS. SHIVER BY PHONE. SHE STATES SHE HAD AN INJURY OVER THE WEEKEND AND WAS SEEN IN THE ED. THE ED PHYSICIAN TOLD HER TO GO TO HER PRIMARY CARE MD, WHICH DID ON MONDAY 3/25/02. MS. SHIVER INFORMED HER IMMEDIATE SUPERVISOR BY E-MAIL THAT... "I AM NOT GOING TO HEALTHWORK BECAUSE I DON'T WANT THEM MESSING WITH MY BACK." I INFORMED MS. SHIVER THAT ALL INJURIES SUSTAINED OVER THE WEEKEND MUST BE FOLLOWED UP BY HEALTHWORKS IN ORDER TO BE COVERED BY WORKER COMP. INSTRUCTED HER TO COME TO OUR OFFICE IF SHE WISHES TO BE SEEN BY OUR NURSE PRACTITIONER OR DOCTOR. SHE INSISTS THAT SHE DOES NOT NEED TO BE SEEN BY US IN ORDER TO BE COVERED BY WORKER COMP. SHE PLANS TO CALL WORKMAN COMPENSATION HERSELF.

(692)

16

HealthWorks

I n j u r y T r e a t m e n t R e p o r t

Date of Report: 04/10/02

INJURY

me: Shiver, Gertrude Injury ID: 2
p ID: 249-98-2546 Injury Date: 03/23/02
jury: INJURY/STRUCK BY CHAIR.
Status:
inic Status: Returned To Work as of: 03/26/02
le Status: CLOSED
mpany: Richland Memorial Hospital Days Lost:
s. Co.: PHT Services, Ltd. Days Lt Duty:
aim No: Estimated on: 04/10/02

TREATMENTS

4/10/02 10:45 Pract : Inez Pempleton
Treatment : Appointment set for 4/24/02 @10:15 to f/u with MD concerning
Restrictions: heel injury.

4/10/2002

Spoke with Ms. Shiver at length about back injury sustained 3/23/02. Explained WC possision concerning treatment by our MD. Ms. Shiver understands that WC says she must come to HW for any injury sustained on the job. She says she was instructed by ED MD to go see primary care physician. I am encouraging Ms. Shiver to f/u with Dr. Durkin concerning this matter. She insists that she would prefer going to her own doctor. She plans to consult an attorney, if she has anymore permanant damage as a result of this injury.

(693)

10417
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STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Gertrude Shiver,

Claimant,

vs.

Palmetto Health Richland,

Employer,

and

PHT Risk Management Services,

Carrier,

Defendants.

BEFORE THE
SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC Number 0227098

NOTICE OF WITNESSES,
WRITTEN REPORTS, OR OTHER
EVIDENCE TO BE INTRODUCED
ON BEHALF OF THE DEFENDANTS

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
AND MS. GERTRUDE SHIVER, ATTORNEY FOR CLAIMANT:

YOU ARE HEREBY NOTIFIED THAT THE Employer, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following reports/physician or other evidence on behalf of the Employer to wit:

NAMES OF REPORT(S)/PHYSICIAN
OR OTHER EVIDENCE

DATE OF
REPORT(S)

NUMBER OF
PAGES

1.	Dr. Gregory Jones	5/13/03-7/1/03	1-3
2.	Palmetto Richland Memorial Hospital	10/24/02	4-8

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purpose of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina

(694)

Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Employer.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Employer: None.

Respectfully submitted,

ELLIS, LAWHORNE & SIMS, P.A.
Post Office Box 2285
1501 Main Street, 5th Floor
Columbia, South Carolina 29202
(803) 254-4190

By: Lana H. Sims, Jr.
Lana H. Sims, Jr.
Attorney for Employer

Columbia, South Carolina

August 20, 2007

(695)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

May 13, 2003 Patient is seen in follow up has failed to show any significant benefit to the PT and appropriate medications given by Dr. Hook. Dr. Hook has now discontinued Mobic and has started patient on Bextra on trial basis, pending further treatment here. See medication section for other details.

Patient has come in today for consideration for possible trigger point/focal injections left neck/shoulder.

Medications: Patient is currently taking alprazolam (Xanax 0.5 mg) prn for anxiety, this prescribed by Dr. Hook. Patient recently started on Bextra, no change in pain as yet with this new medication.

Physical Examination: Reveals significant trigger points left supraspinatus mid-belly, left levator scapulae, and left upper trapezius, but also significant trigger points left posterior and anterior scalene and left splenius cervicis as well as capitis muscles usual sites. Marked tenderness also noted over left C2-3 through C6-7 cervical facets to varying degrees, most significant tenderness at upper four cervical levels. Left greater than right greater occipital nerve route tenderness also noted.

- Impression:**
1. Flared/recurrent cervicothoracic myofascial and/or facet-generated pain (left sided cervical and upper shoulder strain syndrome (S/P work-related neck and shoulder contusion, unresponsive to prior conservative measures (Dr. Hook).
 2. Persistent left sided cervical facet syndrome with significant myofascial pain component, symptomatic/flared S/P work-related contusion to left neck and shoulder 10/24/02 by history (with history of chronic myofascial/facet-generated pain and underlying/pre-existent C4-5/C5-6 cervical spondylosis, initially symptomatic S/P MVA 4/20/97, flared with work injury 10/11/97, also flared more recently with significant recurrence following MVA 11/25/00).
 3. Chronic (but currently stable) low back pain with underlying discogenic, facet-generated, and myofascial pain components, recently flared/symptomatic S/P work-related fall from chair 3/23/02, stable following recent series of blocks (with known L4-5 and L5-S1 symptomatic annular tear/protrusions, previously stable, initially symptomatic S/P work-related MVA 10/11/97, flared/worsened S/P MVA 11/25/00).

Recommendations/Discussion: Patient is candidate for focal injection therapy left shoulder and neck region. She is really the classic "egg-shell" patient in that she has had multiple injuries in past, and even minor injuries to these regions can cause fairly significant flares in this patient. It is not atypical for these patient's to fail to respond to more conservative measures such as PT and medications (those measures that may be effective in less compromised patients), with this in mind, I have accomplished the following today:

1. Left C3-4 and C4-5 cervical facet blocks, 5 mg methylprednisolone acetate per site, sterile technique, non-fluoroscopic, 25 gauge 2" spinal needles used at each site.
2. Left lateral neck trigger point injections, left posterior scalene and left splenius cervicis muscles, 2.5 mg Aristospan per site, non-fluoroscopic, 27 gauge 1 1/4" spinal needle used at each site.
3. Left shoulder girdle trigger point injections, 2 sites (left supraspinatus and levator scapulae muscles), 2.5 mg Aristospan per site, sterile technique, non-fluoroscopic, 27 gauge 1 1/4" spinal needles used.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Follow up will be accomplished in several weeks. I have discussed option regarding use of further cervical facet injections (if necessary), based on response to two levels treated today, for any residual cervical symptoms relating to this underlying pathology. I have also discussed option regarding treatment of recalcitrant trigger points with Myobloc (botulinum toxin type B) if necessary.

At this point, patient remains neurologically stable, as assessed 4/23/03 regarding upper limbs. No need for any specific restrictions regarding vocational and/or avocational pursuits at this time, relating to cervical injuries sustained 10/24/02, to a reasonable degree of medical certainty.

Patient not yet considered at MMI regarding injuries sustained 10/24/02 on the job to left cervical and upper shoulder girdle region.

Gregory M. Jones, M. D.

GMJ/bjl

(696)

1
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June 4, 2003\ page 2

Recommendations/Discussion (continued): to MVC of 11/25/00, to a reasonable degree of medical certainty.

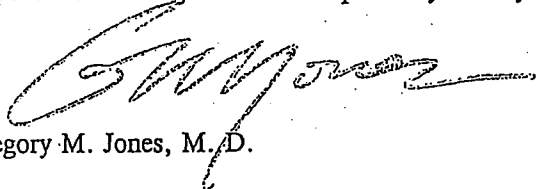
It is noted by history that patient was involved in work-related fall in January 2003, has had significant leg and hip symptoms since that fall, and also left flank and left inguinal pain. This appears to be a separate injury from the stable low back and buttock/sciatica symptoms relating to the lumbar pathologies noted above. Patient is currently under care of separate physician for these injuries sustained on the job January 2003, and any additional or new impairments relating to this injury should be addressed by current treating physician(s), once patient at MMI. I have not addressed any additional impairments that may be related to that specific injury January 2003 on the job, to lumbar spine, as I have not been involved in the patient's care of these new injuries.

Patient is not yet considered at MMI regarding most recent injuries sustained to cervical spine, particularly in relation to work injury 10/24/02. There is no change in assessment of prior impairments or MMI relating to cervicothoracic spine injuries sustained 11/25/00 in MVC, assessed date of MMI 8/13/01. However, since patient is not yet at MMI relating to flaring/worsening of left sided neck and shoulder symptoms since work-related contusion to left neck and shoulder 10/24/02, I cannot address issues regarding MMI or any additional impairment rating (if this becomes appropriate/necessary) until patient is maximized regarding non-surgical measures available to her. It should be noted that the treatments accomplished today (see below) relate to ongoing care regarding MVC 11/25/00, as we had already discussed these options previously (Myobloc injections for recalcitrant trigger points due to chronic myofascial pain components present/flared since MVA 11/25/00), and the injury of 10/24/02 to left neck and shoulder has aggravated this portion of patient's pain in shoulder/neck region to point to where it is necessary to go ahead with the chemodenervation trial as follows:

1. Left shoulder girdle chemodenervation at supraspinatus, levator scapulae, and upper trapezius sites, three sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.
2. Left lateral neck chemodenervation of scalene and splenius trigger sites, four sites noted above, 500 units botulinum toxin type B (Myobloc) instilled at each site, along with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Bupivacaine HCl MPF (methylparaben-free) at each site; each chemodenervation accomplished with 25 gauge 2" spinal needles, following local instillation of 1.5 cc 1% Xylocaine at each site for local anesthetic, using 27 gauge 1 1/4" needles.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Patient is placed out of work as of yesterday through 6/5/03. Patient is to follow up in 3-5 weeks to assess response to cervical facet injections and Myobloc chemodenervation trial. I do not see any reason to consider new MRI cervical spine. If patient gets adequate relief to these two sets of injections accomplished yesterday and today, no need to consider cervical epidural. Should be able to determine best options available to patient for future medical care for flaring, based on response to these injections accomplished yesterday and today.



Gregory M. Jones, M.D.

GMJ/bjl

(697)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESSNOTE

July 1, 2003 Patient is seen in follow up. Has fortunately seen good benefit with the injections accomplished in series 6/3/03 (left cervical facet injections, 5 levels) and 6/4/03 (left shoulder girdle and left lateral neck Myobloc chemodenervation). Patient estimates overall about 80% relief. Still feels that she has persisting pain in left anterior chest wall (upper aspect) and left anterior shoulder region which is "new" and related to most recent injury on the job when a group of charts fell onto her neck and shoulder on left side.

- Impression:**
1. Flared left sided cervicothoracic and shoulder girdle myofascial pain (with flared cervical facer-generated pain concomitant) secondary to work-related contusion to left neck and shoulder region 10/24/02, good relief noted with recent focal injection therapies, now considered at MMI.
 2. History of chronic multifactorial cervicalgia, worse on left, initially symptomatic following injuries 4/20/97 (MVA) and 10/11/97 (work injury) with 5% DRE Category II impairment assessed 7/29/98, followed by additional aggravation of particularly cervical facet injuries in 11/25/00 MVA, with additional 3% impairment assessed 8/13/01, date of MMI.
 3. Chronic, currently stable multifactorial low back pain.

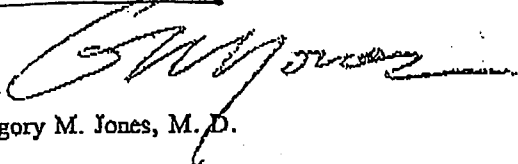
Recommendations/Discussion: There is no change regarding impairment assessed for lumbar pathology in past. Refer to 6/4/03 progress note for details.

As of today's date, we can likely assume Gertie at MMI regarding injuries sustained on the job 10/24/02 due to contusion to left neck and shoulder region with charts. Patient appears to have had flaring of primarily myofascial pain, but also had flaring of cervical facet-generated pain components on left side. Fortunately, patient has gotten significant benefit with treatment directed toward these injuries.

Assuming MMI as of today's date for work injury sustained 3/23/02 to cervical spine and left shoulder girdle, and based on AMA Guides to the Evaluation of Permanent Impairment, 5th edition, I can assess no additional impairment for this injury, as previous impairments have been assessed for both myofascial and cervical facer-generated pain, which was present in this patient to great extent even prior to 10/24/02 injury on the job. Although patient does have residual anterior shoulder and left upper chest wall pain and discomfort which has appeared as "new" myofascial injury following 10/24/02 accident on the job, this would require assessment for myofascial pain, and based on recommendations per AMA Guides to the Evaluation of Permanent Impairment, 5th edition interpretation, it is inappropriate to add further impairments for this type of injury, particularly when impairments have addressed myofascial injuries in this region previously.

Patient had majority of injuries that have resulted in additional impairment cervical spine occurring on 11/25/00. This not only flared neck pain (particularly cervical facer-generated pain component), but also significantly flared multifactorial low back symptoms. Assessments for impairments (where necessary) have already been addressed in regard to these various injuries sustained 11/25/00.

Although patient is released today from active care regarding injuries sustained 10/24/02, patient is candidate for intermittent use of cervical facet and/or trigger point management with focal injections for flares. I can address issues regarding future medical care via Life Care Plan if this becomes necessary. Patient to continue with home exercise protocol life-long. Patient would also benefit from regular aerobic activity at least 3x weekly. Patient is allowed to continue with usual duties, as her work site requirements are primarily for sedentary work at desk/computer, where she is in health information management, working in Columbia for Palmetto Richland Memorial Hospital. There have been no additional restrictions regarding this patient relating to work injury 10/24/02. Follow up hereafter prn.


Gregory M. Jones, M.D.

GMJ/bjl

cc: Palmetto Health Trust
Attn: Lori Sharpe

(698)

10/24/03

3

PALMETTO RICHLAND MEMORIAL HOSPITAL

5 Richland Medical Park Drive

Columbia, SC 29203

(803)434-7000

EMERGENCY DEPARTMENT

PATIENT: Shiver, Gertrude
MR #: 00-99-52-11-7
ADMITTED: 10/24/2002

DICT: Douglas B Ross, MD
DOB: 05/19/1954
PT.LOC:

DATE OF VISITATION: 10/24/2002

CHIEF COMPLAINT: Chart falling on the left shoulder.

HISTORY OF PRESENT ILLNESS: This 48-year-old, about 1800 today was working here at Richland in the Medical Records Department, and a large paper NICU chart, approximately 2 inches thick, fell off a shelf and landed on the left side of her neck over the trapezius muscle. She has had increasing pain in this area throughout the night. Denies any neck pain, denies any radicular symptoms, focal weakness or paresthesias. She has had a history of chronic neck pain secondary to motor vehicle accident and just wanted to make sure that everything was okay.

REVIEW OF SYSTEMS: No loss of consciousness, no headache. No fever or chills, otherwise negative.

FAMILY HISTORY: CVA and diabetes.

SOCIAL HISTORY: No smoking. Again, she works for Richland Memorial Hospital. No alcohol, no drugs.

PAST MEDICAL HISTORY: Again, the motor vehicle accident with chronic neck pain. She has a herniated disk in the back. Hypertension and irregular heartbeat at times.

MEDICATIONS: She has taken Skelaxin p.r.n. in the past but is out of it, due to her neck. She takes morphine p.r.n. for her back, AcipHex, Mobic, aspirin, Tenormin and Cardizem.

ALLERGIES: CT DYE, TETANUS AND TB TEST.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.3, pulse 77, respirations 20, blood pressure 136/83.

GENERAL APPEARANCE: Nontoxic, alert and oriented x 3. Laughing and joking.

HEENT: Pupils equal, round and reactive to light bilaterally. Extraocular movements intact. No scleral icterus. No conjunctival injections. TMs clear bilaterally. OC, OP clear and moist.

NECK: Supple without lymphadenopathy.

CHEST: Clear to auscultation bilaterally.

CARDIOVASCULAR: Regular rate and rhythm. No murmurs, rubs or gallops.

ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds x 4. No hepatosplenomegaly, no masses.

PATIENT: Shiver, Gertrude

MR #: 00-99-52-11-7

Patient Type: ERR

EMERGENCY DEPARTMENT

Page 1 of 2

(699)

PALMETTO RICHLAND MEMORIAL HOSPITAL
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-7000

MUSCULOSKELETAL: No cyanosis, clubbing or edema. Pulses 2+ globally. Full range of motion all extremities actively without pain including the left shoulder. She has tenderness to palpation in the left trapezius muscle. No evidence of spasm. No bony tenderness to palpation of the left shoulder. No midline cervical tenderness to palpation or step-off. No midline dorsal or lumbosacral spine. No tenderness to palpation or step-off. Full range of motion of the neck without any pain. Palpation of the trapezius exactly recreates the patient's pain. No evidence of any contusion over the area.

NEUROLOGICAL: Sensation grossly intact. Strength 5/5 globally. Gait within normal limits. Deep tendon reflexes 2+ globally. Cranial nerves II-XII intact. Sensation intact. Toes downgoing bilaterally. No ankle clonus.

SKIN: No rashes, no lesions.

EMERGENCY DEPARTMENT COURSE: I certainly feel the patient has more than likely a muscle strain of the left trapezius. I certainly feel that by mechanism that is very unlikely if patient has bony fractures, and certainly has no bony tenderness to palpation. I feel she is stable for discharge with symptomatic therapy. She is out of Skelaxin, so we will prescribe her some Flexeril as she does not like taking the morphine because it makes her sleepy, so we will prescribe her some Darvocet each with sedation precautions.

CLINICAL IMPRESSION: Acute left trapezius strain.

DISPOSITION: Will discharge home with Flexeril and Darvocet each with sedation precautions. Sent her home with 15 of each. Recommend rest. Ice alternating with heat. Work excuse for 24 hours. If no improvement in 48 hours, recommend she follow up with her primary MD for recheck. Return to the ED with increasing pain, fever and chills or any other acute changes, signs or symptoms.

Dr. Mike Wade, attending physician, was present and available for questions.

Michael D Wade 11/2/02

Michael D Wade, MD

Dictated by: Douglas B Ross, MD

DR:hs

D: 10/25/2002 3:37 A T: 10/25/2002 9:40 A

Job #: 040385 T Job #: 700535 Doc #: 349807

cc: Michael D Wade, MD

PATIENT: Shiver, Gertrude
MR #: 00-99-52-11-7

EMERGENCY DEPARTMENT
Page 2 of 2

(700)

5

Emergency Center at
Palmetto Richland Memorial Hospital
NURSING RECORD

Triage Level: _____
Date: 10-24-02
Time: 2:50

Shiver - Gertrude 48/f
Neck Pain/Injury on the
Job NICH
OCT 24 PM 10:56

Temp: 97.3 HR: 77 RR: 20 Allergies: doxycycline, tetracycline
BP: 136/83 Pulse Ox: _____ Type of Reaction: _____

Chief Complaint: "phantom feeling of stabber" @ shoulder movement, turned cap result to Lt finger

Tetanus: ☐ UTD ☐ Unk Latex Screening: ☒ No Risk ☐ Moderate Risk ☐ Low Risk ☐ High Risk

PMH: ☒ HTN ☐ SZ ☐ CAD ☐ DM ☐ RAD ☐ HIV ☐ CVA ☐ CA ☐ Chronic Pain _____
☐ Other pulmonary, herniated disks ☐ None
☐ Prior Surgeries _____
Mode of Arrival: ☒ Amb ☐ W/C ☐ EMS
☐ Stretcher ☐ Sent by PMD

Medications: ☐ OTC ☐ Herbal ☐ Stimulants
☐ Rx gabapentin, paracetamol, morphine, morphine, cephalexin, ACE, ASA ☐ None

Pain Assessment: ☒ Yes ☐ No Intensity: "7.5 to 10 scale" Location: Lt shoulder
When did your pain start? _____ Duration: _____
What words best describe the pain that bothers you the most?
☐ Dull ☒ Aching ☐ Shooting ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Other _____
What makes your pain worse?
☐ Moving ☐ Heat ☐ Cold ☐ Coughing/Sneezing ☐ Sitting ☐ Lying Down ☐ Eating
☐ Other _____
What makes your pain better?
☐ Heat ☐ Cold ☐ Lying Down ☐ Medications ☐ Relaxation ☐ Magnet/Herbal Therapy
☐ Other _____
Does your pain interrupt your sleep? ☐ Yes ☒ No
Is there anything else you wish to tell us about your pain? _____

Standing Orders:
☐ X-Ray ☐ Labs ☐ CBC ☐ BMP ☐ UA ☐ UPT ☐ FSBS

Prehospital Treatment: ☐ IV ☐ Other _____
☐ Meds: _____

Time	Reassessment	T	P	R	BP	P.Ox	Pain Interventions	Interventions	Initials

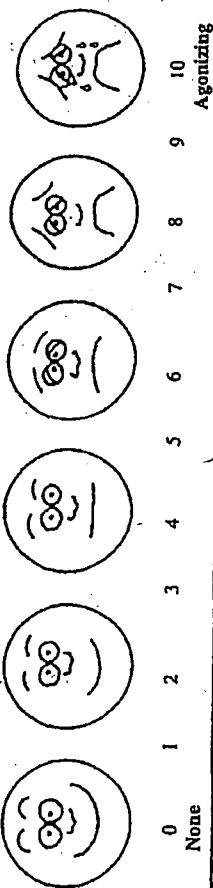
Barriers: ☐ Motor Impairment ☐ Language Impairment ☐ Speech or Hearing Impairment ☐ Visual Impairment ☐ Other _____
Interventions: ☐ Interpreter Contacted ☐ Unable to Locate Interpreter ☐ TDD Phone Used ☐ AT&T Operator Used

Physician: _____ Patient Called: ☐ Yes ☒ No Visual Acuity: *See Assessment
☐ Wants PMD Called ☐ Wants ED MD to Treat L 20/ _____ Both 20/ _____
R 20/ _____

Triaged to: ☐ Pod 1 ☐ Pod 5 ☐ Trauma Room
☐ Pod 4 ☐ Pod 6 ☐ Pod 7
☐ Waiting Room

What questions/concerns do you have about this visit: _____

Triage RN: _____



PALMETTO RICHLAND MEMORIAL HOSPITAL EMERGENCY CENTER AFTERCARE INSTRUCTIONS

YOUR DIAGNOSIS TODAY IS: Date: 10/25/02

① Acute ② Streptococcal

If you are worried about your illness and your doctor cannot be contacted, Palmetto Richland Memorial Emergency Services is available for emergency care. You may call or return to the emergency department. Phone # 434-6350.

Follow-up Care / Referral

Arrange for an appointment in _____ days with:

☐ Private Doctor:

Phone Number: 8 needed

☐ Ambulatory Clinic

Call 434-4100 for appointment

☐ Medicine

☐ Orthopedic

☐ Family Practice

☐ Pediatric

☐ Obstetrics/Gynecology

☐ Other

☒ Emergency Department for hurt or new

Call sooner if not improving or if there is any problem.
Until you contact your follow-up doctor,
follow instructions as directed.

MEDICATIONS GIVEN TO YOU IN THE ER:



☐ Tylenol

☐ Rocephin

☐ Dilantin

☐ Ibuprofen

☐ Toradol

☐ Lidocaine

☐ Benadryl

☐ Floxin

☐ Mylanta/Donnagel

☐ Tetanus

☐ Other

TEST RESULTS:

☐ Your x-rays have been read by the ER Doctor. They will also be reviewed by our radiologist. If any other problems are found that have not been called to your attention, you will be notified.

☐ Cultures require 48-72 hours for final reading. You may call 434-3311 for results.

☐ Pick up x-rays (x-ray file room)

FACT SHEETS GIVEN:



Other Instructions: ① Discharge home with Flexeril (sedation precautions) Danazol - sedation precaution ② rest; ice; alternate with heat; use exers 24 hours ③ If no improvement in 2 days follow up with regular doctor for recheck ④ return to ED with 1 pain; fever; chills or any other changes in signs & symptoms

I have received and understand the above instructions for aftercare. I understand that I have had emergency treatment only, which is not a substitute for continuing medical care. I will arrange for follow-up care as instructed.

Nurse: K. Cohen R.

☐ INT D/C

Patient/

Family: Debra Shum

COUNTY OF RICHLAND

Claimant,

VS.

Palmetto Health Richland,

Employer,

and

PHT Risk Management Services,

Carrier,

Defendants.

BEFORE THE
SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

WCC Number 0322274

**NOTICE OF WITNESSES,
WRITTEN REPORTS, OR OTHER
EVIDENCE TO BE INTRODUCED
ON BEHALF OF THE DEFENDANTS**

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
AND MS. GERTRUDE SHIVER, ATTORNEY FOR CLAIMANT:

YOU ARE HEREBY NOTIFIED THAT THE Employer, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following reports/physician or other evidence on behalf of the Employer to wit:

NAMES OF REPORT(S)/PHYSICIAN
OR OTHER EVIDENCE

DATE OF
REPORT(S)

NUMBER OF
PAGES

Exhibit A	Supervisor's Report of Employee Occurrence	1/20/03	1
1.	Healthworks	1/24/03-2/28/03	2-4
2.	Dr. Jeffrey Hook	2/12/03-9/3/03	5-17

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purpose of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina

(704)

Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Employer.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Employer: None.

Respectfully submitted,

ELLIS, LAWHORNE & SIMS, P.A.
Post Office Box 2285
1501 Main Street, 5th Floor
Columbia, South Carolina 29202
(803) 254-4190

By: Lana H. Sims, Jr.
Lana H. Sims, Jr.
Attorney for Employer

Columbia, South Carolina

August 20, 2007

(705)

Supervisor's Report of Employee Occurrence (S. J.)

Bloodborne Exposure ☐
Other Injury ☒

Facility Name

Occurrence Number

OSHA Log Case #

BLOCKS 1-10 TO BE COMPLETED BY EMPLOYEE

(1) PLEASE PRINT		(2) OCCURRENCE		(3) SEX	
Name <u>Gertrude S. Miller</u>		Date: <u>1-20-03</u> Time: <u>0030</u>		☐ Male	
Address <u>1026 Congregate Church Rd</u>		Location of occurrence <u>2nd Floor</u>		☐ Female	
City <u>Greenville</u> State <u>SC</u>		Reported to <u>Bea Conley</u> Date <u>1-20-03</u>		(4) BIRTHDATE	
Zip <u>29602</u> Home ph <u>803-333-3892</u>		Time Began Work <u>Hall near Medical</u>		<u>05/19/54</u>	
Social Security # <u>249-98-2546</u>		(Supervisor's name)		(7) DATE OF REPORT	
(5) MARITAL STATUS		(6) EMPLOYMENT		(7) DATE OF REPORT	
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		☒ Full time ☐ Part time ☐ Other Employment Date <u>Medical Records Clerk</u> <u>437-7188 Ext 4025</u> Dept./Nursing unit <u>Medical Records</u> Dept./Unit phone # <u>437-7188 Ext 4025</u> Cost Center #		<u>01.21.03</u>	

(8) EMPLOYEE'S DESCRIPTION OF OCCURRENCE
 I was leaving work in the Medical Records dept. when I fell in the hallway. I was keeping my hands on the floor and the whole floor was wet. I was in the middle of the hallway, my whole body hurts especially my back, knees, feet and elbows & left wrist.

BLOCKS 11-15 TO BE COMPLETED BY SUPERVISOR

(9) INJURY TYPE		(10) PART OF THE BODY	
☐ Abrasion ☐ Airborne/Droplet exposure ☐ Allergic reaction ☐ Amputation ☐ Animal bite/sting ☐ Bloodborne exposure* ☐ Foreign body ☐ Fracture ☐ Human bite/scratch ☐ Puncture ☐ Skin irritation ☐ Strain/sprain ☐ Burns ☐ Contusion/bruise ☐ Cut/laceration		☐ Clean needle ☐ Other: ☐ Latex exposure ☐ Dermatitis ☐ Other: ☐ Pushing/pulling ☐ Lifting patient ☐ Lifting other ☐ No apparent injury ☐ Other:	
☐ Foreign body ☐ Fracture ☐ Human bite/scratch ☐ Puncture ☐ Skin irritation ☐ Strain/sprain ☐ Burns ☐ Contusion/bruise ☐ Cut/laceration		Ankle ☐ left ☐ rt Arm ☐ left ☐ rt Ear ☐ left ☐ rt Elbow ☐ left ☐ rt Eye ☐ left ☐ rt Finger(s) ☐ left ☐ rt Foot ☐ left ☐ rt Hand ☒ left ☐ rt Hip ☐ left ☐ rt Knee ☒ left ☐ rt Leg ☐ left ☐ rt Shoulder ☐ left ☐ rt Toe(s) ☐ left ☐ rt Wrist ☒ left ☐ rt	
☐ needlestick/sharp object Type of sharps device involved in injury: ☐ other bloodborne exposure ☐ body fluid exposure/no visible blood		Previous injury, same part? ☒ Y ☐ N Describe:	
☐ other bloodborne exposure ☐ body fluid exposure/no visible blood		(11) ACTIVITY INVOLVED ☐ Contact w/ heat or cold ☐ Lifting/moving other± ☐ Pushing/pulling material ☐ Other: ☐ Contact w/ tox. substance ☐ Motor vehicle related ☒ Slip/trip/fall ☐ Other: ± Assisting Device Used: ☐ Transfer belt ☐ Mechanical lift ☐ 2-person lift	

(12) POSSIBLE CAUSE
☐ Equipment failure
☐ Miscommunication
☐ Personal protective equip not provided
☐ Unknown
☐ Exposure to unguarded equipment
☐ Other external factors
☐ Policy/procedure not followed
☒ Other (describe): see #8
☐ Improper body mechanics
☐ Patient initiated
☐ Weather
☐ Lack of supervision
☐ Personal protective equip not used
☐ Workplace violence

(13) MANAGER'S FOLLOW-UP		(14) WITNESSES		(15) EXPOSURE SOURCE PATIENT INFO	
☐ Retraining ☐ Counseling ☐ None Required (Please complete section on reverse side or attach report)		Name <u>2 S.N.V. Joseph</u> Dept <u>Lab Employee</u> Phone		Record/ID# <u>243</u> Rm# <u>243</u> HIV Status: <u>+</u> <u>-</u> Other HBV Status: <u>+</u> <u>-</u> Other HCV Status: <u>+</u> <u>-</u> Other	
Warnings: ☐ Verbal ☐ Written ☐ Other		Name <u>OK - Hooks</u> Address <u>Midland</u> Date <u>1/1</u> Time <u>12:00</u>		(17) PHYSICIAN/HC PROVIDER Name <u>OK - Hooks</u> Address <u>Midland</u> Date <u>1/1</u> Time <u>12:00</u>	
(16) INITIAL TREATMENT ☐ Employee health ☐ Emergency Rm ☐ Physician ☐ Hospitalized ☐ Refused Treatment ☒ No Treatment ☐ Other: Briefly describe treatment: <u>TO Hu & Health works</u>		Date returned to work: <u>1/1</u> If employee died, date of death:		Patient's Physician	
Rendered by:		Supervisor/Manager's Signature <u>Pam Scagliardi RN</u> Supervisor/Manager Title <u>Administration on duty</u> Date <u>1/21/03</u> Phone <u>x4007</u>		Date <u>1/1</u> Time <u>12:00</u>	

Supervisor signature indicates the form is complete and accurate according OSHA requirements

* With any sharp object injury or bloodborne exposure, an EPINET form must be completed by exposure management personnel

** Completion of appropriate section on reverse side is mandatory

(706)

HEALTHWORKS - RICHLAND MEMORIAL HOSPITAL

Palmetto Health
9 Medical Park, Suite 360
Columbia, SC 29203
803-434-7442

Injury Management Report

Name:	SHIVER, GERTRUDE	Injury ID:	4
Emp ID:	249-98-2546	Injury Date:	1/21/2003
Injury:	924.8 Contusion, multiple		
Co. Status:	Unknown as of:	Days Lost:	0
Clinic Status:	Unknown as of:	Days Lt Duty:	0
File Status:	CLOSED	Estimated on:	2/27/2003
Company:	Richland Memorial Hospital	Next Appt:	
Ins. Co:	PHT Services, Ltd.	Provider:	
Claim No:		Treatment:	

TREATMENTS

1/24/2003 11:00

Practitioner:

Treatment: see F3 memo

Pain Level (0-10):

Meds:

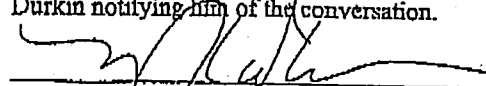
Restrictions:

SSN: 249-98-2546 DATE: 01/24/03 - 11:00 a.m. INITIAL TREATMENT STATEMENT

Gertrude Shiver

Date of Injury: 01/21/03

Ms. Shiver called in today to HealthWorks and refused to come in person to be examined. She stated that she did not want to come to HealthWorks because she did not like Dr. Durkin. She also stated that she did not want to see any nurse practitioners because we were "under Dr. Durkin." She spoke with Libby Holland, case manager, as well as the covering nurse practitioner, Sara Stafford, in the past few days. Both of them report that she was quite agitated and unwilling to come in for an exam. She states that she was leaving work in the Medical Records Department on the 21st about 30 minutes after midnight. When she left Medical Records Department, she fell in the hallway. Housekeeping was cleaning the floors and the whole floor was wet. Two signs were in the middle of the hallway. "My whole body hurts, especially my back, knees, feet, and elbows, and left wrist." When Sara Stafford spoke to her on January 23rd, she stated that she had pain in her back, knees, feet, perineum, elbows, and wrists. Please, refer to F3 memo of 1/22/03. Ms. Shiver was quite agitated over the telephone today. She wanted to know if I would "call in" (prescribe) "narcotics" for her over the phone. I explained to Ms. Shiver that as a nurse practitioner I could not prescribe narcotics and that it is inappropriate to make such demands without first being examined or even discussing the nature of her injury. When I repeatedly offered to see her in the office, she refused to discuss in any detail what happened to her 1/21/03; the location & quality of her discomfort and making an appointment for examination at HealthWorks. She also stated that nurse practitioners & "all y'all there" cannot do anything without a doctor as reason to avoid HealthWorks treatment. I explained NP practice and that Dr. Durkin is my medical director, and I will refer to him or other physicians or other nurse practitioners or other nurses when the time arises for more clinical information. She hung up the phone. I left a message with Dr. Durkin notifying him of the conversation.


Mary Kaye Parham, RN, CFNP

2/27/2003

Injury Management Report

Page 1

(707)

7

Treatment Memo History

Patient ID: 249-98-2546

Patient Name: GERTRUDE SHIVER

Injury ID: 4

Treatment ID: 3

F3 Memo Date
02/27/2003

F3 Memo
249-98-2546
Gertrude Shiver
1/22/03 12:30PM

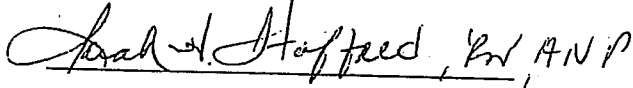
Changed By
MKPR

Changed Date & Time
02/27/2003 11:15

Message received (reviewed) from Ms. Shiver on the answering machine reporting that she had fallen and hurt herself and that her perineum was hurting "real bad." Phone # left for return call.

13:30 PM

I returned the phone call to Ms. Shiver. She reported again that she had fallen. I offered repeatedly to see her in HealthWorks for care. She refused to come stating that we couldn't help her and she did not want any part of Dr. Durkin. She stated that she had been rude to by Dr. Durkin & the staff. She said she knew there was no one here to help her, just nurse practitioners and nurses who take direction from Dr. Durkin and no other doctors. She said "we" couldn't order her anything for pain. I advised her that nurse practitioners could prescribe pain medications such as Motrin, Aleve but not narcotics, but we could consult with the doctor if something more was needed. Again she stated that she did not want to see Dr. Durkin citing an incident when he referred her to a MD @ Providence who was rude to her when he found out that she was a worker's comp. pt. She also said that she had seen Dr. Bethea and Dr. Walsh who were also rude to her. Again, I offered to see her and she said that she didn't want anyone looking at her perineum. She preferred her OB/GYN MD. I advised her that since we were the contact for injured employees, that we should see her for reimbursement purposes by Worker's Compensation and the hospital. I offered to see her this PM (1/22/03) or tomorrow 1/23/03. Again, she refused & stating that she could not come today as she had to go to a funeral. Ms. Shiver stated that she would call Mary Kaye Parham, NP on Friday, 1/24/03 when she returns from personal time off.



Sarah H. Stafford, RN, ANP

(708)

Treatment Memo History

Patient ID: 249-98-2546

Patient Name: GERTRUDE SHIVER

Injury ID: 4

Treatment ID: 1

F3 Memo Date
02/28/2003

F3 Memo

1/22/03 8:30 AM

Gertrude Shiver 249-98-2546

Changed By
SHS

Changed Date & Tin
02/28/2003 12:14

Message reviewed on telephone answering machine by Pam, Nursing Supervisor, Ext. 4013 that Ms. Shiver had fallen on a slippery floor. Ms. Shiver was complaining with pain in her back, knees, elbows, wrists, feet and perineum. Ms. Shiver works 3-11 PM in Medical Records. The supervisor stated that she advised Ms. Shiver to Contact HealthWorks.

Sarah H. Stafford, RN ANP

Sarah H. Stafford, RN, ANP

(709)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, reflux with overlapping stricture status post dilation and chronic back and neck pain, who basically presents with severe left-sided rib and abdominal discomfort status post fall. The patient notes that on 01/21/03, she actually slipped on a wet floor at work, landing on her left side and rib cage. She had a tremendous amount of discomfort almost immediately. She claims that not only was she having a significant amount of left-sided rib and abdominal discomfort but it also exacerbated her underlying neck and back pain as well. Apparently, the patient was seen by a nursing supervisor who suspected that the patient was seeking narcotics and actually the patient had a breathalyzer test as well. This apparently returned normal. Nonetheless, the patient felt that due to the fact that she had not seen a physician, went to Baptist ER. At that time, she had some rib films which were negative. Due to the fact that she was having abdominal discomfort and actually some suprapubic discomfort as well, a urinalysis was run and she was found to have a urinary tract infection. She was placed on Macrochantin. The patient noted that briefly this seemed to help with some of her discomfort but it has since returned. Again, she claims that associated with this discomfort, she has had some nauseousness and at one point some vomiting. She has also had some mild loose stool. She denies any fever or chills. She continues to have suprapubic discomfort as well as some peroneal irritation as well. She has been somewhat hesitant to take any Darvocet for the pain due to the fact that she is concerned that a urine drug screen may show narcotics and thus has basically been trying to take care of this pain with heating pads and ice as well as rest. She also notes that she is having some discomfort in her left foot, left knee, left elbow, and left shoulder on the side in which she fell. The patient claims she is quite concerned that no one is taking her complaints seriously. She notes that she feels that there is some internal damage done and this has not been addressed by any of the physicians she has seen thus far. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.

ALLERGIES: Unchanged as previously documented in the chart.

MEDICATIONS: Unchanged as previously documented in the chart.

SOCIAL HISTORY: Unchanged as previously documented in the chart.

FAMILY HISTORY: Unchanged as previously documented in the chart.

(7/0)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

PAGE 2 of 3

REVIEW OF MEDICATIONS:

1. Tenormin 25mg bid
2. Cardizem CD 120mg q day
3. Mobic 7.5mg bid
4. Baby aspirin daily
5. Occasional Tylenol
6. Skelaxin and Flexeril prn
7. Occasional Green Tea.

REVIEW OF SYSTEMS: The patient notes that she had to re-institute her Cardizem due to the fact that she was having some mild breakthrough palpitations. She notes that she is having no urinary symptoms at this time and claims that for the most part, her bowels have somewhat regulated, even though they are relatively loose but continues to have some formed products. She denies any rectal bleeding, or dark or tarry stool. The patient denies any abdominal distention but notes, again, severe left-sided discomfort as well as continued suprapubic discomfort. The patient also notes that she is having clear phlegm in her throat that is sometimes hard to clear. She feels that this is likely coming from post nasal drip but wants to have an ENT referral. She really has no other major complaints. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Moderately anxious. In no acute distress.

HEENT: Unremarkable.

NECK: Some left-sided muscular tension, otherwise unremarkable.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

CHEST WALL: There is moderate distal left-sided rib tenderness in the lateral aspect.

ABDOMEN: Obese, soft, moderate diffuse tenderness in the left upper and left lower quadrants, radiating to the suprapubic area. There is no rebound or guarding. There is no hepatosplenomegaly or mass.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

LABS: Urinalysis was run and negative.

(711)

6

MIDLANDS INTERNAL MEDICINE

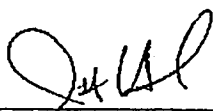
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/12/03

PAGE 3 of 3

ASSESSMENT AND PLAN:

1. Diffuse generalized abdominal pain, most notably left-sided and suprapubic, status post fall. Again, I have reassured the patient that I feel that this is likely more musculoskeletal due to her recent fall with bruised ribs and likely an abdominal strain. However, she feels that there is more going on. We will go ahead and obtain abdominal and pelvic CT with and without contrast for further evaluation. In the meantime, we will place the patient on Ultram, which should not turn her drug screen positive, if this is some concern of her place of work. She should continue, obviously, with the Mobic and use the muscle relaxers as needed.
2. Paroxysmal supraventricular tachycardia. Stable once adding her Cardizem back to her regimen. We will continue.
3. Cervical/trapezius strain. Again, the patient has seen The Spine Clinic in Charleston. They basically have recommended physical therapy.
4. Reflux. Stable on Aciphex.
5. Post nasal drip. We will try the patient on Clarinex. We have given her some samples. If she does not see any improvement there, consider nasal inhaled steroids. I do not feel that ENT referral at this time is necessary.
6. Routine health maintenance. Up to date.



Jeffrey D. Hook, MD

(712)

7



Carolina Medical Imaging

A new image for the Carolinas

PATIENT: Gertrude Shiver
DATE OF BIRTH: 05/19/54
REF PHYSICIAN: Dr. Hook
DATE OF EXAM: 02/26/03
PATIENT PH#: 803-353-9714

CT OF THE PELVIS

HISTORY: Abdominal pain, nausea, and vomiting.

TECHNIQUE: Pelvic CT Images were performed with oral contrast material. I.V. contrast material was not administered.

FINDINGS: The pelvic structures and adnexal regions appear to be clear. The uterus and bladder appear unremarkable. The Inguinal regions appear unremarkable.

IMPRESSION:

1. Normal pelvic CT scan with oral contrast material. I.V. contrast material was not administered.


G. Paul Forsyth, MD
Radiologist

GPF/dag

wofly
CT pelvis / 26d
completely
normal

put
02/27/03

Noted
JB

(713)



Carolina Medical Imaging

A new image for the Carolinas

PATIENT: Gertrude Shiver
DATE OF BIRTH: 5/19/54
REF PHYSICIAN: Dr. Hook
DATE OF EXAM: 02/26/03
PATIENT PH#: 803-353-9714

CT OF THE ABDOMEN

HISTORY: Abdominal pain, nausea, and vomiting.

TECHNIQUE: CT scan of the abdomen was performed without I.V. contrast material and with oral contrast material.

FINDINGS: CT scan of the abdomen demonstrates that the hepatic parenchyma appears unremarkable. The spleen appears normal. The kidneys and adrenals appear to be unremarkable. The pancreas appears to be normal. The bowel gas pattern is non-diagnostic.

IMPRESSION:

1. Normal CT scan of the abdomen with oral contrast material. I.V. contrast material was not administered.

h2

G. Paul Forsyth, MD
Radiologist

GPF/dag

(714)

9

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

The patient is a 48-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for complete physical exam. The patient notes that she is continuing to have a moderate amount of neck discomfort, which somewhat radiates into her left shoulder. This all occurred after a chart from the hospital dropped on her shoulder region. She has undergone physical therapy with very little in the way of improvement. She otherwise has no major complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995

ALLERGIES:

1. Tetanus caused severe edema and induration with pain
2. CT dye gave her hives and palpitations.
3. PPD caused hives and palpitations as well.

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Mobic 7.5mg bid
4. Baby aspirin daily
5. Occasional Tylenol.
6. Skelaxin and Flexeril prn
7. Aciphex 20mg q day
8. Humibid LA bid

SOCIAL HISTORY: The patient does not smoke, nor does she use alcohol. She is not married and has no children. She is not sexually active. She is originally from Gaston and lived in Charleston but has been in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Richland Memorial Hospital and does note a moderate amount of stress.

(7/5)

10

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03

PAGE 2 of 3

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90. She had diabetes, dementia, and actually had a stroke in the end as well. She denies any significant heart disease in the family but does note hypertension and strokes. She also notes diabetes as well as breast cancer. She had a sister in her 50's that was recently diagnosed with colon cancer. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is poor. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient continues to get occasional headaches. These, if anything have somewhat improved. She has her eyes checked regularly. She does note occasional mild dysphagia but this has improved with Aciphex and is not to the point where she needs repeat dilation. She notes occasional nauseated episodes but cannot give any further details in this regards. She denies any significant palpitations as of recent and has done well on her current regimen. She notes, again, diffuse pain in her neck and shoulder region as well as her lower back. She also continues to have some problems with abdominal discomfort but has had normal CT scan of the abdomen and pelvis as of recent. She notes a lesion on her left big toe that she would like to have removed. She really has no other major complaints, other than that of moderate fatigue. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light and accommodation. Extra-ocular movements intact. Fundoscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No lymphadenopathy. No thyromegaly. No bruits.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. There are no murmurs, rubs, or gallops.

ABDOMEN: Soft, nontender, nondistended. There are positive bowel sounds in all quadrants. There is no hepatosplenomegaly or mass.

BREASTS: No palpable masses. Mild fibrocystic changes. No nipple inversion. No skin dimpling.

(716)

11

**MIDLANDS INTERNAL MEDICINE
PHYSICAL EXAMINATION**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/08/03
PAGE 3 of 3

PHYSICAL EXAMINATION: (cont.)

UROGENITAL: The patient has normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: No masses. Normal sphincter tone. Guaiac negative stool.

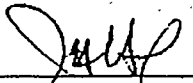
EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS: EKG was obtained and reveals a sinus bradycardia and nonspecific STT wave abnormalities, otherwise unchanged from prior tracings.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Extremely well controlled with current regimen, on Cardizem CD and Tenormin. Will continue with this regimen.
2. Reflux with overlapping stricture, status post dilation. Has improved with Aciphex. Will continue.
3. Adenomatous polyp. The patient had colonoscopy performed in May, 2002, which revealed a tubular adenoma. She will have repeat colonoscopy in two years.
4. Hoarseness. Had been a complaint. The patient went to see ENT, who basically claimed the patient had muscle tension dysphonia. She did have fiber optic exam, which basically was unremarkable. The patient was given speech therapy and Humibid LA. She claims that she was not completely satisfied with her evaluation.
5. Neck pain. Will send back to Charleston Spine Institute, which the patient has been followed there closely.
6. Chronic back pain. Again, followed by the Spine Institute. We will switch her Mobic over to Bextra, which hopefully will give her more relief.
7. Abdominal discomfort. The patient continues to have mild tenderness in the left upper and left lower quadrant, radiating to the suprapubic area. Again, there are no significant findings here. We will continue to follow. The patient was reassured in regards to a normal CT scan.
8. Lesion, left big toe. It appears that the patient has a small cyst on her left great toe tendon sheath. She was reassured.
9. Routine health maintenance. Have gotten the patient completely up to date. We will continue to follow closely.



Jeffrey D. Hook, MD

(712)

12

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/11/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for follow-up of her multiple medical problems. Since last being seen, the patient has gone to the Charleston Spine Institute and apparently has had questionable nerve block but definitely an epidural steroid injection in the neck region. She notes that this has been somewhat helpful for her. She also feels as though the Bextra has been better tolerated and has given her more relief. The patient also notes that she apparently had some Botox injections in the neck as well. She now notes that she is continuing to have problems with her left ankle. This has been somewhat long-standing and she has seen Neurology as well as Orthopedics for this. She is requesting a second opinion and has basically been set up with Dr. McBride at the University Clinics. Apparently, this ankle and foot has given her a tremendous amount of pain status post trauma and we have discussed the possibility of this perhaps being a reflex sympathetic dystrophy, even though I have told her that an orthopedist or a neurologist would need to make this absolute diagnosis. She really has no other major complaints and otherwise feels relatively well. She denies that she has had any palpitations and notes that her blood pressure has been well controlled. She has very little in the way of complaints at this time.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin and Flexeril prn
7. Aciphex 20mg q day
8. Ultram prn

(7/8)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/11/03

PAGE 2 of 2

REVIEW OF SYSTEMS: The patient notes that the hoarseness that she had evaluated by ENT has completely resolved. She was taking Humibid LA short term. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac but regular.

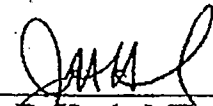
ABDOMEN: Benign.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will continue with this as the patient is asymptomatic.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex. Will continue.
3. Adenomatous polyp. The patient will have repeat colonoscopy in May of 2004.
4. Hoarseness. Completely resolved. She did use Humibid LA as needed.
5. Neck pain. Has improved with Botox injections as well as an epidural steroid injection, perhaps even a nerve block. Will follow at the Charleston Spine Institute.
6. Back pain. Again, followed by the Charleston Spine Institute. Continue Bextra and Ultram as needed.
7. Left ankle pain. Again, have encouraged her to obtain further work-up. Consider the diagnosis of reflex sympathetic dystrophy and she may actually see some improvement with Neurontin. We will hold off on this until further diagnosis is made.
8. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(719)

14

PATIENT: Gertrude Shiver
DATE OF BIRTH: 5-19-54
DATE OF VISIT: 8/14/03

This is concerning a fall.

SUBJECTIVE: Ms. Shiver is a patient of Dr. Hook's. She was at a hotel yesterday. She got up to take a break and she tripped over a chair. She caught her left foot on the chair and then she fell back on the floor. She said she hit her buttocks first and then her legs fell. She caught herself with her hands. She did not hit her head. She says she was able to get up and move around okay but as the days progress and yesterday she got progressively sore. She is just concerned. She says the Skelaxin and Ultram that she took did help her a little bit.

PHYSICAL EXAM: Weight: 185. Temp. 98.2. Pulse 76. Respiratory: 16. Blood pressure 100/74. HEENT: unremarkable. Neck: supple. Lungs: clear. Heart is S1/S2. No rubs, gallops or murmurs. Deep tendon reflexes are 2+. Peripheral pulses are 2+. Straight leg raising is negative. There is some tenderness to palpation in the lower legs especially on the left. A little bit of tenderness to palpation along the buttocks.

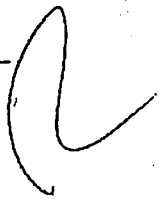
ASSESSMENT/PLAN:

1. contusions.

PLAN:

1. Reassurance.
2. She is going to continue on medication.
3. Plan on seeing her back in about a week or 10 days if she is not improved.
4. I have told her that she can try some heat and ice, that this may help.



Jean A. Massey, ANP, Ph.D. 

PPM-C/clong

(720)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for worsening back pain status post fall on 08/13/03. The patient apparently "slipped" on carpet at a conference and landed quite violently on her buttocks. She claims that since that time, she has had a moderate amount of low back pain. She claims that she has recently begun to feel a "pop" in her back with torsion of the trunk and at times will feel a radiating pain down into her left lower extremity. She has had disc problems in the past and has been evaluated by The Spine Clinic in Charleston. She has had numerous falls and various traumas in the past and seems to be somewhat inclined to get injured relatively easily. She has gone through numerous Workman's Comp cases and again has a very low threshold for pain. She denies any change in her bowel or bladder and denies any lower extremity weakness or numbness. She has gone to The Brace and Boot Shop and she has had a back brace made for her, which she claims has helped. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day

REVIEW OF SYSTEMS: See History of Present Illness. The patient denies any palpitations, etc. All other systems reviewed at this time and negative.

(721)

16

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac and regular.

ABDOMEN: Benign.

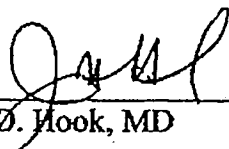
BACK: No significant spinous process tenderness. Straight leg raise is positive on the left.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Back pain status post fall. At this time, we will treat the patient with a Medrol dose pack. She may have a small herniated disc. If she sees no improvement, will obtain lumbosacral spine films, even though she has had numerous films performed in the past and has actually had an MRI of the lumbosacral spine within the year. We will follow closely. The patient was also given a few Lortab to take in place of her Ultram if absolutely needed. She was given Lortab 5mg, 50 with no refills. She can continue with Skelaxin and was encouraged to continue her back strengthening exercises.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex.
3. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will follow.
4. Left ankle pain. Will be seeing Dr. McBride. Again, it is felt that she may have a reflex sympathetic dystrophy.
5. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(722)

17

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 0321756

GERTRUDE SHIVER,

Employee,

Claimant,

vs.

PALMETTO HEALTH RICHLAND,

Employer,

AND

KEY RISK MANAGEMENT SERVICES,
INC.,

Carrier,

Defendants.

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

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
GERTRUDE SHIVER, CLAIMANT:

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:

NAME OF PROVIDER/OTHER	DATE(S) OF RECORD(S)	PAGE NUMBER(S)
1. ImageCare	8/17/04	1
2. Palmetto Health Richland Radiology	4/21/06	2
3. Center for Paint Management – Drs. Thomas	2/04/05 – 4/25/05	3 – 11

1
(723)

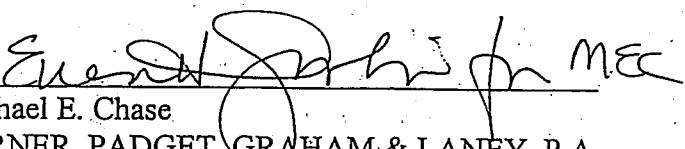
4. Palmetto Health Richland Emergency Room	10/24/03	12 – 16
5. Charleston Spine & Physical Medicine – Gregory M.. Jones, M.D.	4/23/04 – 7/07/04	17 – 22
6. The Center for Pain Control – Dr. Brandt	11/15/05 – 3/22/06	23 – 32
7. Jeffrey Hook, M.D.	8/14/03 – 4/21/06	33 – 62
8. Employee Occurrence Report	10/23/03	63
9. Correspondence from Claimant	3/2/04 – 12/17/06	64 – 109
10. Claimant's Deposition Responses	8/8/06	1 – 161

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: Defendants may call Libby Holland, Debbie Maslow, or Sandy Sullivan in rebuttal, if necessary.

(724)


Michael E. Chase
TURNER, PADGET, GRAHAM & LANEY, P.A.
17th Floor, 1901 Main Street
P. O. Box 1473
Columbia, SC 29202
Telephone: (803) 254-2200
Facsimile: (803) 799-3957
ATTORNEYS FOR THE EMPLOYER/CARRIER

Columbia, South Carolina

August 24, 2007

(725)

8/16
ImageCare, LLC-CPG
710 Rabon Rd
Columbia 29203
Phone: (803)462-3680

Name:	Gertrude Shiver #71705	Exam Date:	8/17/2004
Patient ID:	1000021995	Exam:	Ribs (unilateral)
DOB:	5/19/1954	Reason:	786.50 - PAIN, RIB
Phone:	(803)353-3892	Referrer:	JEFF HOOK-CPG
Acc#:	42610	2nd Referrer:	

Results

DATE EXAM PERFORMED: 8-16-04

HISTORY: Fall.

FINDINGS: AP and oblique views of the left ribs were submitted for interpretation. The left thorax appears to be intact with no evidence of acute fracture.

Steve Glassman, MD

Transcribed By:	Dee Dee Martin	Pt. Name:	Gertrude Shiver #71705
Transcribed Date:	8/18/2004	Patient ID:	1000021995
Interpreting Rad:	Steve Glassman, MD	Exam:	Ribs (unilateral)
Finalized Date:	8/18/2004	Acc:	42610

no lly rib films
normal. No old or
acute frx seen. No
other lesions noted

✓ Pro AM
x Home
JH

DD

08/18/04

(dict 8/18)

9-18-04

(726)

4/21

PALMETTO HEALTH

Palmetto Health Richland
5 Richland Medical Park
Columbia, SC 29203

Patient Name: SHIVER, GERTRUDE
Patient Address: 1026 CONGAREE CHURCH ROAD
GADSDEN, SOUTH CAROLINA 29052
Patient Telephone: (803) 353-3892

Hook MD, Jeffery D
3000 NE MEDICAL PARK
SUITE 108
COLUMBIA, SC 29223

Date of Birth: 5/19/1954
SSN: 249-98-2546
Medical Record Number: R009952117
Account Number: R0611101072
Location: , Patient Type: OQR-Outpatient Quick Reg
Room Number:
Ordering Physician: Hook MD, Jeffery D
CC:

RADIOLOGY SERVICES

Exam:	Exam Date/Time:	Accession Number:	Ordering Physician:
CR Ribs Unilateral Left W/ PA Chest	4/21/2006 1:04:32 PM	CR-06-060418	Hook MD, Jeffery D

Reason for Exam:

RIB / CHEST PAIN

Findings:

LEFT RIBS:

CLINICAL HISTORY: LEFT RIB AND CHEST PAIN.

FOUR VIEWS.

COMPARISON: CHEST RADIOGRAPH OF 10-24-03.

No fractures are identified. No evidence of infiltrates or effusions are identified. No evidence of a pneumothorax is noted. The heart is borderline in size.

CONCLUSIONS:

Patient Name : SHIVER, GERTRUDE

Chart ID: 3812212

Page 1 of 1

PHR RadNet Ordering Physician
Hardcopy and Fax
Print Date/Time: 4/21/2006 4:10 PM

(727)

PALMETTO HEALTH

THE CENTER FOR PAIN MANAGEMENT

PATIENT: Gertrude Shiver

PHYSICIAN: Thomas E. Brandt, Jr., D.O.

DATE: February 4, 2005

MEDICAL RECORD #: 521249

SHIVER, GERTRUDE

0503400249

MR 000521249 BRANDT, THOMAS E JR

05/19/54 50Y F



cc: CHS, Blanding Street
Jeffrey Hook, M.D.

PAIN HISTORY: This 50-year-old right-handed African American female presents with pain in her left chest wall. Onset of pain, October 2003, following a fall injury. She states on 10/23/03, she was working in the Medical Records Department of Palmetto Health Richland when she became entangled in a telephone cord, causing her to fall directly onto a concrete floor, striking the left chest area and both of her hands, while she was trying to break her fall. She states she became very nauseated following the injury, and was initially told to take some ice to help her nausea. She continued to have severe pain and later that afternoon, another supervisor returned, and told her to report to the emergency room. She was seen at Palmetto Health Richland emergency room and underwent x-rays, and was told to follow-up with Dr. Hook, her primary care physician. The patient was treated conservatively with medication, but continued to have a significant amount of pain. The patient underwent a second x-ray, which was also unremarkable, and has not responded well to any conservative measures. The patient describes pain as a constant ache that will increase when the area is palpated. She denies any burning, but she does sting at times, which is an intermittent pain, but denies any numbness. Pain starts under the axilla, radiates around under the breast, and also can cross into the spine. She has been seen by Dr. Gregory M. Jones in Charleston and has undergone apparently cervical facet injections as well as Botox injections for her neck, but her thoracic area has never been treated. The patient has also received attention to the lower lumbar area.

PAIN DESCRIPTION: Musculoskeletal. Neurogenic. The patient does not display any symptoms of dramatization or exaggeration. She denies being nervous, depressed, anxious, or irritable. She does suffer from a sleep disturbance, only sleeping 4-6 hours per night. The patient's appetite and weight are stable. She is not dieting. She has knowledge of pain language. Current VAS score is a 3, best score being a 0, worst score being a 5. **RELIEVING FACTORS:** Pain medications. **AGGRAVATING FACTORS:** Lifting heavy objects will increase her pain.

ONSET OF PAIN: 10/23/03, when involved in a fall injury at work. This is a work-related injury and third party liability is involved.

HABITS: The patient denies use or abuse of alcohol, tobacco, or illicit drugs.

ALLERGIES: PPD; TETANUS, causing tachycardia and itching, while **RADIOPAQUE DYE** caused seizures. The patient does use anticoagulant medication, i.e., aspirin, but denies any easy bruisability.

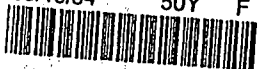
CURRENT MEDICATIONS: Lortab 5 mg p.r.n., Ultram 50 mg 1-2 q.6h., Bextra 20 mg q.d., Cardizem CD 20 mg q.d., Tenormin 25 mg q.d., Aciphex 20 mg q.a.m., Skelaxin 800 mg p.o. p.r.n., and aspirin 81 mg q.d.

PAST MEDICAL HISTORY: Significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with esophageal stricture, requiring bouginage, i.e., dilatation x 2.

PAST SURGICAL HISTORY: Significant for breast reduction in the past.

PATIENT:
PHYSICIAN:
DATE:
MEDICAL RECORD #:
Page 2

Gertrude Shiver
Thomas E. Brandt, Jr., D.O.
February 4, 2005
521249

SHIVER, GERTRUDE
0503400249
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F


REVIEW OF SYSTEMS: All systems reviewed. **CONSTITUTIONAL:** Positive for chills. No fevers, history of swollen lymph nodes, or weight loss. **EYES:** No pink or red eyes, history of conjunctivitis, blurred vision, dry eyes, blind spots, or tender scalp. **EARS, NOSE, MOUTH, AND THROAT:** No dry mouth, changes in sense of smell or taste, tinnitus, decreased hearing acuity, epistaxis, sinusitis, sore throat, or hoarseness. **CARDIOVASCULAR:** History of palpitations. No chest pain, shortness of breath, history of orthopnea greater than 1 pillow, paroxysmal nocturnal dyspnea, or diaphoresis. **RESPIRATORY:** No cough, wheeze, shortness of breath, or dyspnea. **GASTROINTESTINAL:** Positive for nausea, vomiting, and diarrhea, as well as constipation. No abdominal burning, loss of appetite, melena, hematochezia, difficulty swallowing, diarrhea lasting longer than two weeks, or history of jaundice. **GENITOURINARY:** No history of pain with urination, urinary frequency, hematuria, swelling in feet and ankles, urinary urgency, or dysuria. **INTEGUMENTARY:** Positive for itching. **NEUROLOGIC:** Positive for syncopal episode in the past. No seizures, convulsions, near syncopal episodes, history of strokes, perceptions of strange tastes or odors, difficulty initiating movement, localized numbness, tingling, or tremor. **ENDOCRINE:** No history of diabetes, high blood sugars, glucose in the urine, thyroid disease, osteoporosis, goiter, history of heat intolerance, or hot flashes. **PSYCHIATRIC:** No history of hallucinations, suicidal ideations or attempts. **HEMATOLOGIC/LYMPHATIC:** No history of anemia, easy bruisability or bleeding, or swollen lymph nodes. **ALLERGIC/IMMUNOLOGIC:** No history of hay fever, recurrent infections, or asthma.

FAMILY HISTORY: Significant for history of colon cancer in her sister; stroke in her father and mother, both now deceased. Hypertension, herself, sister, brothers, and parents. Arthritis in mother and father. Her mother, sister, and brothers all had diabetes mellitus.

SOCIAL PROFILE: This is a 50-year-old African American female, single, with no children.

EDUCATIONAL BACKGROUND: She has a bachelor's degree.

EMPLOYMENT HISTORY: She works as a Medical Director at Palmetto Health Richland. She has had her present job for four years and currently is working.

SOCIAL ACTIVITY: Unsatisfactory. She stays by herself.

SEXUAL ACTIVITY: She is inactive, and that is satisfactory.

MAJOR SUPPORT SYSTEMS: She has no real support systems. She does not talk to her family and will not discuss this issue, nor does she have any friends or consider church a support system. Estimated uptime in a 24 hour period: 12 hours per day. There has been no change in salary since the onset of her pain. **PREVIOUS TREATMENTS:** Include physical therapy. No occupational therapy, behavior medicine, chiropractic, or massage.

SPIRITUALITY: The patient was raised in the Baptist faith, which she continues to practice. She is active. She finds comfort in her faith, and her prayers do help.

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: This is a very pleasant 50-year-old African American female who is in no acute distress. She is alert and oriented x 3.

VITALS: Blood pressure 125/73. Pulse 67. Respirations 20. Height 5 feet 3.5 inches. Weight 200 pounds.

HEAD: Normocephalic, nontraumatic.

NECK: No masses, tenderness, or carotid bruits noted. Trachea midline.

EYES: Pupils equal, round, reactive to light and accommodation. Extraocular muscles are intact. Funduscopy evaluation reveals no hemorrhage or exudates.

EARS: External and auditory canals are bilaterally patent. Tympanic membranes are intact without bulge, retraction, or erythema.

779

PATIENT: Gertrude Shiver
PHYSICIAN: Thomas E. Brandt, Jr., D.O.
DATE: February 4, 2005
MEDICAL RECORD #: 521249
Page 3

SHIVER, GERTRUDE
0503400249
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F


PHYSICAL EXAMINATION (cont):

NOSE: No septal deviation noted.

THROAT: Teeth in good repair. Uvula is midline. Posterior pharynx without erythema or exudate.

HEART: Regular without murmur.

LUNGS: Bilaterally clear to auscultation.

ABDOMEN: Soft, bowel sounds are x 4, nontender to palpation.

EXTREMITIES: Present x 4. Peripheral pulses are intact, with the left foot being somewhat cold and shiny in appearance, but, once again, peripheral pulses are intact.

SKIN: No erythemas or ecchymoses noted.

NEUROLOGIC EVALUATION: Deep tendon reflexes are noted to be +2/4 bilaterally with biceps, triceps, brachioradialis, patellar, and Achilles. Babinski is absent. Decreased cutaneous sensation is noted on the left from T7 to L1 with both alcohol wipe and pinprick. No trophic or motor function changes are noted. Muscle strength is assessed and found to be 4-5/5 bilaterally with grip strength, triceps, and biceps, as well as dorsiflexion, plantar extension, quadriceps and hamstrings.

STRAIGHT LEG RAISING: 90 degrees bilaterally, sitting.

MUSCULOSKELETAL REVIEW: Ambulation, slow and antalgic gait, flatfooted gait with slight footdrag. Positive heel and toe walk causing left ankle pain and heel pain. Standing balance is within normal limits. Active and Passive Range of Motion: Cervical spine adequate. Thoracic spine adequate. Lumbar flexion to 90 degrees, extension to 20 degrees. Side bending and rotation adequate. No gross postural or vertebral column defects are noted. No limb defects are noted.

TRIGGER POINTS AND ZONES: Positive tenderness over the left midaxillary line over the rib margins from T6, T7, T8, and T9. No allodynia or hyperalgesia is noted over the chest wall.

OBJECTIVE DATA: Beck's Depression Inventory Score: Noted to be 9/10, indicating no significant depression.

ASSESSMENT/DIAGNOSES:

1. Left chest wall pain, etiology unclear. Intercostal neuralgia versus discogenic process.
2. Multiple somatic complaints. Currently being treated by another physician, i.e., Dr. Jones in Charleston, South Carolina.

The patient made an Emory Classification II, (indicating low pathology/low behavior).

PLAN OF MANAGEMENT:

1. MRI of the thoracic spine.
2. Possible thoracic epidural steroid injection.
3. Possible intercostal nerve blocks.
4. Possible neurosurgical assessment.
5. Will start Gabitril 2 mg 1 p.o. q.h.s. x 10 d., then increase to 4 mg q.h.s. Patient was explained off-label usage.
6. Will consider Arthrotec 75 mg 1 p.o. b.i.d. to be taken with food.
7. Will start Lidoderm patch, apply q.12h. on, q.12h. off, over area of pain.
8. Will assess patient for chest wall pain symptoms. Other pain complaints will be deferred to the other physician in Charleston at this juncture, and narcotic analgesics will be deferred to this physician at this time.
9. Will reassess patient in three to four weeks.

Total face-to-face contact with patient: 59 minutes.



Palmetto Imaging

THE CENTER AT LADY & MARION

PATIENT: Shiver, Gertrude
MRN: 348937
DATE OF BIRTH: 5/19/1954
REF PHYSICIAN: Thomas Brandt, MD
DATE OF EXAM: 2/15/2005
PATIENT PH#: 803-353-3892

MRI OF THE THORACIC SPINE

HISTORY: Left rib and breast area pain.

TECHNIQUE: The following sequences were obtained using a Siemens 0.2 Tesla open viba: Sagittal T1, sagittal proton density and T2, and axial T1.

FINDINGS: The vertebral bodies are of normal height and position. The marrow signal of the visualized vertebral bodies appears normal. The thoracic cord appears normal. Specifically, there is no evidence of cord compression, injury, or gliosis.

There is a small anterior osteophyte seen at T11-12. There is disc desiccation at T10-11 and T3-4. There is no significant posterior disc bulge. No focal disc herniations are seen. No soft tissue paraspinal masses are seen.

CONCLUSION:

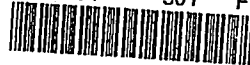
1. Mild degenerative disc disease.

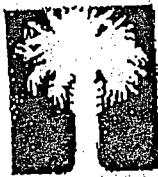
Robin Daum-Kowalski, MD
Radiologist

RD/bl

This document has been electronically reviewed and signed.

SHIVER, GERTRUDE
0505600363
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F





Palmetto Imaging

THE CENTER AT LADY & MARION

PATIENT: Shiver, Gertrude
 MRN: 348937
 DATE OF BIRTH: 5/19/1954
 REF PHYSICIAN: Thomas Brandt, MD
 DATE OF EXAM: 2/15/2005
 PATIENT PH#: 803-353-3892

MRI OF THE THORACIC SPINE

HISTORY: Left rib and breast area pain.

TECHNIQUE: The following sequences were obtained using a Siemens 0.2 Tesla open viva: Sagittal T1, sagittal proton density and T2, and axial T1.

FINDINGS: The vertebral bodies are of normal height and position. The marrow signal of the visualized vertebral bodies appears normal. The thoracic cord appears normal. Specifically, there is no evidence of cord compression, injury, or gliosis.

There is a small anterior osteophyte seen at T11-12. There is disc desiccation at T10-11 and T3-4. There is no significant posterior disc bulge. No focal disc herniations are seen. No soft tissue paraspinal masses are seen.

CONCLUSION:

1. Mild degenerative disc disease.

Robin Daum-Kowalski, MD
 Radiologist

RD/bl

This document has been electronically reviewed and signed.

(732)



THE CENTER FOR PAIN MANAGEMENT

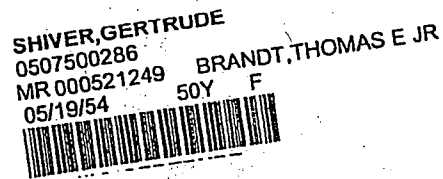
PATIENT: Gertrude Shiver

PHYSICIAN: Thomas E. Brandt, Jr., D.O.

DATE: March 2, 2005

MEDICAL RECORD #: 521249

cc: CHS, Blanding Street
Jeffrey Hook, M.D.



PAIN HISTORY: The patient presents to the Center for Pain Management today for evaluation and treatment. The patient continues to have pain in her left chest wall. She states that her MRI results are back. She states the Gabitril has helped decrease the burn and actually improve her sleep, but she continues to have throbbing, aching pain in her left chest wall, as well as pain over her left breast area. She states the Lidoderm patch will not stay on during the daytime, as any movement over the chest site will actually cause the patch to detach itself.

PHYSICAL EXAMINATION: Blood pressure 136/84. Pulse 66. Respirations 18. Temperature 98.1 degrees. VAS score is a 6.

HEART: Regular without murmur.

LUNGS: Bilaterally clear to auscultation.

ABDOMEN: Soft, bowel sounds are x 4, nontender to palpation.

NEUROLOGIC EVALUATION: Deep tendon reflexes are noted to be +2/4 bilaterally with biceps, triceps, and brachioradialis, patellar, and Achilles. Muscle strength is assessed and found to be 5/5 with grip strength, triceps, and biceps, as well as dorsiflexion and plantar extension. Positive hyperalgesia is noted over the dorsal rib margins at T4, T5, T6, and T7. No elevated or depressed rib lesions are present. No allodynia or hyperalgesia is noted over the chest wall region.

ASSESSMENT/DIAGNOSIS: Left chest wall pain, etiology unclear. MRI negative for any discogenic disease. Apparent intercostal neuralgia pain state, etiology unclear.

PLAN OF MANAGEMENT:

1. Will schedule intercostal nerve blocks on the left at T3 to T8.
2. Will continue current dosing of Gabitril.
3. Ativan premed has been dispensed.
4. Will consider Yamamoto new scalp acupuncture in the future.

Total face-to-face contact with patient: Slightly over 15 minutes, with greater than 50% of this time spent counseling patient on current pain syndrome, the use of Gabitril, once again, for off-label use of decreasing dysesthesia, which has been very effective for her, as well as improving pre-REM sleep.

Thomas E. Brandt, Jr., D.O.
TEB/sdm-3/7/05

(733)

PALMETTO HEALTH



THE CENTER FOR PAIN MANAGEMENT

PATIENT: Gertrude Shiver

PHYSICIAN: Thomas E. Brandt, Jr., D.O.

DATE: March 21, 2005

MEDICAL RECORD #: 521249

SHIVER, GERTRUDE
0507500286
MR 000521249 BRANDT, THOMAS E JR
05/19/54 50Y F


cc: CHS, Blanding Street
Jeffrey Hook, M.D.

PAIN HISTORY: The patient presents to the Center for Pain Management today with continued left chest wall pain secondary to intercostal neuralgia. The patient presents today for scheduled intercostal nerve blocks at the levels of T3, T4, T5, T6, T7, and T8 on the left.

RISK ASSESSMENT: The risks, benefits, and alternatives to intercostal nerve blocks were discussed with the patient at length. She understands and wishes to proceed. Signed informed consent was obtained. Ativan premed dispensed.

PRE-BLOCK DIAGNOSIS: Left chest wall pain, left intercostal neuralgia at multiple sites.

POST-BLOCK DIAGNOSIS: Same.

ANESTHESIA: None.

PROCEDURE: The patient was taken to the treatment room and placed in a right lateral decubitus position. The rib margins were identified and marked dorsally at T3 to T8 on the left. Using clean technique and ethyl chloride for topical anesthesia, a total of 0.5 ml of 1% lidocaine was injected at each site, following retraction of the skin. Sterile prep and drapes were then applied. Using a #23 gauge 1.5 inch needle placed in a walking-off technique over the intercostal nerves, following negative aspiration for heme, a total of 3 ml of a mixture of 18 ml of 0.25% bupivacaine and 60 mg of methylprednisolone was injected, following negative aspiration every 1 ml. The patient tolerated the procedure well. Pre-block blood pressure 126/80. Pulse 80. Respirations 16. Temperature 98.1 degrees. VAS score was a 5 to a 6. Post-block blood pressure 112/84. Pulse 79. Respirations 16. SpO2 on room air, 97%. Breath sounds were bilateral and equal both pre and post-blockade.

DISPOSITION: Will reassess patient in four weeks.

Thomas E. Brandt, Jr. D.O.
TEB/sdm-3/25/05

(734)

**PALMETTO HEALTH
THE CENTER FOR PAIN MANAGEMENT**

NAME: Shiver, Gertrude

RECORD NO: 521249

Date: 4-25-05

ACCOUNT #: 0511001927

CHIEF COMPLAINT: Left chest wall pain.

SHIVER, GERTRUDE
0511001927
MR 000521249 ZGLESZEWSKI, TIMOTHY
05/19/54 50Y F


HISTORY : Gertrude Shiver is a 50-year-old female who is a patient of Dr. Branson being treated for left chest wall pain and left intercostal neuralgia. She is currently on Gabitril by Dr. Brandt and that is doing a fairly good job at controlling her symptomatology. She underwent some recent left intercostal nerve blocks that she said gave her about two weeks worth of significant relief. At this point in time, her pain has returned. It is 5/10 on the pain scale. It is in the left chest wall and lateral thorax. She is reporting no new symptomatology. No new fevers, chills, or drainage from the procedure site since the injection. She also is taking Lortab or Ultram prescribed by Dr. Hook. She reports no other new pain symptomatology. No new side effects from the medicines.

CURRENT MEDICATIONS: As per the New Patient Questionnaire filled out today as well as the history.

ALLERGIES: PPD, TETANUS TOXOID, AND CT DYE.

PAST MEDICAL HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

PAST SURGICAL HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

SOCIAL HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

FAMILY HISTORY: As per the New Patient Questionnaire filled out today as well as the history.

REVIEW OF SYSTEMS: As per the New Patient Questionnaire filled out today as well as the history.

PHYSICAL EXAMINATION: Blood pressure 141/85. Heart rate 80. Respirations 16. VAS is 10 /10.

GENERAL APPEARANCE: Physical examination reveals a well-developed, well-nourished female in a minimal to moderate amount of discomfort. Grooming, nutrition, and a body habitus are normal for her age. She is alert and oriented to time, place, and person with normal mood and affect.

Gait and station are not antalgic. Inspection of the left thorax reveals a well-healed thoracotomy incision. There are no skin lesions present. No signs of infection from prior procedure site.

Neurologic examination of the upper extremities is intact, including motor strength and sensation.

DIAGNOSTIC TESTING: Medical-records from Dr. Brandt are reviewed today.

An MRI of the thoracic spine demonstrates mild degenerative changes at T11-12 and T10-11, T3-4. There is no significant disk herniations or protrusions.

PALMETTO HEALTH
THE CENTER FOR PAIN MANAGEMENT

NAME: Shiver, Gertrude

RECORD NO: 521249
ACCOUNT #: 0511001927

continued - page 2

DIAGNOSES: Left intercostal neuralgias.

PLAN: Gertrude Shiver is going to continue on her Gabitril prescribed by Dr. Brandt. She was given 4 mg tablets #30 to be taken at bedtime. She was given two refills. She will follow up with Dr. Brandt as soon as his office opens up. Other than that, no changes in her treatment plan at this time. She was told that Dr. Brandt will most likely want a repeat the intercostal nerve blocks when he sees her back in followup, but was informed that I do not perform that type of nerve block.

Timothy Zgleszewski, MD/hs
D: 04/25/2005 11:50 A T: 04/26/2005 11:55 A
Job#: 000303855 HS Job#: «HS_Job_ID» Doc #: 534047
CC:

SHIVER, GERTRUDE
0511001927
MR 000521249 ZGLESZEWSKI, TIMOTHY
05/19/54 50Y F


(736)



EMERGENCY DEPARTMENT RECORD

FIVE RICHLAND MEDICAL PARK

COLUMBIA, S.C. 29203

UNIT NUMBER	DATE	TIME	BIRTH DATE	AGE	NAME	SEX	DOB	PHYSICIAN	
009862117	10/24/03	00:49	05/19/54	49Y	LUCY	F	8 B	ERR0329700191	
NAME ADDRESS	NIGHT PHONE (CITY, ST, ZIP)		PHYSICIAN DATA		ADMIT BY		ACCIDENT DATE AND TIME		
SHIVER, GERTRUDE 1028 CONGAREE CHURCH ROAD GADSDEN SC 29052	(803)353-3892 249-98-2548		PALMETTO RICHLAND WORKERS REGULAR PHYSICIAN		JMM		10/23/03 20:00		
ADMITTING PHYSICIAN	PHYSICIAN		EMERGENCY PHYSICIAN		EMERGENCY PHYSICIAN		EMERGENCY PHYSICIAN		
SHIVER, GERTRUDE 1028 CONGAREE CHURCH ROAD GADSDEN SC 29052	249-98-2548 (803)353-3892		Q		MODE OF ARRIVAL: SELF DRIVEN		VALUABLES: ☐ YES ☐ NO WHERE?		
BELONGINGS: ☐ HOME ☐ WITH PATIENT ☐ OTHER		DATE OF LAST VISIT		LAST TETANUS		TIME TO TREATMENT		TIME TO TREATMENT	
09/08/03									

CHIEF COMPLAINT	FALL	DATE OF LAST VISIT	09/08/03	LAST TETANUS	TIME TO TREATMENT
VITAL SIGNS	TEMP 98.6	ORAL PULSE 72	RECTAL PULSE 72	BLOOD PRESSURE 110/70	PULSE OX 98
VITAL SIGNS	TEMP 98.6	ORAL PULSE 72	RECTAL PULSE 72	BLOOD PRESSURE 110/70	PULSE OX 98
HISTORY	Patient reports tripping on a phonocall and fell on both knees and caught herself on her wrist/hands & arm (B) knee pain & low back pain & left body pain.				

ROS	CVR / D / C / HA / Chills	REST OF ROS	None
FE	DM, CVA	HT	Tobacco, Diet, works in medical records @ PRM
PMH / MEDS	HTN, GERD, herniated disk	HTN	lisin, cardizem, acetaminophen, vitamin, tylenol
PHYSICAL	General - Alert, wt, pleasant	HEENT	no / no, no, no, no
	Neck - supple	Chest	clear - no wheezes
	Abd - soft, no tenderness	Ext	no edema
	Neuro - no focal deficits	Gen	no
CLINICAL IMPRESSION	① Acute minor knee, wrist, and low back pain		

TREATMENT:	600mg Motrin / 5mg Valium p.o.
------------	--------------------------------

DISPOSITION / SPECIAL PATIENT INSTRUCTIONS	① Discharge to home ② Return for pain ③ Return for wound ④ Follow up if no better in 1 week
--	---

PRESENT AND REVIEWED WITH RESIDENT	DATE	TIME	WENT TO PRUDENT LAYPERSON
ADMIT ROOM	1-504		☐ YES ☐ NO

(737)

* Final Report *

Result Type: CR Wrist 3 Views Minimum Left
Result Date: 24 October 2003 2:41
Result Status: Auth (Verified)
Verified By: Bayard MD, Walter J on 24 October 2003 14:37
Encounter info: Richland, ERR-Emergency Room, 10/24/2003 - 10/24/2003

*** Final Report ***

Reason For Exam
719.43-JOINT PAIN-FOREARM

Impression:
LEFT WRIST FOUR VIEWS: 10/24/03 0256 HOURS

CLINICAL HISTORY: Blunt trauma. The patient complains of wrist pain.

AP, lateral, oblique and navicular views are submitted for interpretation.

Soft tissues are normal. No evidence of fracture or dislocation is appreciated.

IMPRESSION:

NORMAL.

Signature Line
*** Final ***

Read by: Bayard MD, Walter J
Released By: Walter J. Bayard
on: 10/24/2003 14:37

Transcriptionist: HJO
Trans Date/Time: 10/24/2003 14:09
Technologist: Mcfarland, Kelly L, Bouknight, Traci L

Completed Action List:

- * Perform by Wooten, Kelly L on 24 October 2003 2:41
- * Assist by Bouknight, Traci L on 24 October 2003 2:41

Printed by: Maslow RN, Debra H
Printed on: 3/9/2006 8:12

Page 1 of 2
(Continued)

(738)

* Final Report *

Result Type: CR Chest 2 Views PA + Lateral
Result Date: 24 October 2003 2:40
Result Status: Auth (Verified)
Verified By: Bayard MD, Walter J on 24 October 2003 14:37
Encounter info: Richland, ERR-Emergency Room, 10/24/2003 - 10/24/2003

* Final Report *

Reason For Exam
786.50-CHEST PAIN NOS

Impression:
CHEST, TWO VIEWS 10/24/2003

CLINICAL HISTORY: Blunt trauma. The patient complains of chest wall pain.

PA and lateral views reveal the lungs to be normally expanded and clear. The cardiomediastinal silhouette is normal. No pleural abnormalities are identified.

IMPRESSION:

NORMAL.

Signature Line

*** Final ***

Read by: Bayard MD, Walter J
Released By: Walter J. Bayard
on: 10/24/2003 14:37

Transcriptionist: SDH

Trans Date/Time: 10/24/2003 14:10

Technologist: Mcfarland, Kelly L, Bouknight, Traci L

Completed Action List:

- * Perform by Wooten, Kelly L on 24 October 2003 2:40
- * Assist by Bouknight, Traci L on 24 October 2003 2:40
- * VERIFY by Bayard MD, Walter J on 24 October 2003 14:37

Printed by: Maslow RN, Debra H
Printed on: 3/9/2006 8:12

Page 1 of 2
(Continued)

(739)

Result Details

Patient: SHIVER, GERTRUDE
MRN: R009952117

Printed by: Maslow RN, Debra H
Printed on: 3/9/2006 8:13

Chief Complaint: tripped on phone cord while working, c/o left side pain along with nausea; also c/o left arm, wrist and bilateral knee pain; denies hitting her head

Date / Time: 24 October 2003 1:08

LMP Date: 10/1/2003 0:00

Triage Date/Time: 10/24/2003 1:08

Mode of Arrival: Ambulatory

Chief Complaint: tripped on phone cord while working, c/o left side pain along with nausea; also c/o left arm, wrist and bilateral knee pain; denies hitting her head

Patient Pregnant?: No

Temperature Route: Oral

Pulse Rate: 70 bpm
Normal Low: 60

Respiratory Rate: 20 bpm
No Reference Range Found

NIBP Systolic: 111 mmHg
No Reference Range Found

NIBP Diastolic: 74 mmHg
No Reference Range Found

ED Pain Screen: Yes

Chronic Conditions: Hypertension

Last Tetanus Date: < 5 years

Immunization Up To Date: Yes

Influenza Vaccination Up to Date: Unknown

Pneumovax Vaccination Up to Date: Unknown

Latex Allergy Screen: Open Screen

Communication Barriers: None evident

Allergies: ct contrast, sulfa, Td

Private Physician: hooks

Private Physician Called in ED?: Wants EMS to see

ED Triage Nurse: Wells, Kelley H

Acuity: 1

Result Details

Patient: SHIVER, GERTRUDE
MRN: R009952117

Printed by: Maslow RN, Debra H
Printed on: 3/9/2006 8:13

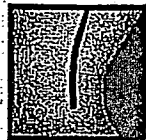
Contributor System: PowerChart
Status: Auth (Verified)

Action List:

VERIFY by Wells, Kelley H on 24 October 2003 1:08
Action status: Completed

Perform by Wells, Kelley H on 24 October 2003 1:08
Action status: Completed

(741)



Charleston Spine & Physical Medicine, PA

Gregory M. Jones, M.D.
1930 Charlie Hall Boulevard
Charleston, South Carolina 29414
Office (843) 402-0111
FAX (843) 402-9010
Toll Free (800) 393-7008

PT # 4559

SSN 249-98-2546

NAME Last Shiver First Gertie MI _____ Nickname _____
Address 1026 Congaree Church Rd City Columbia State SC ZIP 29052
Home Phone (803) 353-3892 Work Phone (803) 434-2045 Cell Phone/Beeper _____
DATE OF BIRTH 5/19/54 AGE 49 SEX F Marital Status S
In case of emergency contact William T. Shiver Relationship brother Telephone (803) 353-0598
Primary physician: Dr. Jeffery D. Hook
Occupation Medical Records Specialist Employer Pulmetto Health Richland
Employer's Address Smalwood Park City Columbia State SC ZIP _____
Is an attorney involved? NO Name of attorney _____ Telephone _____
Was injury the result of an accident? yes What type? Had 2 falls Date of injury 8-13-03
Was injury work-related? The second fall The first fall aggravated my back

PRIMARY INSURANCE	SECONDARY INSURANCE	WORKERS' COMPENSATION
Company <u>Companion Health Care</u>	Company _____	Carrier _____
Address <u>P.O. Box 6170</u>	Address _____	_____
City <u>Columbia</u>	City _____	Contact _____
State/ZIP <u>SC 29260-6170</u>	State/ZIP _____	Address _____
Policy Holder _____	Policy Holder _____	_____
Policy # <u>241 249 98 2546</u> Group # <u>Pulmetto Health</u>	Policy # _____ Group # _____	_____
Phone # <u>1-800-868-2528</u>	Phone # _____	Phone # _____
Fax# _____	Fax # _____	Fax # _____

INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS / PATIENT-PHYSICIAN RELATIONSHIP

To ensure that Charleston Spine is able to comply with DEA/DHEC regulations I agree to inform the physicians of this practice of any scheduled narcotic medications that other providers have prescribed, or do prescribe while under the care of Charleston Spine. I authorize the physicians of Charleston Spine & Physical Medicine to render reasonable and proper medical care by today's standards.

I hereby authorize Charleston Spine & Physical Medicine, P. A. to furnish information to insurance carriers concerning my illness and/or treatment and hereby assign to the physician all payment(s) for medical services rendered to myself or my dependents. I understand that Charleston Spine & Physical Medicine files all insurance as a courtesy to the patient only, that I am responsible for any balance not covered by insurance, and for any charges incurred unless a third party payor has been authorized in advance. I authorize Charleston Spine and Physical Medicine, P.A. to file for claims, or request letters of protection from my attorney to cover expenses following settlement if this is appropriate.

I AUTHORIZE RELEASE OF ALL OF MY MEDICAL RECORDS TO CHARLESTON SPINE & PHYSICAL MEDICINE, P. A.

A photostatic copy of this authorization shall be considered as valid and effective as the original. This authorization is valid until revoked by me in writing. I understand there may be a charge for preparation of this information and agree that these charges may be included in invoices for services by the physician. I authorize the staff of Charleston Spine & Physical Medicine to release my records to other physicians, laboratories or hospitals for treatment purposes. I understand the records may be transmitted electronically. If, in the course of transmission, these records are received by another party in error, I absolve Charleston Spine & Physical Medicine and its staff from any and all liability relating to such submission of said records.

Dorinda Shiver 14-23-04
signature of patient or legal guardian date

[Signature] 4/23/04 17
witness date

(742)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

April 23, 2004 Patient is seen in follow up. Continuing to have significant flaring of low back pain. Has had flare of left sciatica as well.

PMH: I completed Second Injury Fund questionnaire for this patient 12/18/03. Patient does have history of multiple injuries, and is definitely candidate for Second Injury Fund.

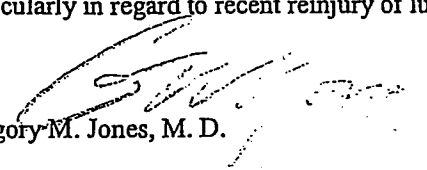
Patient has history of several injuries to cervicothoracic spine in April and October 1997, resulting in DRE Category II (per *AMA Guides to the Evaluation of Permanent Impairment, 4th edition*) impairment to cervicothoracic spine (3-5%) on 7/29/98. Patient was assessed additional 3% impairment for aggravation of cervical injuries (per *AMA Guides to the Evaluation of Permanent Impairment, 4th edition*) 8/13/01 for injuries sustained in MVC 11/25/00. No additional impairment assessed for contusion to left shoulder and neck with significant flaring/aggravation of same symptoms relating to 10/24/02 work injury, placed at maximum medical improvement 7/1/03 visit. Patient now notes that she fell in a hotel in August 2003, flaring symptoms. This apparently occurred approximately one month after patient was last seen in office. Flared/injured low back, and patient suffered left sciatica following this injury. Patient given Medrol Dosepak by Dr. Hook, benefit noted, symptoms did not quell completely following this medication. Patient unfortunately was then reinjured on 10/23/04, apparently tripped on phone cord, this injury happening at patient's work at hospital. Dr. Hook is current treating physician for this work injury per patient.

ROS: Patient continues to experience intermittent left sciatica. Sometimes with subjective weakness left leg, occasional giving-out. No bowel or bladder complaints of new onset.

Physical Examination: Reveals no definite focal motor deficits either lower limb, no clonus, negative Homan's, but there is decrement noted to light touch noted over medial and lateral calf on left, and SLR is positive on left at 90 degrees in sitting position, negative on right at 90 degrees sitting. No increase in pain on internal and external rotation at either hip. Marked tenderness noted left greater than right L1-2 through L5-S1 lumbar facets as wells as over both SI joints and sciatic notches.

Impression: 1. Chronic cervicothoracic/shoulder girdle myofascial and facet-generated pain, symptomatic S/P multiple injuries noted above.
2. Chronic multifactorial low back pain with left sciatica, with history of prior stable L4-5 disc protrusion/shallow HNP left paracentral with annular tear, recently symptomatic S/P work-related MVA 10/11/97, flared in MVA 11/25/00 and work-related fall from chair 3/23/02, now re-flared/re-aggravated with falls in August 2003 and apparent work-related fall 10/23/04.

Recommendations/Discussion: Gertrude has symptoms consistent with discogenic pain relating to left sciatica. The findings clinically are consistent with this problem. Would recommend that if these symptoms continue, patient will need to be scheduled for left paracentral L4-5 or L5-S1 translaminar epidural block. Will leave scheduling up to patient, based on how symptoms do over next several weeks. Trial oral anti-inflammatory samples given (COX-II inhibitor) with Skelaxin for muscle spasm. Will follow up on as needed basis for flaring. Patient may also require lumbar facet blocks to maximize benefit, particularly in regard to recent reinjury of lumbar spine with these several falls that have occurred over past 8 months.


Gregory M. Jones, M. D.

GMJ/bjl

(943)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE

May 13, 2004 PROCEDURE NOTE

PROCEDURE: 1. Left L5-S1 translaminar lumbar epidural steroid injection.

DIAGNOSIS: 1. Recurrent discogenic low back pain with sciatica.

CLINICAL DATA: Refer to Charleston Spine progress notes for details of prior work up and treatment as well as reasoning behind utilization of block procedure(s) today.

PROCEDURE: Informed consent signed and patient's questions answered prior to procedure; risks, benefits, alternative treatment options, and expected prognosis/efficacy discussed. Risks including, but not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring explained to patient's satisfaction.

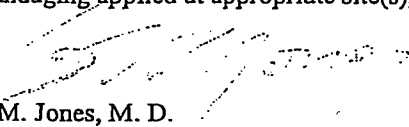
Patient is placed prone on fluoroscopy table following IV placement. 2 mg Versed given for relaxation prior to and during procedure per IV. Skin and subcutaneous tissue over left L5-S1 interlaminar space identified and anesthetized using 8 cc 1% Xylocaine and 4 cc 0.5% Marcaine.

18 gauge 3.5" Crawford needle used to enter epidural space using loss of resistance to normal saline technique, confirmed by 2 cc 300 Omnipaque epidurogram on AP and lateral views.

AP and/or lateral epidurogram copies obtained via pulse sequence fluoroscopic imaging, copies available in Charleston Spine chart for review.

After assurance of appropriate needle tip location at level(s) noted above, 100 mg DepoMedrol (methylprednisolone acetate injectable suspension 80 mg/mL) injected with 1cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% Sensorcaine HCl MPF (methylparaben-free bupivacaine HCl injection 5 mg/mL), along with 1 cc normal saline into epidural space, tolerated well, needle withdrawn, no untoward effects or blood leakage noted.

Sterile bandaging applied at appropriate site(s), patient transferred to recovery room in stable condition.


Gregory M. Jones, M. D.

GMJ/bjl

(744)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

June 8, 2004 Patient is seen in follow up. Has fortunately gotten significant benefit from lumbar epidural block accomplished 5/13/04. Low back and leg symptoms are much improved since this procedure. Pleased with response. Still experiencing midline bilateral low back pain from thoracolumbar junction down to upper buttock regions. Here today for consideration for lumbar facet blocks as previously discussed.

Physical Examination: Reveals significant tenderness bilaterally L1-2 through L5-S1 facet joints to varying degrees, most significant over lower four levels, moderate over L1-2 level. Moderate tenderness also noted T11-12 and T12-L1 facets to varying degrees bilaterally. Marked tenderness noted over bilateral SI joints at superior aspects of joints. Only minimal tenderness noted over sciatic notches bilaterally on today's exam.

Lower extremity exam reveals downgoing plantar responses, no clonus, negative SLRs bilaterally at 90 degrees sitting, no focal motor deficits, no focal sensory deficits to light touch, reflexes 2+ and symmetric patellar and Achilles responses. No increase in pain on internal and external rotation at the hips. No palpable step off lumbar spine, no spinous process tenderness. No CVA tenderness to percussion, no scapulohumeral motion deficits or scapular winging.

Impression:

1. Chronic multifactorial low back pain with bilateral left predominant sciatica and bilateral buttock pain, with significant discogenic component (symptomatic L4-5 disc protrusion/shallow HNP left paracentral with annular tear), with history of multiple injuries and flares recently, good response noted to recent epidural block.
2. Chronic multilevel lumbar facet syndrome/sacroiliitis, concurrent with above discogenic lumbar pathology, recently flared with multiple injuries.
3. Chronic cervicothoracic/shoulder girdle/interscapular myofascial/facet-generated pain, symptomatic S/P multiple injuries.

Recommendations/Discussion: Gertrude has always done well with epidurals. This has likely quelled any inflammation relating to symptomatic disc lesion L4-5 level. Patient is still candidate for use of this type of epidural procedure every 3-4 months for severe flares of low back pain with left sciatica particularly.

In interim, for residual pain post-block, or for flares of primarily low back and/or buttock pain, patient is still good candidate for use of lumbar facet/SI joint blocks, and the following are accomplished today for this purpose:

1. Right L2-3, L3-4, L4-5, and L5-S1 lumbar facet blocks, 5 mg methylprednisolone acetate (DepoMedrol), with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free) per site, sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needles used at each site; each site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.
2. Right SI joint block, 10 mg Aristospan with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free), sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needle used; site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Follow up will be accomplished in 2-4 weeks at patient's convenience with driver, can go ahead with treatment of left side at that time (if necessary).

This patient had stabilized regarding her low back symptoms, and then re-flared/aggravated low back symptoms with sciatica, particularly after a work-related fall 10/23/03. Goal here regarding treatment since that injury 10/23/04 is simply to stabilize patient's low back and leg symptoms, get her back to her "baseline" level, and we are nearing that level now fortunately. Basically, once left sided facet injections accomplished, assuming that no further lumbar epidural blocks necessary over next 3-6 months, can assume patient at maximum medical improvement relating to 10/23/04 work-related fall within next 2-4 months. Unlikely that additional impairment rating will need to be assessed for this injury, as no definitive "new" pathology delineated relating specifically to 10/23/03 work injury. Since patient is known to have pre-existent pathology lumbar spine prior to 10/23/03 work-related injury, patient would therefore be candidate for inclusion in South Carolina Second Injury Fund relating to the aggravation of lumbar symptoms following 10/23/03.

Gregory M. Jones, M. D.

GMJ/bjl

(745)

SHIVER, Gertrude
#4559

CHARLESTON SPINE & PHYSICAL MEDICINE
PROGRESS NOTE

July 7, 2004 Patient is seen in follow up. Has fortunately noted significant benefit for low back and buttock symptoms on right side from 6/8/04 right lumbar facet/SI joint blocks. Here today for similar treatment opposite side. No change in symptoms otherwise.

Past Surgical History: Patient underwent laparoscopic adhesiolysis with pelviscopy on 6/24/04. Was initially scheduled for ovarian cystectomy, but due to extensive pelvic adhesions to large intestine, could not accomplish latter procedure laparoscopically. Patient is pending further work up in this regard by her gynecologist.

Physical Examination: Reveals most significant tenderness over left L2-3, L3-4, L4-5, and L5-S1 lumbar facet regions. Marked tenderness also noted over left SI joint, again worse at superior aspect of joint. Moderate sacrococcygeal/midline tenderness still present. No treatment accomplished on right side, now using this side as "control."

Impression:

1. Chronic multifactorial low back pain with bilateral left predominant sciatica and bilateral buttock pain, with significant discogenic component (symptomatic L4-5 disc protrusion/shallow HNP left paracentral with annular tear), with history of multiple injuries and flares recently, good response noted to recent epidural block.
2. Chronic multilevel lumbar facet syndrome/sacroiliitis, concurrent with above discogenic lumbar pathology, recently flared with multiple injuries.
3. Chronic cervicothoracic/shoulder girdle/interscapular myofascial/facet-generated pain, symptomatic S/P multiple injuries.

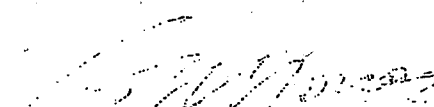
Recommendations/Discussion: I have accomplished the following focal injections today:

1. Left L2-3, L3-4, L4-5, and L5-S1 lumbar facet blocks, 5 mg methylprednisolone acetate (DepoMedrol), with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free) per site, sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needles used at each site; each site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.
3. Left SI joint block, 10 mg Aristospan with 0.5 cc each 0.5% lidocaine HCl 5 mg/mL (preservative-free) and 0.5% bupivacaine HCl MPF (methylparaben-free), sterile technique, non-fluoroscopic, 25 gauge 3.5" spinal needle used; site anesthetized locally, after sterile preparation, via instillation of 1.5 cc each 0.5% Marcaine HCl 5 mg/mL (bupivacaine HCl) and 2% Xylocaine (lidocaine HCl 20 mg/mL) using 27 gauge 1 1/4" needle.

The patient was prepped and draped in a sterile fashion after informed consent was signed, and patient's questions answered including the risks, benefits, alternative treatment options, and expected prognosis/efficacy (risks include, but are not limited to, infection, allergic reaction, nerve or tissue damage, paralysis, transient muscular weakness, hematoma, syncope, headache, transient increased pain, respiratory or cardiac dysfunction, and/or scarring).

Patient can now be considered at maximum medical improvement relating to 10/23/04 work-related fall. Patient's impairments have already been addressed in regard to her various/multiple complex low back, buttock, hip, and lower extremity injuries, with multiple injury history noted in past. No additional impairment rating assessed today's date, date of maximum medical improvement, relating to 10/23/03 work injury to lumbar spine, as patient aggravated pre-existent pathology lumbar spine with that work injury, based on current understanding of patient's condition. Patient is felt to be candidate for inclusion in SC Second Injury Fund relating to this aggravation of lumbar symptoms with work injury of 10/23/03.

Patient continues to be good candidate for intermittent use lumbar facet/SI joint blocks for flares of back/buttock pain relating to joint-related pain complaints of chronic nature. Patient also is candidate for intermittent use (not to exceed 2-4 in any 12 month time frame) of lumbar facet blocks for flares of discogenic/neurogenic low back and/or leg symptoms. Follow up on prn basis for flaring. Patient can simply call office to set up epidural block if necessary for flares in future.


Gregory M. Jones, M.D.

GMJ/bjl

(746)



Charleston Spine &
Physical Medicine, PA

PATIENT

Gertrude Shiver

BIRTHDATE 5/19/54

MALE

☒ FEMALE

CHART NUMBER 4559

DATE

PROGRESS NOTES

7/7/04 (cont) → (L) L₂₋₃ → (L) L_{5-S}, Lumbal facet blocks (± arthrography) +
(L) SI jt. block (± fluor) accomplished today & complications;
pt. placed @ MMI (± no additional impairment assessed as of
today's date per AMA Guides 5TH) for low back injuries /
aggravation SLP 10/23/03 work injury (denied currently) for
→ FIC prn in office 2-4 X monthly for unilateral or bilateral
lumbal facet / SI jt blocks (± fluor) prn flares
LBP / buttock pain
→ FIC prn in block suite q 3-4 months (or less) for (L) L_{5-S}
LESI (± fluor) for flares LBP ± sciatica / hr

(742)

Pt presents today for eval/tx. Pt has not been seen by me since 3/31/05 at which time she underwent intercostal nerve block of C2 chest wall pain leading to intercostal neuralgia. Pt now is having burning pain in her C2 ankle foot which is ongoing for several yrs. Pt is having Achilles tendinopathy treated at Muller Orthopedic. Pt still on Gabapentin. But makes her sleep.

PE

22 025

MS 92550

Heart Regs 10

Lung COT 7A

AND Soft BSx2 neutrophils to palpation

↓ distal as 1 pc
C2 at upper ankle to distal leg

(+) tenderness over

C2 paravertebral

Chest wall for T4

- T7- N8 hyperreflexia

Assessment / Rx

- 2 C2 Chest wall Pain Intercostal Neuralgia
- 2 C2 ~~extremity~~ extremity pain concerning peripheral neuropathy

LOWES

Plan

- Return Intercostal Nerve Block C2 T3-T8
- EMG C2 lower extremity
- Start Lyrica 75x 2x0 Bed T 15ch Bed
- Continue night time Gabapentin
- Pain Control S/NB
- ATUWMS Amed
- Paroside anodyne
- Reassess 3w post Blockage

G. J. 11/15/05
(748)

12-8-05

PATIENT NAME: Gertrude Shiver

MRN: M443

The patient presents today for scheduled intercostal nerve blocks at the levels of T3 - T8 on the left.

Risk Assessment:

The risks benefits and alternative to intercostal nerve blocks were discussed with the patient at length. They state they understand and wish to proceed. (+) signed informed consent was obtained. (+) return premed dispensed.

Pre Block Dx: chestwall Pain Intercostal Neuralgia

Post Block Dx: SAME

analgesia: none

Procedure

Pt taken to treatment room placed in a right lateral decubitus position. Monitors were applied continuous pulse oximetry heart rate monitoring and intermittent Noninvasive Blood Pressure Monitoring q 5 minutes. The intercostal margins of T3 T4 T5 T6 T7 T8 were identified and marked on the left. A total of 1/2 ml of 1% lidocaine was injected over each site. Sterile prep and drapes were applied. Using 23 g 1 1/2 inch needle placed after retracting the skin cephalad and using a walking off the rib technique, following negative aspiration for hema a total of 3ml of a mixture of 19 ml 0.25% Bupivacaine and 80 mg of methyl prednisone was injected at each site following aspiration of 1ml. Pt tolerated procedure well. RS (B) = Pre Block vital 123/67 70 16 SpO2 99% VAS (B) Temp 97.9 Post Block vital 106/73 70 16 SpO2 99% VAS (B)

Disposition: Ambulatory @ Home (Meds) Reopen 3 Yr. (749) 2/26/12 LP/AS

THE CENTER FOR PAIN CONTROL, LLC

DATE 12-15-05 MODE OF ENTRY ☒ AMBULATORY ☐ WHEELCHAIR ☐ CANE/WALKER ☐ CART
 PATIENT Meltrude Shivers STATUS NPO PREANALGESIA ☐
 PHYSICIAN Brandt POSITION ☐ PRONE ☐ SUPINE ☒ LATERAL ☐ SITTING ☐ OTHER
 NURSE Jessie P. Rn PREP ☐ BETADINE ☐ ALCOHOL ☐ HIBICLEN ☐
 CONSENT done 12-15-05 IV SITE L/R ☐ ARM ☐ HAND ☐ WRIST
 PROCEDURE START 1205 IV ACCESS ☐ 20G ☐ 22G ANGIOCATH not done
 PROCEDURE FINISH 1220 IV ☐ FLUID ☐ HEPLOCK ☐ DC'D WITH PRESSURE DRESSING APPLIED

PROCEDURE: Intercostal Nerve Blocks

3 XYLOCAINE 1% LOCAL
19ml BUPIVACAINE (25%) .5%
80mg METHYL PREDNISOLONE
☒ OMNIPAQUE
☐ OTHER
 FLUORO: OPERATED BY _____

DISCHARGE	TIME	B/P	P	R	O ₂ SAT	LOS	ALD
☐ WEIGHT BEARING	1055	123/67	70	16	99%		
☐ HORNERS SIGN	1200	112/58	72	16	99%		
☐ WARMTH	1205	116/55	74	16	99%		
☐ NUMBNESS	1210	112/67	67	16	99%		
MODE OF EXIT	1215	114/63	65	16	99%		
DISCHARGE HOME AT	1220	118/75	63	16	99%		
DRIVER <u>neice Kelly</u>	1225	106/73	70	16	99%		

NOTES: VAS: /s

PLAN OF CARE

POTENTIAL PROBLEMS	ACTIONS			OUTCOMES
	PRE-PROCEDURE	INTRA-PROCEDURE	POST-PROCEDURE	
Cardiovascular: Changes from initial assess	☒ Access vital signs Other _____	☐ Cardiac monitor ☒ Assess vital signs Other _____	☐ Cardiac monitor ☒ Assess vital signs Other _____	☒ Vital signs stable ☒ No symptomatic arrhythmia ☒ No chest pain
Respiratory: Changes from initial assessment	☒ Baseline O ₂ sat <u>99%</u> ☒ Assess resp status Other _____	☒ Monitor O ₂ sat ☒ Assess resp status Other _____	☒ Assess resp rate & rhythm Other _____	☒ No resp difficulty ☒ O ₂ sat 90% Other _____
Musculoskeletal: Changes from initial assess	☒ Position for comfort Other _____	☒ Correct anatomical position for procedure and pt. limitation Other _____	☒ Position for comfort within pt. procedural limitations Other _____	☒ No S & S of skin breakdowns Other _____
Neurological/reaction: Changes from initial assess	☒ Chart Labeled ☒ MD notified	☒ Alternate mode/measures used	☒ Alternate meds/measures used	☒ No S & S of reaction
Need for a safe & comfortable environment: Changes from initial assess	☒ Time out protocol observed with nurse & physician ☒ Proper ID of patient ☒ Proper procedure / consent ☒ Proper site / position ☒ Site marked if required ☒ Provide appropriate equip. Signature <u>[Signature]</u> ☒ Assure patient privacy ☒ Provide comfort measures ☒ Assess patient for fall-risk and prevention; Institute fall protocol	☒ Proper ID of patient & procedure ☒ Create & maintain sterile field ☒ Monitor & control environment ☒ Assure electrical safety ☒ Proper positioning during procedure ☒ Provide appropriate size equipment ☒ Institute fall protocol Other _____	☒ Proper ID of patient & procedure ☒ Provide comfort measures ☒ Administer medications as ordered by MD according to P & P ☒ Proper positioning following procedure ☒ Provide appropriate size equipment ☒ Institute fall protocol Other _____	☒ The patient will be free of injury
Other _____	Other _____	Other _____	Other _____	Other <u>25</u>

(750)

THE CENTER FOR PAIN CONTROL, LLC

DATE 2-16-06

PATIENT Gertrude Shiver

PHYSICIAN Dr. Thomas Brandt

NURSE Monique Jacula (en)

CONSENT yes

PROCEDURE START 1220

PROCEDURE FINISH 1230

MODE OF ENTRY ☒ AMBULATORY ☐ WHEELCHAIR ☐ CANE/WALKER ☐ CART

STATUS NPO ☒ PREGNANCY ☐

POSITION ☐ PRONE ☐ SUPINE ☒ LATERAL ☐ SITTING ☐ OTHER ☐

PREP ☒ BETADINE ☐ ALCOHOL ☐ HIBICLEN

IV SITE L/R ☐ ARM ☐ HAND ☐ WRIST N/A

IV ACCESS ☐ 20G ☐ 22G ANGIOCATH ☒

IV ☐ FLUID ☐ HEPLOCK ☐ DC'D WITH PRESSURE DRESSING APPLIED ☒

PROCEDURE:

8mL XYLOCAINE 1% LOCAL

16mL BUPTIVACaine (25%) .5%

80mg METHYL PREDNISOLONE

OMNIPAQUE

OTHER

FLUORO: OPERATED BY

DISCHARGE

☐ WEIGHT BEARING

☐ HORNERS SIGN

☐ WARMTH

☐ NUMBNESS

MODE OF EXIT Amb

DISCHARGE HOME AT 1245

DRIVER Kelly / niece

TIME	B/P	P	R	O ₂ SAT	LOS	ALD
1220	109/71	68	18	94%		
1225	107/71	70	18	97%		
1230	115/71	63	18	93%		
1235	110/61	65	18	98%		
1240	119/66	62	18	98%		

NOTES:

Pre VAS 4

Post VAS 1 1/2 - OACIC

PLAN OF CARE

POTENTIAL PROBLEMS

Cardiovascular:
Changes from initial assess

Respiratory:
Changes from initial assessment

Musculoskeletal:
Changes from initial assess

Bergies/reaction:
Changes from initial assess

Need for a safe & comfortable environment:
Changes from initial assess

ACTIONS

PRE-PROCEDURE

☒ Access vital signs
Other

☒ Baseline O₂ sat 94
☐ Assess resp status
Other

☒ Position for comfort
Other (R) side

☐ Chart Labeled
☒ MD notified

☐ Time out protocol observed with nurse & physician
☐ Proper ID of patient
☐ Proper procedure / consent
☐ Proper site / position
☐ Site marked if required
☐ Provide appropriate equip. Signature

☐ Assure patient privacy

☐ Provide comfort measures

☐ Assess patient for fall risk and prevention: Institute fall protocol

Other

INTRA-PROCEDURE

☐ Cardiac monitor
☒ Assess vital signs
Other

☒ Monitor O₂ sat
☒ Assess resp status
Other

☒ Correct anatomical position for procedure and pt. limitation
Other

☒ Alternate meds/measures used

☒ Proper ID of patient & procedure
☒ Create & maintains sterile field
☒ Monitor & control environment
☒ Assure electrical safety
☒ Proper positioning during procedure
☒ Provide appropriate size equipment
☒ Institute fall protocol
Other

Other

POST-PROCEDURE

☐ Cardiac monitor
☒ Assess vital signs
Other

☒ Assess resp rate & rhythm
Other (R) regular

☒ Position for comfort within pt. procedural limitations
Other (R) side

☒ Alternate meds/measures used

☒ Proper ID of patient & procedure
☒ Provide comfort measures
☒ Administer medications as ordered by MD according to P & P
☒ Proper positioning following procedure
☒ Provide appropriate size equipment
☒ Institute fall protocol
Other

Other

OUTCOMES

☒ Vital signs stable

☒ No symptomatic arrhythmias

☒ No chest pain

☒ No resp difficulty

☒ O₂ sat 90%

☒ No S & S of skin breakdowns

☒ No S & S of reaction

☒ The patient will be free of injury

☒ No S & S of skin breakdowns

☒ No S & S of reaction

☒ The patient will be free of injury

☒ No S & S of skin breakdowns

☒ No S & S of reaction

☒ The patient will be free of injury

☒ No S & S of skin breakdowns

☒ No S & S of reaction

☒ The patient will be free of injury

2/16/06

Gertrude Shiver

11443

The patient presents today for scheduled intercostal nerve blocks at the levels of T3 T4 T5 T6 T7 on the left.

Risk Assessment:

The risks benefits and alternative to intercostal nerve blocks were discussed with the patient at length. They state they understand and wish to proceed. (+) signed informed consent was obtained. (+) ativan premed dispensed.

Pre Block Dx: Left Chest wall Pain, Intercostal Neuralgia

Post Block Dx: SAME

Respiration: NONE

Procedure

Pt taken to treatment room placed in a right lateral decubitus position. Monitors were applied continuous pulse oximetry heart rate monitoring and intermittent Noninvasive Blood Pressure Monitoring q 5 minutes. The intercostal margins of T3 T4 T5 T6 T7 were identified and marked on the left. A total of 1/2 ml of 1% lidocaine was injected over each site. Sterile prep and drape were applied. Using 23 g 1 1/2 inch needle placed after retracting the skin cephalad and using a walking off the rib technique, following negative aspiration for hem a total of 3ml of a mixture of 16 ml 0.25% Bupivacaine and 80 mg of methyl prednisone was injected at each site following aspiration of 1ml. Pt tolerated procedure well BSB=

Pre Block vital 109/71 68 18 SpO2 94% VRS 4

Post Block vital 110/66 62 18 SpO2 98% VRS 1 1/2

28

Disposition: Ambulatory (+) Driver reassessed B-4 w/o

(753) - 12/11/07 2/16/07

3-9-06

Gertrude Shiver

443

Pt presents today for eval / tx. Pt reports she is having pain in her (L) anterior chest wall as well as burning pain in her (L) ankle. Pt unable to tolerate Lyrica at 150mg Bid due to "makes me too sleepy". Pt report that the chest wall pain has overshadow her foot until recently as her pain has decrease follow the intercostal Nerve Blocks.

PE

Wt 68 66 16 97⁸ 1-2 (5 activity)

Heart Reg 5 (M)

Lung (B) CTA

ABD Soft Bx 4 non tender
no palpation

MS 5/5 9+ (B)
- Bi cutaneous
- Sensation (L) ankle
down to toes (stocking)
- hyperalgesia

Assessment / Dx

Chest wall Pain (Anterior) (L) Costochondritis
improved Intercostal Nerve
(L) lower extremity Pain
Peripheral Polyneuropathy (Idiopathic) / amblyopia or dactyl.
Lyrica dosing causing hypersomnolence

Plan

Return Costochondral Injection @ T5 T6 T7
Possible Mod SCA B (L) lower extremity

↓ Lyrica 100mg Bid

PT eval / tx Anodyne Tx

ATIVIA premed

Reassess 2-3 wk Post Block

(754)

THE CENTER FOR PAIN CONTROL, LLC

Prevas-2

DATE 3-22-06

PATIENT Gertrude Shiver

PHYSICIAN Brandt

NURSE R. J. Shiver

CONSENT done 3-9-06

PROCEDURE START 1257

PROCEDURE FINISH 1254

MODE OF ENTRY ☒ AMBULATORY ☐ WHEELCHAIR ☐ CANE/WALKER ☐ CART

STATUS NPO ☒ PREGNANCY

POSITION ☐ PRONE ☐ SUPINE ☐ LATERAL ☐ SITTING ☐ OTHER

PREP ☐ BETADINE ☐ ALCOHOL ☐ HIBICLEN

IV SITE L/R ☐ ARM ☐ HAND ☐ WRIST

IV ACCESS ☐ 20G ☐ 22G ANGIOCATH

IV ☐ FLUID ☐ HEFLOCK ☐ DC'D WITH PRESSURE DRESSING APPLIED

PROCEDURE: Costochondral joint

XYLOCAINE 1% LOCAL

2ml BUPIVACAINE (25%) 5%

40mg METHYL PREDNISOLONE

OMNIPAQUE

OTHER

FLUORO: OPERATED BY

DISCHARGE	TIME	BP	P	R	O ₂ SAT	LOS	ALD
☐ WEIGHT BEARING	1140	118/65	16	70	97		
☐ HORNERS SIGN	1200	102/50	16	68	99		
☐ WARMTH	1255	102/62	16	66	99		
☐ NUMBNESS	1300	107/64	16	63	99		
MODE OF EXIT							
DISCHARGE HOME AT	1305						
DRIVER <u>Kelly (me)</u>							

NOTES:

Pre = 2
post = 1-2

PLAN OF CARE

POTENTIAL PROBLEMS	PRE-PROCEDURE	INTRA-PROCEDURE	POST-PROCEDURE	OUTCOMES
Cardiovascular: ☒ Changes from initial assess	☐ Assess vital signs Other <u> </u>	☐ Cardiac monitor ☐ Assess vital signs Other <u> </u>	☐ Cardiac monitor ☐ Assess vital signs Other <u> </u>	☐ Vital signs stable ☐ No symptomatic arrhythm ☐ No chest pain
Respiratory: ☒ Changes from initial assessment	☐ Baseline O ₂ sat <u>99%</u> ☐ Assess resp status Other <u> </u>	☐ Monitor O ₂ sat ☐ Assess resp status Other <u> </u>	☐ Assess resp rate & rhythm Other <u> </u>	☐ No resp difficulty ☐ O ₂ sat 90% Other <u> </u>
Musculoskeletal: ☒ Changes from initial assess	☐ Position for comfort Other <u> </u>	☐ Correct anatomical position for procedure and pt limitation Other <u> </u>	☐ Position for comfort within pt. procedural limitations Other <u> </u>	☐ No S & S of skin breakdowns Other <u> </u>
Allergies/reaction: ☒ Changes from initial assess	☐ Allerg Labeled ☐ MD notified	☐ Alternate meds/measures used	☐ Alternate meds/measures used	☐ No S & S of reaction
Need for a safe & comfortable environment: ☒ Changes from initial assess	☐ Time out protocol observed with nurse & physician ☐ Proper ID of patient ☐ Proper procedure / consent ☐ Proper site / position ☐ Site marked if required ☐ Provide appropriate equip. Signature <u>R. J. Shiver</u> ☐ Assure patient privacy ☐ Provide comfort measures ☐ Assess patient for fall risk and prevention; institute fall protocol	☐ Proper ID of patient & procedure ☐ Create & maintain sterile field ☐ Monitor & control environment ☐ Assure electrical safety ☐ Proper positioning during procedure ☐ Provide appropriate size equipment ☐ Institute fall protocol Other <u> </u>	☐ Proper ID of patient & procedure ☐ Provide comfort measures ☐ Administer medications as ordered by MD according to P & P ☐ Proper positioning following procedure ☐ Provide appropriate size equipment ☐ Institute fall protocol Other <u> </u>	☐ The patient will be free of injury
Other <u> </u>	Other <u> </u>	Other <u> </u>	Other <u> </u>	Other <u> </u>

PROGRESS NOTE

DATE:

3/22/06

PATIENT NAME:

Gertrude Shiver

MRN:

443

Patient presents today for scheduled Left costochondral joint injections at the levels of T5 T6 T7 T8 on Left

Risk Assessment: The risks benefits and alternatives to costochondral injections were discussed with the patient at length. Pt states they understand and wish to proceed. Positive signed informed consent was obtained.
() Arrows prepared was taken.

Pre Block Diagnosis: Anterior chest wall Pain, Costochondritis

Post Block Diagnosis:

SAME

Anesthesia:

none

Procedure:

Pt taken to treatment room placed in a supine position on treatment table. Monitors applied continuous pulse oximetry and heart rate monitoring as well as NIBP q 5 minutes. The costochondral joints on the left were identified and marked at T5 T6 T7 T8. Using clean technique and ethyl-chloride for topical anesthesia a 20g 1/2" needle was placed at each site. Following C1 Aspiration for Hemo at Total of 34 ml of a mixture of 2 ml 0.25% Bupivacaine + 40 mg methylprednisone was injected into each site without complication. Pt tolerated procedure well. Pre Post B&B:

Pre Block vitals 111/65 70 16 97% SpO2 VAS (2) Block
Post Block Vitals 107/64 63 16 99% SpO2 VAS (1-2)

Disposition: Ambulatory, Gr drive Referred 34ml

(756)

PATIENT: Gertrude Shiver
DATE OF BIRTH: 5-19-54
DATE OF VISIT: 8/14/03

This is concerning a fall.

SUBJECTIVE: Ms. Shiver is a patient of Dr. Hook's. She was at a hotel yesterday. She got up to take a break and she tripped over a chair. She caught her left foot on the chair and then she fell back on the floor. She said she hit her buttocks first and then her legs fell. She caught herself with her hands. She did not hit her head. She says she was able to get up and move around okay but as the days progress and yesterday she got progressively sore. She is just concerned. She says the Skelaxin and Ultram that she took did help her a little bit.

PHYSICAL EXAM: Weight: 185. Temp. 98.2. Pulse 76. Respiratory: 16. Blood pressure 100/74. HEENT: unremarkable. Neck: supple. Lungs: clear. Heart is S1/S2. No rubs, gallops or murmurs. Deep tendon reflexes are 2+. Peripheral pulses are 2+. Straight leg raising is negative. There is some tenderness to palpation in the lower legs especially on the left. A little bit of tenderness to palpation along the buttocks.

ASSESSMENT/PLAN:

1. contusions.

PLAN:

1. Reassurance.
2. She is going to continue on medication.
3. Plan on seeing her back in about a week or 10 days if she is not improved.
4. I have told her that she can try some heat and ice, that this may help.



Jean A. Massey, ANP, Ph.D.

PPM-C/clong

(757)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for worsening back pain status post fall on 08/13/03. The patient apparently "slipped" on carpet at a conference and landed quite violently on her buttocks. She claims that since that time, she has had a moderate amount of low back pain. She claims that she has recently begun to feel a "pop" in her back with torsion of the trunk and at times will feel a radiating pain down into her left lower extremity. She has had disc problems in the past and has been evaluated by The Spine Clinic in Charleston. She has had numerous falls and various traumas in the past and seems to be somewhat inclined to get injured relatively easily. She has gone through numerous Workman's Comp cases and again has a very low threshold for pain. She denies any change in her bowel or bladder and denies any lower extremity weakness or numbness. She has gone to The Brace and Boot Shop and she has had a back brace made for her, which she claims has helped. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day

REVIEW OF SYSTEMS: See History of Present Illness. The patient denies any palpitations, etc. All other systems reviewed at this time and negative.

(758)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 09/03/03

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac and regular.

ABDOMEN: Benign.

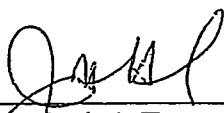
BACK: No significant spinous process tenderness. Straight leg raise is positive on the left.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Back pain status post fall. At this time, we will treat the patient with a Medrol dose pack. She may have a small herniated disc. If she sees no improvement, will obtain lumbosacral spine films, even though she has had numerous films performed in the past and has actually had an MRI of the lumbosacral spine within the year. We will follow closely. The patient was also given a few Lortab to take in place of her Ultram if absolutely needed. She was given Lortab 5mg, 50 with no refills. She can continue with Skelaxin and was encouraged to continue her back strengthening exercises.
2. Reflux with overlapping stricture. Asymptomatic with Aciphex.
3. Paroxysmal supraventricular tachycardia. Well controlled with current regimen. Will follow.
4. Left ankle pain. Will be seeing Dr. McBride. Again, it is felt that she may have a reflex sympathetic dystrophy.
5. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(759)

**MIDLANDS INTERNAL MEDICINE
OFFICE VISIT NOTE**

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/25/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain as well as left ankle pain, who basically presents for follow-up of her medical problems. The patient unfortunately has suffered another fall, most recently on 10/23/03. Apparently she tripped over a phone cord at work and landed on her left side. She was sent to her nursing supervisor and was evaluated by Dr. Durkan at Employee Health and apparently had some films performed, which revealed no rib fractures, etc. She continues to have some left rib pain nonetheless. She also notes that when she lies on her left side, she develops palpitations at night and this, at times, can be associated with mild nausea. She claims that she has also continued to have severe heel discomfort as well as foot discomfort. The patient was evaluated by numerous orthopedists including Dr. McBride at USC Specialty Clinics. Basically, her MRI was read as an abnormality about the flexor hallucis longus. However, her MRI was reviewed with Dr. McBride and it is felt that this is not a surgical situation, that it is not a post traumatic problem and that there are no further diagnostic or procedural studies or treatments that need to be done. The patient claims that she was somewhat frustrated with this diagnosis as her MRI was grossly abnormal. She actually went to see another doctor in Georgia, who basically gave her an ankle brace. The patient notes that she is still quite uncomfortable in her left foot and heel and she does note that she has continued strengthening and occasional icing indefinitely as well as stretching. Dr. McBride specifically suggested that heel counters in her left or right heel should not be used. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.
ALLERGIES: Unchanged since previously documented in the chart.
MEDICATIONS: Unchanged since previously documented in the chart.
SOCIAL HISTORY: Unchanged since previously documented in the chart.
FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day
9. Lortab prn (rare)

(760)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/25/03

PAGE 2 of 3

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac and regular.

CHEST WALL: Significant discomfort to even light palpation in the lateral left rib area.

ABDOMEN: Obese but benign.

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

MUSCULOSKELETAL: The patient does have pes planus. There is some tenderness throughout the hind foot and mid foot on the left. Otherwise, basically unremarkable.

ASSESSMENT AND PLAN:

1. Left ankle and heel pain as well as diffuse left foot pain. At this point, I cannot add much to the patient's work-up or diagnosis. I have encouraged her to perhaps follow-up with The Miller Clinic in Charlotte or The Houston Clinic in Columbus, Georgia and I have given her these addresses, as they are more specialty clinics directed towards the foot. However I would have to agree with Dr. McBride as I fully respect his opinion. She has also seen other orthopedists in town including Dr. Belding, who I respect as well and deals specifically with the feet. I will hold off on further work-up at this time and defer to her other subspecialists.
2. Palpitations. Again, the patient does have a history of paroxysmal supraventricular tachycardia. This only occurs when she lies on her left side. We cannot reproduce symptoms having her in this position. We will set up a Holter monitor over the next 24 hours and see how she does.
3. Nausea. The patient will be given Phenergan. I am unsure of the etiology. She has had a recent CT scan of the abdomen and pelvis, which was unremarkable.

(761)

MIDLANDS INTERNAL MEDICINE

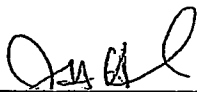
OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 11/25/03

PAGE 3 of 3

ASSESSMENT AND PLAN: (cont.)

4. Left chest wall pain. Likely due to bruised ribs. The patient did have recent rib films, which apparently were unremarkable. I have told her that this can take anywhere from six to eight weeks to completely resolve. She should continue her Bextra. I have also encouraged her to ice this area, perhaps even use a heating pad and we have also suggested she use her Ultram or Lortab as needed.
5. Reflux. Stable on Aciphex.
6. Routine health maintenance. Basically up to date.



Jeffrey D. Hook, MD

(762)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/15/03

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain as well as left ankle pain, who basically presents for follow-up of her medical problems. Since last being seen, the patient did go to The Miller Clinic in Charlotte and has basically been placed in an immobilization boot of her left ankle and heel. She notes that, if anything, this has been quite helpful. She continues to have problems with neck and back pain. She notes that she has not been down to The Spine Clinic in Charleston due to the fact that she claims that she owes them money as Workman's Comp has not paid them and she does not want to run up her bill. She continues to use Bextra on a daily basis with Ultram versus Lortab prn. She otherwise has felt relatively well since placing a Holter monitor on her for palpitations. She has been palpitation free. Again, her Holter monitor was completely normal. She notes that her reflux has tremendously improved with Aciphex and has cut this down to as needed. She is having no difficulty swallowing. She really has very little in the way of complaints, other than chronic pain.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. Aciphex 20mg q day prn
9. Lortab prn (rare)

REVIEW OF SYSTEMS: The patient still notes occasional episodes of mild abdominal discomfort. Again, she has had a CT scan of the abdomen and pelvis within the last year, which was completely unremarkable. All other systems reviewed at this time and negative.

(763)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/15/03

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress, mildly anxious.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Regular.

ABDOMEN: Obese but benign.

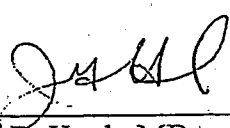
EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

MUSCULOSKELETAL: Again, left ankle in an immobilization boot.

ASSESSMENT AND PLAN:

1. Left ankle and heel pain as well as diffuse left foot pain. The patient actually saw the PA at The Miller Clinic, who immobilized her ankle. She has noted improvement thus far. She will go back and see one of the physicians there in a few weeks.
2. Chronic neck and back pain. Continue to follow with The Spine Clinic. We will continue her Bextra and prn Ultram versus Lortab. Obviously we have encouraged more in the way of Ultram due to its lesser addictive potential.
3. Palpitations. The patient has a history of paroxysmal supraventricular tachycardia. Her Holter monitor has been negative and she has been asymptomatic. Continue to follow.
4. Reflux. Continue Aciphex on an as needed basis.
5. Abdominal pain. Again, unknown etiology. However, CT scan of the abdomen and pelvis normal. This has not been as significant as it has been in the past.
6. Routine health maintenance. Basically up to date.


Jeffrey D. Hook, MD

PHYSICAL EXAMINATION

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents for complete physical exam. The patient notes that she is doing relatively well. She continues to have chronic back and neck pain and is followed by Carolina Spine Clinic in Charleston. She notes that she needs to go back there for an injection as oral medications are not necessarily helpful. She really has no other major complaints and otherwise feels relatively well.

1. Breast reduction in 1997
2. Myomectomy in 1995

1. Tetanus caused severe edema and induration with pain
2. CT dye gave her hives and palpitations.
3. PPD caused hives and palpitations as well.

5048 (C)

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn, which is rare

(765)

MIDLANDS INTERNAL MEDICINE
PHYSICAL EXAMINATION

NAME: Gertrude Shiver

SS#: 249-98-2546

DATE: 03/29/04

PAGE 2 of 3

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90. She had diabetes, dementia, and a stroke in the end as well. She denies any overwhelming amount of heart disease in the family but does note hypertension and strokes. She also notes diabetes. There is a history of breast cancer in the family and her sister had colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is fair. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient does note occasional sinus headaches but these are minimal in nature. She gets her eyes checked yearly by Dr. Blake. She notes significant amounts of left-sided neck pain that, at times, radiates into her left shoulder and notes muscular tightness. Skelaxin and Ultram do seem to be somewhat helpful. She notes fluctuating bowel habits, mostly with constipation. Seems to be worsened on Ultram. She did have a colonoscopy in 2002 and interestingly did have an adenomatous polyp that will need to be repeated. She notes diffuse abdominal and pelvic pain. She continues to have ankle pain and was evaluated by the Miller Clinic. She notes some insomnia. She notes some fatigue. All other systems reviewed at this time and negative.

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round and reactive to light and accommodation. Extra-ocular movements intact. Funduscopic exam unremarkable.

TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No lymphadenopathy. No thyromegaly. No bruits.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. There are no murmurs, rubs, or gallops auscultated.

ABDOMEN: Soft, nondistended. There is mild tenderness diffusely. There are positive bowel sounds in all quadrants. There is no hepatosplenomegaly or mass.

BREASTS: No dominant masses. Mild fibrocystic changes. Some scar tissue from previous mammoplasty. No nipple inversion. No skin dimpling. No axillary nodes.

UROGENITAL: The patient has normal external female genitalia. Cervix visualized.

Pap smear obtained. By manual exam, unremarkable. Perhaps some mild irregularity to the uterus.

RECTAL: No masses. Normal sphincter tone. Guaiac negative stool.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

MIDLANDS INTERNAL MEDICINE

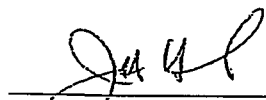
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 03/29/04

PAGE 3 of 3

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Continue current regimen. The patient seems to be extremely well controlled. She did have a recent Holter monitor, which was normal. EKG was not repeated today.
2. Reflux with overlapping stricture, status post dilation. Continue Aciphex on a daily basis.
3. Adenomatous polyp. Will call the patient in May for repeat colonoscopy as she is due this year.
4. Neck pain. Needs to go back to Charleston Spine Institute, where she is also followed for her chronic back pain.
5. Abdominal discomfort. The patient did have a CT scan but this was done without contrast. We will try ultrasound of the pelvis and abdomen for further evaluation.
6. Fatigue. Will check endocrinologic and metabolic etiologies.
7. Diffuse arthralgias. Again, consider rheumatologic panel in the future.
8. Routine health maintenance. Have encouraged increasing exercise, perhaps non weight bearing, for instance an exercise bike. She is otherwise completely up to date.


Jeffrey D. Hook, MD

(767)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/19/04

The patient is a 49-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who presents for follow-up of her medical problems. The patient was having some vague pelvic pain at her last visit. Her pelvic exam was basically unremarkable. Nonetheless, she had a pelvic ultrasound performed which revealed fibroids throughout the uterus and two cysts on the right ovary. One perhaps was septated. The other appeared to be simple. With these findings, she was referred to OB-GYN. Dr. Odom has since evaluated her and will follow with her closely. He did claim that one of the options was hysterectomy but he does not feel that this is necessary. He will be following up her ovarian cysts. The patient notes that her biggest complaint continues to be that of neck and back pain. She is going to go to Charleston to the Carolina Spine Institute, where she has been seen in the past. The patient also continues to have some left ankle instability. She went back to Charlotte for further evaluation and they basically did not change her regimen. She has since been using an immobilizer/brace on her left ankle, which has provided some support but she still has some discomfort. She has no other major complaints and otherwise has felt relatively well.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn, which is rare

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

(768)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/19/04

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

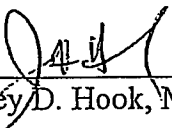
ABDOMEN: Benign, other than mild tenderness diffusely.

EXTREMITIES: No edema. Left ankle brace in place.

NEUROLOGICAL: Intact.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Continue current regimen. She seems to be well controlled in this regards.
2. Reflux with overlapping stricture status post dilation. Continue Aciphex.
3. Adenomatous polyp. Will call the patient in May for repeat colonoscopy as she is due this year.
4. Neck and low back pain. Continue to follow with Charleston Spine Institute.
5. Abdominal discomfort. Perhaps related to her ovarian cysts. She will follow-up with Dr. Odom.
6. Routine health maintenance. Otherwise up to date.


Jeffrey D. Hook, MD

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/16/04

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who presents for follow-up of her medical problems. The patient claims that she continues to have left rib pain status post a fall in October. This has been somewhat frustrating for her. She also notes that she has now developed some mild headaches, which seem to radiate from the cervical spine up into the occipital region and at times feels as though it is band-like in nature. She also notes that she has had some nerve blocks followed by facet blocks by the Charleston Spine Institute in Charleston. This has been somewhat helpful. Her left ankle pain has been braced. She is followed in Charlotte and this has been somewhat helpful, even though she continues to have some discomfort. She also notes that she has developed some right hand and arm numbness and "shock-like" sensation. She notes her entire hand, she feels, is involved as well as her arm. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn.

REVIEW OF SYSTEMS: The patient did undergo laparoscopic left ovarian cystectomy. However, due to severe adhesions involving the left ovary, tube, and posterior fundus of the uterus and bowel, this could not be done. These were felt to be due to her previous myomectomy. She continues to have some left lower quadrant discomfort. All other systems reviewed at this time and negative.

(770)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 08/16/04

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits. There is some tightness in the trapezius muscles.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

CHEST WALL: The patient has moderate left lateral rib discomfort to deep palpation.

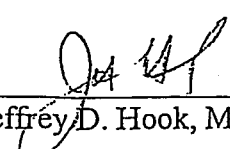
ABDOMEN: Benign, other than mild tenderness diffusely.

EXTREMITIES: No edema. Left ankle brace in place.

NEUROLOGICAL: Intact. Negative Tinel and Phalen sign.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Continues to be asymptomatic. We will keep her on her current regimen.
2. Reflux with overlapping stricture status post dilation. Continue Aciphex. She is not necessarily symptomatic in this regards.
3. Adenomatous polyp. The patient did undergo repeat colonoscopy. This was negative.
4. Headaches. Likely due to tension type headaches. I have encouraged her to try the Skelaxin when this occurs.
5. Left rib pain. Again, status post a fall in October of 2003. We will obtain rib films, even though she had original negative rib films in the past.
6. Right hand "shocks." Likely due to her disc disease in the neck. She does not necessarily have signs of carpal tunnel syndrome or ulnar neuropathy. We will follow.
7. Left ankle pain. Continue to wear left ankle brace and follow-up in Charlotte.
8. Abdominal discomfort. Persistent. Noted to have adhesions. Will follow-up with Dr. Odom.
9. Low back pain. Again, improved with nerve blocks. Followed by facet blocks at Charleston Spine Institute.
10. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

(771)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/19/04

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who basically presents with new onset of rash. The patient notes that she has had an extremely pruritic rash on the back of her neck. She denies any new exposures, such as detergents, soaps, jewelry, etc. She claims that it is limited to the back of her neck. She also notes that her left nipple has been itching but she sees no rash there. She denies any discharge or mass. She has no other major complaints and otherwise has been doing relatively well. She has been followed by The Miller Clinic in Charlotte and has had some injections performed to her left ankle and she does note some improvement in this regards. She has no other major complaints.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn.

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

(772)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/19/04
PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

BREASTS: No palpable masses. No nipple inversion. No nipple discharge. No visible rash. Minimal fibrocystic change. No axillary nodes. No skin dimpling.

ABDOMEN: Benign

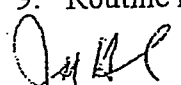
EXTREMITIES: No edema.

NEUROLOGICAL: Intact.

SKIN: Macular erythematous rash on the posterior aspect of the neck. It is nonvesicular, minimally raised, and somewhat excoriated.

ASSESSMENT AND PLAN:

1. Rash. Appears to be a contact dermatitis. I have given the patient some Olux foam to use on a daily basis. The patient was encouraged to pay closer attention to any new exposures. If she is not seeing any improvement, consider dermatologic consultation. She was also told that she could use oral Benadryl if needed, which would likely help with some of the itching. We will follow.
2. Left nipple itching. Again, no rash is visible. It does not appear that this is related to the rash that she has on the back of her neck. Her exam is unremarkable. She is up to date on mammogram. I have reassured her in this regards.
3. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
4. Reflux. Continue Aciphex.
5. Right hand "shocks." Again, continues. Likely due to disc disease in her neck.
6. Left ankle pain. Again, has improved with injections by The Miller Clinic in Charlotte.
7. Abdominal discomfort. This has been persistent and felt to be due to adhesions.
8. Low back pain. Again, improved with nerve blocks. Followed by facet blocks at Charleston Spine Institute.
9. Routine health maintenance. Up to date.


Jeffrey D. Hook, MD

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/20/04

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, and chronic back and neck pain, who presents for follow-up of her medical problems. The patient notes that her ankle is still giving her problems. She is followed by the Miller Clinic in Charlotte and notes that it is improved status post injections but still not where she thinks it should be. She also continues to have left rib cage discomfort in the intercostal region. This has been giving her more and more discomfort. She seems to find that this does not respond to anti-inflammatories or Ultram as well. She really has no other major complaints. She has been basically palpitation free as well as reflux free, as long as she continues her Aciphex. She has very little in the way of complaints, other than that.

PAST MEDICAL HISTORY: Unchanged since previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged since previously documented in the chart.

ALLERGIES: Unchanged since previously documented in the chart.

MEDICATIONS: Unchanged since previously documented in the chart.

SOCIAL HISTORY: Unchanged since previously documented in the chart.

FAMILY HISTORY: Unchanged since previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day
4. Baby aspirin daily
5. Tylenol prn
6. Skelaxin prn
7. Ultram qid prn
8. Aciphex 20mg q day
9. Lortab prn.

gabapentin 400 mg q hs, Lido cream
REVIEW OF SYSTEMS: The patient did have rib films performed at the last visit and they were basically unremarkable. All other systems reviewed at this time and negative.

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 12/20/04

PAGE 2 of 2

PHYSICAL EXAMINATION: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2.

CHEST WALL: Moderate intercostal rib cage pain in the left lateral rib cage, radiating around into the right anterior rib cage.

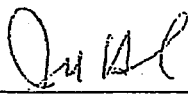
ABDOMEN: Completely benign

EXTREMITIES: No edema.

NEUROLOGICAL: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
2. Reflux. Continue Aciphex.
3. Degenerative disc disease. Again, known in her neck and lumbosacral spine. She continues to follow with the Carolina Spine Clinic in Charleston.
4. Left ankle pain. Follows with the Miller Clinic in Charlotte.
5. Left-sided intercostal rib pain. Will send her to Pain Management to see if perhaps injections or manipulation would be helpful.
6. Abdominal discomfort. Again, this has been persistent. Felt to be due to adhesions.
7. Routine health maintenance. Basically up to date.



Jeffrey D. Hook, MD

(775)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

The patient is a 50-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, and left chest wall pain, who basically presents for complete physical exam. The patient has been evaluated by Dr. Brandt at the Pain Management Center and basically suspects that the patient has intercostal neuralgic pain and has basically performed intercostal nerve blocks on the left at T3 through T8, has placed her on Gabitril, and also has given her Lidoderm patches. She notes that this has improved her discomfort level but she does continue to have some discomfort. She otherwise has generally felt relatively well. She was recently seen at the Miller Clinic in Charlotte regarding her left ankle and received an injection there as well, which has been extremely effective. She really has no other major complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995
3. Laparoscopic lysis of adhesions by Dr. Odom last year.

ALLERGIES:

1. Tetanus caused severe edema with induration.
2. CT dye has given her hives and palpitations.
3. PPD caused hives and palpitations.
4. Questionably sulfa (unknown reaction)

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Bextra 20mg q day (switching to Mobic 15mg q day)
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. AcipHex 20mg q day
9. Maalox for breakthrough
10. Lortab prn (extremely rare)
11. Gabitril 4mg q HS
12. Lidoderm, 12 hours on and 12 hours off

(776)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

PAGE 2 OF 4

SOCIAL HISTORY: The patient does not smoke, nor does she drink alcohol. She is not married and has no children, and is currently not sexually active. She is originally from Gaston and has lived in Charleston but has resided in Columbia since 1998. She was a cardiac nurse but became disabled due to back pain. She now works in Medical Records for Palmetto Richland and notes mild stress. She puts in about 40 hours a week. In her free time, she basically reads and is currently taking a course for medical transcription.

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90 with underlying diabetes, dementia, which is felt to be multi-infarct. She denies any overwhelming amount of heart disease in the family but does note hypertension and stroke. She also notes diabetes. There is a history of breast cancer in her family as well as a sister who had colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is relatively poor. Her exercise is minimal.

REVIEW OF SYSTEMS: The patient is up to date on eye exam by Dr. Blake. She does get occasional breakthrough from her reflux and will have to add Maalox, which seems to help with her symptoms. This is generally due to dietary indiscretion. She continues to have moderate neck and low back pain and is followed at The Spine Clinic in Charleston. Her left ankle and heel have been followed by The Miller Clinic in Charlotte. Her left costochondral chest wall pain has been followed by Dr. Brandt. Full work-ups, including multiple MRI's, bone scans, etc. have been negative. The patient does note a mild fatigue. She notes a rare palpitation but this has basically been well controlled. She did have an unremarkable Holter monitor approximately one year ago. All other systems reviewed at this time and negative.

PHYSICAL EXAM: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light and accommodation. Extraocular movements intact. Fundoscopic exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No bruits. No lymphadenopathy. No thyromegaly.

LUNGS: Clear to auscultation and percussion bilaterally.

(777)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

PAGE 3 OF 4

PHYSICAL EXAMINATION: (cont.)

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. No murmurs, rubs, or gallops auscultated.

CHEST WALL: Left-sided chest wall pain improved but present.

BREASTS: No dominant masses. Mild fibrocystic changes. Scar tissue noted from previous mammoplasty. No nipple inversion. No skin dimpling. No axillary nodes.

ABDOMEN: Soft, nondistended. Mild tenderness diffusely. Positive bowel sounds in all quadrants. No hepatosplenomegaly or mass.

UROGENITAL: Normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: Normal sphincter tone. No palpable masses. Guaiac negative stool in the vault.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS: EKG was obtained and reveals a sinus bradycardia. There are no significant STT wave abnormalities.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. For the most part, asymptomatic on current regimen.
2. Reflux. Continue AcipHex with prn Maalox.
3. Degenerative disc disease. Known in her neck and lumbosacral spine. She will follow with Carolina Spine Clinic in Charleston. Will change her Bextra to Mobic 15mg q day
4. Left ankle pain. Follows with The Miller Clinic in Charlotte.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. She has seen improvement with Pain Management. Will follow with Dr. Brandt or Zgleszewski.
6. Abdominal discomfort. Has been persistent but improved since lysis of adhesions. Will continue to follow along with Dr. Odom.

(778)

MIDLANDS INTERNAL MEDICINE

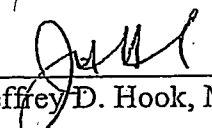
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/15/05

PAGE 4 OF 4

ASSESSMENT AND PLAN: (cont.)

7. Fatigue. Will check all endocrinologic and metabolic markers.
8. Routine health maintenance. Basically up to date. The patient had repeat colonoscopy in June of 2004 and will not need to be rescreened for 5 years. She is still having periods and we will not get a baseline DEXA at this time, until she is postmenopausal. She was strongly encouraged to increase her cardiovascular exercise regimen, watch her diet more thoroughly and perhaps lose some weight, as this has been trending upwards. We will continue to follow her closely.



Jeffrey D. Hook, MD

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/21/05

The patient is a 51-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, and left chest wall pain, who basically presents for follow-up of her medical problems. The patient notes that she is doing extremely well in all facets, except for her pain. She continues to have moderate amounts of neck and low back pain, as well as intermittent intercostal neuralgic pain. She actually has an appointment to go back and see Dr. Brandt now at his Lugoff office. She is taking occasional Ultram, which she feels as though is somewhat helpful. She has noted some improvement in her left ankle pain. She has gone back to the Miller Clinic in Charlotte and has had another injection there as well. She denies any palpitation, shortness of breath, nausea, or vomiting. She claims that her bowel habits are regular and is having no urinary symptoms as well. She otherwise feels reasonably well, other than the pain.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.

PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.

ALLERGIES: Unchanged as previously documented in the chart.

MEDICATIONS: Unchanged as previously documented in the chart.

SOCIAL HISTORY: Unchanged as previously documented in the chart.

FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

1. Cardizem CD 120mg q day
2. Tenormin 25mg bid
3. Mobic 15mg q day
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn
7. Ultram prn
8. AcipHex 20mg q day
9. Maalox prn breakthrough
10. Lortab prn (extremely rare)
11. Gabitril 4mg q HS
12. Lidoderm, 12 hours on and 12 hours off (minimal)

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 10/21/05

PAGE 2 OF 2

PHYSICAL EXAM: Vital signs noted.

GENERAL: In no acute distress.

HEENT: Unremarkable.

NECK: No JVD. No bruits.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac but regular.

CHEST WALL: Left-sided chest pain present with deep palpation. Improved but still minimally present.

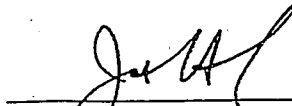
ABDOMEN: Obese but benign.

EXTREMITIES: No edema.

NEUROLOGIC: Nonfocal.

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. For the most part, asymptomatic on current regimen.
2. Reflux. Continue AcipHex with prn Maalox.
3. Degenerative disc disease. Known in her neck and lumbosacral spine. She will continue to follow with Carolina Spine Clinics in Charleston. She will continue Mobic 15mg q day with Ultram for breakthrough.
4. Left ankle pain. Follows with the Miller Clinic in Charlotte. This has improved with local injections.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. She will follow-up with Dr. Brandt. Continue Lidoderm as needed.
6. Abdominal discomfort. Has actually improved since lysis of adhesions with Dr. Odom.
7. Routine health maintenance. Completely up to date. We have encouraged more cardiovascular exercise regimen with better dietary habits and weight loss. We will follow closely.


Jeffrey D. Hook, MD

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 02/15/06

The patient is a 51-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilatation times two, chronic back and neck pain, left ankle pain, and left chest wall pain, who basically presents with complaints of acute onset of left ear pain times one week and recent complaints of nausea, vomiting, and diarrhea. The patient claims that symptoms began approximately one week ago with left ear pain. She has used Hydrogen Peroxide in her ear, which she claims has given her little benefit. She notes that the ear feels clogged, as though there is fluid behind it. She claims that she may have had some low grade fever, even though she did not check her temperature. This persisted until the weekend, when she suddenly developed nausea, vomiting, and loose stool. This was associated with some abdominal cramping but without any significant pain. She denies any hematochezia, dark or tarry stool, or frank blood. She has felt somewhat weak, as she has not been able to eat due to the nausea. She has been trying to increase her fluid intake, actually with orange juice. She really has no other major complaints.

PAST MEDICAL HISTORY: Unchanged as previously documented in the chart.
PAST SURGICAL HISTORY: Unchanged as previously documented in the chart.
ALLERGIES: Unchanged as previously documented in the chart.
MEDICATIONS: Unchanged as previously documented in the chart.
SOCIAL HISTORY: Unchanged as previously documented in the chart.
FAMILY HISTORY: Unchanged as previously documented in the chart.

REVIEW OF MEDICATIONS:

- ✓ 1. Cardizem CD 120mg q day (branded)
- ✓ 2. Tenormin 25mg bid (branded)
- ✓ 3. Mobic 15mg q day
- ✓ 4. Baby aspirin q day
- ✓ 5. Tylenol prn
- ✓ 6. Skelaxin prn
- 7. Ultram prn (Ultram CR 100mg qd)
- ✓ 8. AcipHex 20mg q day
- ✓ 9. Maalox prn
- 10. Lortab prn (vial)
- ✓ 11. Gabitril 4mg q HS
- ✓ 12. Lidoderm prn →

(Lidoderm 100mg bid)

(782)

MIDLANDS INTERNAL MEDICINE

OFFICE VISIT NOTE

NAME: Gertrude Shiver

SS#: 249-98-2546

DATE: 02/15/06

PAGE 2 OF 2

REVIEW OF SYSTEMS: See History of Present Illness. All other systems reviewed at this time and negative.

PHYSICAL EXAM: Vital signs noted. The patient is afebrile.

GENERAL: In no acute distress.

HEENT: Mild serous fluid seen behind the left TM. Right TM clear, otherwise unremarkable.

NECK: No JVD. No bruits. No lymphadenopathy.

LUNGS: Clear.

CARDIOVASCULAR: Bradycardiac.

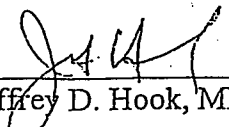
ABDOMEN: Obese, soft, nontender. There are slightly hyperactive bowel sounds. No hepatosplenomegaly or mass.

EXTREMITIES: No edema.

NEUROLOGIC: Nonfocal.

ASSESSMENT AND PLAN:

1. Serous otitis media. Will treat the patient with Duraphen Forté, ½ tablet bid. I doubt that this will affect her paroxysmal supraventricular tachycardia. She was also given some Zoto Otic HC drops to use on an as needed basis.
2. Viral gastroenteritis. Will treat the patient with Phenergan 25mg q 4 to 6 hours prn nausea. She was also given some Levsin sublingual to use for cramping. I told her that I do not want her to use any antidiarrheals, as this is the body's mechanism to get rid of the underlying virus. If she develops any significant abdominal pain, etc., she will let me know. She was given an excuse to miss today and tomorrow of work.
3. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
4. Reflux. Continue AcipHex with prn Maalox.
5. Degenerative disc disease. Known in her cervical and lumbosacral spine. Continue Mobic with prn Ultram.
6. Left-sided intracostal rib pain. Felt to be neuralgic in nature. She will continue Lidoderm as needed.
7. Routine health maintenance. Otherwise up to date.


Jeffrey D. Hook, MD

(783)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

INAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

The patient is a 51-year-old black female with past medical history significant for hypertension, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease with stricture status post dilation times two, chronic back and neck pain, left ankle pain, and left chest wall pain felt to be neuralgic in nature, who basically presents for complete physical exam. The patient's biggest complaint at this time continues to be left-sided intercostal rib pain. This is felt to be neuralgic in nature. She is following with Dr. Brandt of Pain Management. She is currently using a topical Lidoderm patch, which seems to be helpful. She has been placed on Lyrica, which she is now using on an as needed basis, as regular use did cause some oversedation. Other than her pain, she feels as though she is doing reasonably well. She has very little in the way of other complaints.

PAST MEDICAL HISTORY: As above.

PAST SURGICAL HISTORY:

1. Breast reduction in 1997
2. Myomectomy in 1995
3. Laparoscopic lysis of adhesions by Dr. Odom in 2004

ALLERGIES:

1. Tetanus caused severe edema with induration localized
2. CT dye has given her hives and palpitations.
3. PPD caused hives and palpitations.
4. Questionably sulfa drugs (unknown reaction)

CURRENT MEDICATIONS:

1. Cardizem CD 120mg q day (branded)
2. Tenormin 25mg bid (branded)
3. Mobic 15mg q day
4. Baby aspirin q day
5. Tylenol prn
6. Skelaxin prn
7. Ultram CR 100mg q day
8. AcipHex 20mg q day
9. Maalox prn
10. Lortab prn (rare)
11. Lyrica 100mg bid
12. Lidoderm, 12 hours on and 12 hours off

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

PAGE 2 OF 4

SOCIAL HISTORY: The patient is not a smoker, nor does she drink alcohol. She is not married and has no children, and is not sexually active. She is originally from Gadsden and has lived in Charleston but has been back to Gadsden since 1998. She was a cardiac nurse but became disabled due to back pain. She currently works in Medical Records for Palmetto Richland and notes moderate stress. She puts in about 40 hours a week. She was planning on a medical transcription job but is having difficulty in getting hired for this.

FAMILY HISTORY: The patient's father died in his 60's from a stroke. Mother passed away at the age of 90 with diabetes, dementia, which is felt to be multi-infarct. She denies any overwhelming amounts of heart disease in the family but does note hypertension and occasional stroke. She also notes diabetes. There is a history of breast cancer in her family as well as a sister who passed away from colon cancer in her 50's. There is a strong history of arthritis as well.

DIET AND EXERCISE: The patient's diet is somewhat poor. Her exercise, she has been increasing this and has been going to a gym.

REVIEW OF SYSTEMS: The patient is up to date on eye exam with Dr. Blake. She does note, at times, some mild nausea. She is unsure what causes this but is generally short lived. She does have Phenergan available, if needed. She does have a tendency towards reflux, only if she overeats. She notes diffuse pain, most notably in her neck, low back, and rib cage. She was recently diagnosed with a peripheral neuropathy and has been undergoing Anodyne therapy. This has been helpful. She did have full peripheral neurology work-up. She continues to have some left ankle and foot pain but this has improved as well. She does note some rare constipation. She does feel somewhat fatigued. She has had no further palpitations and her blood pressure has been extremely well controlled. She really has no other major complaints. All other systems reviewed at this time and negative.

(785)

MIDLANDS INTERNAL MEDICINE

PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

PAGE 3 OF 4

PHYSICAL EXAM: Vital signs noted.

GENERAL: Pleasant, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light and accommodation. Extraocular movements intact. Funduscopy exam unremarkable. TM's clear. Oropharynx clear with moist mucus membranes.

NECK: No JVD. No bruits. No lymphadenopathy. No thyromegaly.

LUNGS: Clear to auscultation and percussion bilaterally.

CARDIOVASCULAR: Bradycardiac. Normal S1 and S2. No murmurs, rubs, or gallops auscultated.

CHEST WALL: Left-sided chest pain somewhat moderate in nature, diffusely through the left-sided chest wall.

BREASTS: No dominant masses. Mild fibrocystic changes. Scar tissue noted from previous mammoplasty. No nipple inversion. No skin dimpling. No axillary nodes. There is some tenderness but this appears to be more chest wall in nature, rather than breast in nature.

ABDOMEN: Soft, nondistended, nontender. Positive bowel sounds in all quadrants. No hepatosplenomegaly or mass.

UROGENITAL: Normal external female genitalia. Cervix visualized. Pap smear obtained. By manual exam, unremarkable.

RECTAL: Normal sphincter tone. No palpable masses. Guaiac negative stool in the vault.

EXTREMITIES: No clubbing, cyanosis, or edema. The patient has 2+ distal pulses bilaterally.

NEUROLOGIC: Grossly intact.

LABS:

1. EKG was obtained and reveals a sinus bradycardia. There are no significant STT wave abnormalities.
2. Urinalysis unremarkable.

(786)

MIDLANDS INTERNAL MEDICINE

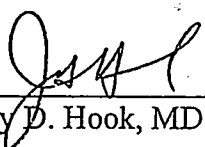
PHYSICAL EXAMINATION

NAME: Gertrude Shiver
SS#: 249-98-2546
DATE: 04/21/06

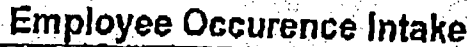
PAGE 4 OF 4

ASSESSMENT AND PLAN:

1. Paroxysmal supraventricular tachycardia. Asymptomatic on current regimen.
2. Hypertension. Extremely well controlled.
3. Reflux. Continue AcipHex with prn Maalox.
4. Degenerative disc disease with findings positive in the cervical and lumbosacral spine. She will continue with Mobic 15mg daily, as well as appropriate pain medications, as above.
5. Left-sided intercostal rib pain. Felt to be neuralgic in nature. We will obtain rib films to make sure no bony abnormalities. She will continue to follow with Dr. Brandt. Continue her Ultram CR, her Lyrica, and her Lidoderm patch.
6. Abdominal discomfort. Has been persistent but significantly improved since lysis of adhesions. She will follow with Dr. Odom, if needed.
7. Fatigue. Will check all endocrinologic and metabolic markers.
8. Bradycardia. EKG unremarkable. I suspect that this is medication induced, as she is both on a rate controlling calcium channel blocker and beta blocker.
9. Routine health maintenance. Basically up to date. She will need repeat colonoscopy in 2009, as her last was in 2004 and unremarkable. She was strongly encouraged to increase her cardiovascular exercise regimen, which she has done, watch her diet more thoroughly and perhaps lose some weight. We will continue to follow her extremely closely. See routine health maintenance form.


Jeffrey D. Hook, MD

(782)



188-B

- 12A
#0 Show

10-23-03
Date



"Gertrude Shiver"
<Gertrude.Shiver@PalmettoHealth.org>

03/02/2004 04:18 PM

To: SNSullivan@keyrisk.com

cc:

Subject: Re: Elizabeth.Holland@palmettohealth.org

02041416

DROP FILE

If you are not going to authorize any treatments with Dr. Hook, do not send for my medical records from him. I am not going to stop with my physician since I have already started with him to go to a nurse practitioner. This is a very unprofessional thing for you to ask. If I was already going to a physician over at healthwork, then this would be a different story. Please do not interfere with a patient-physician relationship. Furthermore, who is key risk anyway? Thank you.

Sincerely,

Gertrude Shiver

>>> <SNSullivan@keyrisk.com> 03/02/04 07:22AM >>>

Dear Ms. Shiver:

I have requested the medical records from your family physician, Dr. Hook; however

I wanted to advise once again that we will not authorize any medical treatment with

Dr. Hook per your injury of October 23, 2003.

If you feel that you are still in need of medical treatment per this injury, you will need to schedule an appointment for an evaluation with Health Works as soon as possible.

If you should have any questions, please give me a call....Thank you, Sandy Sullivan

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=====

(789)



"Gertrude Shiver"
<Gertrude.Shiver@Pal
mettoHealth.org>

03/02/2004 08:38 PM

To: SNSullivan@keyrisk.com
cc:
Subject: Re: Elizabeth.Holland@palmettohealth.org

Also, please send a letter to the Worker's Compensation Commission about your position concerning my medical care with Dr. Hook with this accident, the accident of October 2002, and January of 2003. Once again, do not send for my records from Dr. Hook. If you have already send for them, please send a cancellation letter and return the records if you have already received them. You had better destroyed the tape of January 26, 2004. In addition, please do not call back to my house again. Thank you.

>>> <SNSullivan@keyrisk.com> 03/02/04 07:22AM >>>

Dear Ms. Shiver:

I have requested the medical records from your family physician, Dr. Hook; however

I wanted to advise once again that we will not authorize any medical treatment with

Dr. Hook per your injury of October 23, 2003.

If you feel that you are still in need of medical treatment per this injury, you will need to schedule an appointment for an evaluation with Health Works as soon as possible.

If you should have any questions, please give me a call....Thank you, Sandy Sullivan

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=====

From: Gertrude Shiver
To: Elizabeth Holland
Date: 2/28/04 6:07PM
Subject: New doctor now at Health works

Dear Ms. Holland:

I have heard that there is a new doctor now working over at Health work. You didn't tell me that he was there in October of last year during the time of my accident. What is his name and when was he hired to work. Thank you.

Sincerely,

Gertrude Shiver

11/04 Saved to Ken Risk
29

(791)

From: Elizabeth Holland
To: Shiver, Gertrude
Date: 3/1/04 9:16AM
Subject: HealthWorks Physicain

Ms. Shiver, We only had a Physician in HealthWorks at that time on Wednesdays from 1:00 - 2:00 pm. And, employees with injuries were seen by him only if seen by the Nurse Practitioner first and then referred to him. I can not send an employee to see the Physician first, without being seen by our Nurse Practitioner first. That's why I did not mention it. We have a physician in HealthWorks now on Mondays from 1-2pm. The same applies, as for as a referral.

Thanks,
Elizabeth Holland LPN

(792)

67

From: Gertrude Shiver
To: Elizabeth Holland
Date: 3/2/04 5:22PM
Subject: KeyRisk

Dear Mrs. Holland:

Thursday, February 26, 2004, when you called, you didn't tell me who KeyRisk was. You told me to give authorization to them so that my bills could get paid. Today, I received an E-Mail from them and they didn't say anything about paying my bills for the accident of October of 2002, January of 2003, and October of 2003. She took some information about my health history over the telephone. If you told me that lie over the telephone under false pretense so that she could obtain my health information, then I am going to have to go further with this. I only received a call from this person and you on Thursday, February 26, 2004.

When she called she didn't tell me who Key Risk was. She started asking me about my accidents and I thought she was someone with PHTS, your worker's compensation carrier. I supposed to be dealing with worker's compensation, not with someone else. I am not going to sign a release for her to get anymore of my medical history from Dr. Hooks, in that she has already pretended she was someone else to get my information over the telephone. The release that I sign with you was only for the records for my emergency room visit of October 2003, not my own private physicians. Thank you.

Sincerely,

Gertrude Shiver

(793)

68

From: Gertrude Shiver
To: Elizabeth Holland
Date: 3/2/04 6:10PM
Subject: Giving out my phone number

Please do not give out my phone number to KeyRisk or other folks so that they will be calling my house asking about my worker's compensation injuries if they are not with PHTS, your worker's compensation carrier. Please tell that lady from Key Risk not to call back to my house anymore. In addition, you better tell her to destroy that tape of my telephone conversation with her about my health history and injuries. This is privilege information and I thought she was from PHTS and was going to pay for my previous treatments like you had told me over the phone. Thank you.

Sincerely,

Gertrude Shiver

(7 94)

From: Gertrude Shiver
To: Elizabeth Holland
Date: 3/3/04 4:35PM
Subject: Re: Workmans Comp.

No one ever said anything about you all switching worker's compensation company, and you did not mentioned this fact when you called the other day. Ms. Sullivan did not mentioned this fact in her letter the other day nor did she said anything about it when she called me and had me to give her my health information over the phone. As a matter of fact, no one ever told me who KeyRisk was. I don't appreciate what was done and how it was done to me on Thursday, February 26, 2004.

In addition, none of the nursing supervisors said anything about this either. Furthermore, nothing has been send out on the computer on the bulletin for different changes and happening concerning the hospital like public relations always send out to the employees, etc. As far as I have known, PHTS is your worker's compensation carrier and that is who I am dealing with. In addition, please do not give out my E-Mail address to anyone, because I didn't give you permission to do it. Thank you.

Sincerely,

Gertrude Shiver

>>> Elizabeth Holland 03/03/04 11:19AM >>>

Ms. Shiver,

I received your e-mail. Any injuries that you had prior to Oct. 1 2003, Would be under PHTS Workmans Comp. We switched Workmans Comp. Companies Oct. 1, 2003. Key Risk is the new Workmans Comp. company. So the injury that you had 10/23/03 would be under the new Workmans Comp. company Key Risk. And Sandy Sullivan is the person at Key Risk responsible for getting information and contacting you on this claim. The bills that you sent me from Oct. 24, 2003, was sent to Key Risk, Sandy Sullivan for payment. Any bills prior to Oct. 1, 2003 would go to PHTS. I did not, and would not give any information to anyone other than Workman Comp. carriers regarding any of your injuries. And I have not lied to you, so that she could receive your health information, for any purpose other than for your Workmans Comp. case of Oct. 23, 2003. The release that you signed here at HealthWorks on Oct. 24, 2003, was for any record related to this injury, and any treatment in regards to this injury of Oct. 23, 2003. I'm sorry if you mis-understood, but, we have switched to a different Workmans Comp. company, as of Oct. 1, 2003.

Sincerely,

Elizabeth Holland
HealthWorks RMH

(795)

October 18, 2005

Worker's Compensation Injury of October 23, 2003. W.C.C. NO. 0321756

Dear Sir:

On Thursday, October 23, 2003, around 8 p. m., I fell in the Medical Records Department at Palmetto Health Richland when my right foot got caught in the telephone cord that some of the workers had left in the aisle. After falling, I went to the Nursing Supervisor, Ms. Lenora Bell, and told her what had happened. There, she handed me the occurrence report and told me that I had to sign it. The hospital has made a new form with some of their worker's compensation instructions on the top area of the occurrence report. I was very hesitant about signing the form after I read what was written in the top section. I told Ms. Bell that I wasn't going to sign the form. Ms. Bell threatened me that if I didn't sign the form that she was going to tear it up; therefore, my employer wouldn't be put on notice of the accident. She also stated that their worker's compensation program was a process and that I had to go over to HealthWorks the next day and finish filling out some paper work.

After signing the form, she told me to go back to work. After returning to work, the pain in my entire left side became worst and I became very nauseated. I returned to the office to Ms. Lenora Bell and told her that I was sick. She was very angry and nasty with me, and she told me that I wasn't sick from the fall. Then, she told me to go to the doctor's lounge and get some ice and some crackers and used that for my nausea and to go back to work. Later on, I must call back to the nursing office if I didn't feel any better. After sucking on some ice because I didn't find any crackers, I didn't feel any better. In fact the pain and nausea was getting worst. Near the end of the shift, I paged the nursing supervisor about my condition and a Ms. Pam Schglione told me to go to the emergency room to be seen. After this, I went to the emergency room to be seen.

(796)

On Friday, October 24, 2003, I got up in the evening to go to HealthWorks to finished filling out my paper work. When I got to HealthWorks later that evening, Ms. Holland, the LPN start in after me as soon as I got there. After she took me into the room to fill out some more paper work she asked me if I needed to be seen. The only person that she offered me was the nurse practitioner. I asked, "Where are the doctors?" She replied, "Dr. Durkin is not here." I responded, "The emergency room physician instructed me to be off today and if I didn't feel any better after seven days, to follow up with my private physician." She taunted, "The emergency room physician don't know anything about worker's comp. If you go to your own doctor, worker's comp. is not going to pay for it." After I finished filling out the paper work, I left and went home.

I decided to follow the emergency room physician's instructions because I didn't want to get into anymore confrontation with Ms. Holland or the nurse practitioner. I remembered how they had tried to get me fired from my job with the injury of January 21, 2003. Besides, another emergency room physician on another occasion had told me not to go back over to HealthWorks. Even though management knows that the long telephone cord helped me to fall, no one has bothered about putting a short cord on the telephone. It has been over two months and I have not received a letter from PHTS with my worker's compensation number nor have I heard anything from them. In addition, another bad thing about all of these worker's compensation injuries is that now I cannot obtain any private medical insurance coverage for myself. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

Addendum: Management had removed the long cord off of the telephone and applied a short cord for a while. At the present time, someone has replaced a long telephone cord back on the telephone and the workers are stretching the cord from one cubicle to the other. I am afraid that I may have another accident.

Gertrude Shiver 10-28-05

(797)

0000
6/05

May 21, 2006

J. Michelle Childs, Commissioner
S. C. Workers' Comp. Commissioner
P. O. Box 1715
Columbia, S. C. 29202-1715

Re: W.C.C. File NO: 0321756

Dear Commissioner Childs:

I didn't go for an oral deposition because I don't feel comfortable going down on Main Street again for an oral deposition. In addition, I don't feel safe with the white attorneys. I think a written deposition sent to me would be better for me. Each time that I have taken an oral deposition, the white attorneys misinterpret what they found and then use the deposition against me. As a consequence, I am made to suffer some more needlessly each time.

In addition, the request for a hearing was only done in response to the denial letter that I had received from the worker's compensation carrier for Palmetto Health and because of the statute of limitation of two years. I need an attorney's help with my claims, but unfortunately, no one is willing to help me. In addition, I have not finished with my treating physician yet for this continuing left sided pain especially at and around the rib cages.

Furthermore, Attorney Chase had indicated in a prior letter sent to me that he was still denying my claim because I wouldn't go to their worker's compensation doctors. I have had about five accidents at Palmetto Health Richland Hospital and I think this accident of October 23, 2003, was only a continuation of the other four. At the time of this accident and the other four, there were only occupational health nurses and nurse practitioners taking care of the injured workers at HealthWorks. I believe this is still the situation at HealthWorks today. The Medical Director, Dr. Martin Durkin only came to HealthWorks on Wednesdays. By his actions, I believe he was incompetent to take care of me. I have some prior conditions and this fall help to aggravate these conditions. The

RECEIVED

MAY 25 2006

S.C. WORKERS' COMP. COMM.
OFFICE OF COMMISSIONER

(798)

Page 2

nurse practitioners couldn't take care of these conditions. In addition, there are only a few doctors that I can safely go to for care without being mistreated, or not getting the proper treatment, or no treatment at all.

The nurse practitioners didn't always refer the injured workers out to a specialist when indicated and this included me. I had been mistreated by the Nurse Practitioners and Dr. Durkin and not given the proper treatment with a prior accident. With another accident, one of the nurse practitioners had tried to get me terminated from my position at the hospital. In fact, I was placed on suspension for about a week and I was subjected and humiliated by having to take a urine test for drugs and a test for alcohol. The ER physicians had instructed me to follow up with my private physicians with these last accidents. One of the ER physicians had even instructed me not to go back over to HealthWorks.

The workers and the occupational health nurse at HealthWorks continue to mistreat me. I had to find work in another department at the hospital in order to pay on my medical bills that occurred as a result of these accidents that I have had at the hospital. On Friday, May 19, 2006, I was sent over to HealthWorks by this particular department to have a test done that wasn't related to worker's compensation. Libby Holland the LPN and one of the workers at HealthWorks was very verbally abusive and very argumentative with me. Because the second job wasn't my main job, she refused to send me for the test. In addition, someone had placed some false information in my chart.

In addition, Section 42-15-60 of the Codes of Laws of South Carolina didn't mention anything about the occupational health nurse or nurse practitioner taking care of the injured worker or being the soul medical provider for an injured worker. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd
Gadsden, C. C. 29052
(803) 353-3892

(799)

Spoke w/ MS. Shiver 6/2/06 and she said she would attend a scheduled deposition 6/16/06 @ 1901 Main St. w/ Attorney Mike Chase. Sneeze

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

File # 0321756
Carrier File #
Carrier Code #
Employer FEIN

Gertrude Shiver
Claimant's Name
1026 Congaree
Church Rd. Gadsden S.C. 29052
Address City State Zip
(803) 353-3892 (803) 434-2045
Home Phone # Work Phone #
Palmetto Health Richland
Employer's Name 29203
5 Medical Park Drive Columbia, S.C.
Address City State Zip
Key Risk Management Ser INC
Insurance Carrier
Gertrude Shiver (803) 353-3892
Preparer's Name Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☒ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of accident 10/23/03 2. AWW: Comp. Rate.

3. Type of injury and body part(s) Chronic pain on the left side. See attached sheet.

4. Facts in controversy: Was the fall of 10/23/03 a compensatory accident?

5. Legal issues involved: Refusal of the insurance company to pay for medical care as a punishment for me not going over to Health Works. See attached sheet and not following the Hospital's Injury Policy.

6. Unusual problems: See attached sheet.

7. Witnesses (designate if expert)* None.

8. Exhibits: None

9. Medical evidence: (indicate report pursuant to R.67-612; deposition or appearance)
Appearance Physicians notes have to be obtained.

10. Name, address, and specialty, if any, of the treating physician: See attached sheet.

11. Impairment rating(s); body part(s); physician and date of opinion: Unknown as of 5/29/06. I have not finished with the present treating physician yet. See attached sheet.

SIGNATURE Detrick Shiver 5/29/06

DATE OF HEARING: TIME OF HEARING: 7:00 AM
On behalf of ☒ Claimant ☐ Employer

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.

ATTACHMENT TO FORM 58

Number 3.

I have chronic pain on the left side especially in and around the rib cages and left breast. The pain in and around the rib cages is something new that occurred with this accident.

Also, I have some prior disability to my cervico-thoracic area that occurred from some prior worker's compensation injuries and car accidents. (See Dr. Gregory Jones notes.)

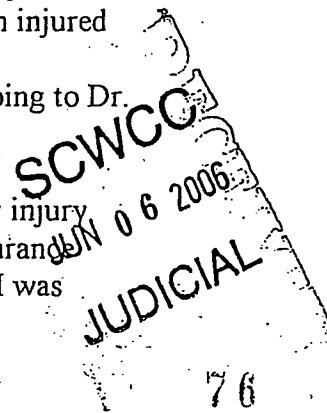
In addition, I have some conditions, some from workers compensation injuries that were aggravated by this fall. I had to have some surgery around June of 2004. I have some prior disability in my back that occurred from some worker's compensation injuries and car accidents. (See Dr. Gregory Jones notes and prior worker's compensation hearing with Commissioner Holly Saleeby Atkins.)

I continue to have some chronic pain in the left leg, heel, and foot. This accident helped contribute to some of the pain in the left leg. The pain, tingling, stinging, and numbness, in the left leg, heel, and foot first started with the worker's compensation injury at Palmetto Health Richland on 11/15/01. I had some pain in the feet occasionally because of some prior worker's compensation injuries in 1994 and January of 1995. With the accident of January 1995, the tendons and ligaments dropped in both of my feet where by my feet became flat.

Number 5.

Key Risk Insurance Company refused to pay for some of my medical care as punishment for me not going over to HealthWorks. Administration, the occupational health nurse, and the nurse practitioner were angry at me for not following their hospital's injury policy that pertained to the workers compensation injured employee. In addition, Sandy Sullivan of Key Risk Company stated that she was not going to pay for me going to Dr. Hook.

Subsequently, she sent me a denial letter concerning my injury. Therefore, I along with Blue Cross and Blue Shield Insurance Company had to pay for my medical care. After 2003, I was insured with Comparison Health Care.



(801)

In addition, administration along with the nurse practitioners and occupational health nurses, etc became angry with me with the accident of 3/23/02. Their anger and resentment toward me escalated with this accident of 10/23/03.

At the time of the accident of 10/23/03 at HealthWorks, there were only occupational health nurses and nurse practitioners to take care of the injured worker. The only doctor that I ever saw was Dr. Martin Durkin who I found out was the medical director and he only came on Wednesdays. By his action with a previous injury that I had at Palmetto Health, he seemed to be incompetent to take care of me. At least that is what happened with a prior accident of 11/15/01. Also, I had some problems with the nurse practitioners with this accident as well as the accident of 11/15/01 and the accident of 1/20/03. With all of my following accidents including the accident of 10/23/03, the emergency physician told me to follow up with my private physician. With my second accident of 3-23-02, the emergency room physician at Baptist Hospital had told me not to go back over to HealthWorks.

In addition, I had been mistreated at HealthWorks. As recent as May 19, 2006, I had some trouble with Libby Holland and another one of the office staff. Also, the nurse practitioners does not always referred the injured worker out to a specialist when warranted. Furthermore, I can only go to a few physicians without being mistreated, or not getting the proper treatment, or no treatment at all. There is no way that the Worker's Compensation Laws or a Commissioner can make a physician, nurse practitioner, or occupational nurse take care of me.

In addition, The Codes of Laws didn't saw anything about the occupational health nurse and nurse practitioners being substituted for the physician in taking total care of the injured worker.

Number 6.

As a result of Key Risk Company along with the other insurance companies not paying any on my medical bills, I was forced to obtain a prn job in another department to continue paying on my medical bills. In addition, I had to struggle to write and publish a book in order to generate some money in order to pay on my medical bills. In addition, I need an attorney to help me with my claim, but no attorney will help me. None of them would give me a reason why. I can't seem to find the time within working to study so that I can take the entrance exam for law school so that I can learn how to represent myself and file a law suit.

(802)

SCWCG
JUN 06 2006
JUDICIAL

I have some prior medical conditions, especially my back that was aggravated by the fall. With all of the workers' compensation injuries that I have had, I am a victim of the Worker's Compensation Laws of South Carolina, because I don't have an attorney and some prior things that were done to me by the Commissioners.

I have had four more worker's compensation accidents at Palmetto Health Richland and I believe that this one is only a continuation of the other four.

Number 10.

At the present time, I am being treated by Dr. Thomas E. Brandt Jr. D. O. Address: The Center for Pain Controlled West Wateree Medical Complex, 1165 Highway 1, Suite 300, Lugoff, S. C. 29078. Telephone: (803) 408-3033. Fax: (803) 408-3011

Number 11.

This is unknown at present. I am still treating with my physician.



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803)353-3892

SCWCC

JUN 06 2006

JUDICIAL

(803)

0321756

PR

June 20, 2006

The Honorable J. Michelle Childs
South Carolina Workers' Compensation Commission
Post Office Box 1517
Columbia, S. C. 29202-1715

Re: Oral Deposition with Attorney Michael E. Chase on 6/16/06

Dear Commissioner Childs:

I did my oral deposition with the above attorney as ordered, but the deposition is not accurate. I called to his office around June 2, 2006, and spoke with his paralegal Heather K. Zemp to inquire about a written deposition and about the kinds of questions that I would be asked. I was only given a few generalized questions.

The accidents and injuries that I have had happened over too great a span of time and I have had more than a few of them. They were too much to talk about and to remember them all in one setting. I have been traumatized by all of the workers' compensation accidents that I have had thus far, especially the ones that I have had in Charleston, S. C. Some of the Commissioners before you made the conditions worst for me mentally. I don't like to think about them or to bring them up because I get anxious and nervous and I don't remember things about them that I should have during these times. This also includes all of the ones that I have had at Palmetto Health Richland and my car accidents.

He told me that I could correct the errors when the deposition is printed out before I sign it. I have not received the printed deposition yet. I would like the opportunity to correct the errors before the hearing. I am going to give him some material that contains the correct information for some of the questions that he asked that I remembered and that he wanted the answer to concerning some of the accidents that he asked me about on the deposition. Also, I am going to give him a copy of a book that I have written and publish where he can reference some of the major worker's compensation accident and injuries and some of the accidents that I forgot to tell him about. The book also contains some information where I was terminated from my last major nursing job. Thank you.

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JUN 21 2006

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(804)

Sincerely,

Gertrude Shiver

Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

(803)

80

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December 17, 2006

Ms. Ashley Jacobs Bloom, Judicial Director
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, S. C. 29202

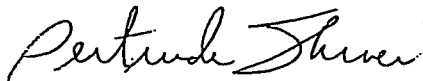
RE: WCC File No.: 0321756

Dear Ms. Bloom:

Enclosed is a letter that I wrote Attorney Michael E. Chase, after I found out that it was he who was the first ball in the chain in me being fired from Palmetto Health Richland.

The book was give to him as part of my deposition to the above reference worker's compensation case that he had Commissioner Childs to subpoena me to attend. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

(806)

SCWCC
DEC 19 2006
JUDICIAL

81

October 18, 2005

Worker's Compensation Injury of October 23, 2003. W.C.C. NO. 0321756

Dear Sir:

On Thursday, October 23, 2003, around 8 p. m., I fell in the Medical Records Department at Palmetto Health Richland when my right foot got caught in the telephone cord that some of the workers had left in the aisle. After falling, I went to the Nursing Supervisor, Ms. Lenora Bell, and told her what had happened. There, she handed me the occurrence report and told me that I had to sign it. The hospital has made a new form with some of their worker's compensation instructions on the top area of the occurrence report. I was very hesitant about signing the form after I read what was written in the top section. I told Ms. Bell that I wasn't going to sign the form. Ms. Bell threatened me that if I didn't sign the form that she was going to tear it up; therefore, my employer wouldn't be put on notice of the accident. She also stated that their worker's compensation program was a process and that I had to go over to HealthWorks the next day and finish filling out some paper work.

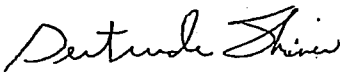
After signing the form, she told me to go back to work. After returning to work, the pain in my entire left side became worst and I became very nauseated. I returned to the office to Ms. Lenora Bell and told her that I was sick. She was very angry and nasty with me, and she told me that I wasn't sick from the fall. Then, she told me to go to the doctor's lounge and get some ice and some crackers and used that for my nausea and to go back to work. Later on, I must call back to the nursing office if I didn't feel any better. After sucking on some ice because I didn't find any crackers, I didn't feel any better. In fact the pain and nausea was getting worst. Near the end of the shift, I paged the nursing supervisor about my condition and a Ms. Pam Schglione told me to go to the emergency room to be seen. After this, I went to the emergency room to be seen.

(807)

On Friday, October 24, 2003, I got up in the evening to go to HealthWorks to finished filling out my paper work. When I got to HealthWorks later that evening, Ms. Holland, the LPN start in after me as soon as I got there. After she took me into the room to fill out some more paper work she asked me if I needed to be seen. The only person that she offered me was the nurse practitioner. I asked, "Where are the doctors?" She replied, "Dr. Durkin is not here." I responded, "The emergency room physician instructed me to be off today and if I didn't feel any better after seven days, to follow up with my private physician." She taunted, "The emergency room physician don't know anything about worker's comp. If you go to your own doctor, worker's comp. is not going to pay for it." After I finished filling out the paper work, I left and went home.

I decided to follow the emergency room physician's instructions because I didn't want to get into anymore confrontation with Ms. Holland or the nurse practitioner. I remembered how they had tried to get me fired from my job with the injury of January 21, 2003. Besides, another emergency room physician on another occasion had told me not to go back over to HealthWorks. Even though management knows that the long telephone cord helped me to fall, no one has bothered about putting a short cord on the telephone. It has been over two months and I have not received a letter from PHTS with my worker's compensation number nor have I heard anything from them. In addition, another bad thing about all of these worker's compensation injuries is that now I cannot obtain any private medical insurance coverage for myself. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

Addendum: Management had removed the long cord off of the telephone and applied a short cord for a while. At the present time, someone has replaced a long telephone cord back on the telephone and the workers are stretching the cord from one cubicle to the other. I am afraid that I may have another accident.

Gertrude Shiver 10-28-05

June 17, 2006

Attorney Michael E. Chase:
Turner Padgett Graham and Laney PA
P. O. Box 1473
Columbia, S. C. 29202

RE: 1. Oral Deposition of 6/16/06
 2. Reminder that I haven't forfeited my chance to make corrections to the oral deposition.

Dear Attorney Chase:

I forgot some things yesterday, but that is what happens to me. The oral deposition is not accurate because I forgot some of the accidents. I have had quite a few of accidents and worker's compensation injuries that occurred over a span of time and I couldn't remember all of them. They were too much to remember and talk about in one setting. In addition, I have been traumatized by the many injuries and accidents and I forget things that I should remember when I become anxious or nervous. This is what happened with this accident of 10/23/03 concerning my left wrist. Also, the physician in the ER didn't record that I was lying on the floor after hitting the floor. I fell over on the floor after hitting the floor. That was the position I was in when the coder helped me off of the floor.

I have written and publish a book where I have chronicled a lot of the major compensation accidents and injuries starting with Trident Regional Medical Center. If the publisher didn't make any mistakes, you can use it as a reference for a lot of the major worker's compensation injuries and accidents that I have had and for some of the ones that I have forgotten to tell you about. I haven't read the book since it was published. The book is to be used as part of my deposition if no objection from Commissioner Childs. The ones from Palmetto Health Richland are also included. The book was not written in an attempt to try to discredit your client, though. In addition, please don't take anything you find in the book personally. The book also contains some

information about my firing from my last major nursing job. Along with the book, I have enclosed a Directory if you need to find some of my prior doctors that live in Charleston, S. C. In addition, I have included some papers with the correct information in them concerning some of the questions that you asked me. They are to correct some of the misinformation that I gave you during the deposition. I am asking that you don't interfere with what is occurring with me naturally or to attack me personally.

In addition, I forgot to tell you that around August 13, 2003, that I fell at the Embassy Suites Hotel at 200 Stoneridge Drive in Columbia when I was at a 3 M Conference. I slid on the carpet and fell when I got up to go to the bathroom. I couldn't find an attorney to help me with this claim so I am going to loose it as of August 13, 2006. The manager didn't tell me to come and fill out a form nor would the managers tell me the name of the insurance company so that I could file the claim myself.

It was my personal physician William E. Crouch who had been helping taking care of me while I was in Charleston S. C. during the two falls of 1994, and the fall of 1995. I think I may have visited him several times after the patient hurt my back in October 11, 1997. It was around May of 1998, that I found out that Dr. Crouch had lost his license to practice and he had to subsequently close his office. Afterward, I went to Dr. William P. Clare, Jr. for care. He was located in a building West of the Ashley near St. Francis Hospital. I think Dr. Crouch is still in Charleston. Perhaps you can use the directory for his whereabouts.

I fell up the steps on October 24, 1994, at Trident Regional Medical Center Human Resource office. It was after this incident that I began to notice some swelling in my left ankle of my left foot. I was sent to Dr. Robert Bowles, an orthopedic, who was treating me for this injury. The hospital refused to accept responsibility for it. With the fall of January of 1995, I fell and hurt myself again. After I had gotten a denial letter from their worker's compensation carrier Alexis, Thomas White and E. Douglas Pratt-Thomas had Commissioner Bryan Lyndon to issue an Order where they only included the injury to my right shoulder and right foot. By this Order, they had gotten rid of my injuries for the falls of 1994 and the other injuries of January of 1995. Dr. Bowles had turned me a loose and they had included in the Order that Dr. James J. McCoy would take care of my right shoulder and right foot. However, Dr. McCoy never took care of me but hurt my chest in the initial visit and told me never to come back to his office again.

With the car accident of April 1997, the orthopedic Dr. James C. McIntosh, Jr. of Charleston Bone and Joint was taking care of me. Later on after I left Charleston in 1998, he left Charleston Bone and Joint and he was working at one of the orthopedic offices located near the East Cooper Medical Center in Mt. Pleasant, S. C. The insurance company for the other motorist was Geico Insurance Company. I had to end up settling the claim because the attorneys wouldn't help me. The last attorney that had the claim was Attorney W. Scott Palmer from Santee S. C. I had to end up settling the claim myself because the statute of limitation of three years had run out.

Dr. George F. Warren of Carolina Spine Institute of Charleston was the orthopedist who saw me after the Worker's Compensation injury of October 11, 1997 at Trident Regional Medical Center. It was this accident that I incurred a herniated disk at the L-4, L-5 level.

With the car accident of November 25, 2000, I was never under the care of an orthopedist because Dr. Jaiprakash Patel of Peterson and Plante office on Laurel Street never referred me out to one. Driver's Choice was the insurance carrier for the other motorist. Attorney Barry George represented me.

With the workman compensation injury of November 15, 2001, I went to Dr. Robert Belding and Dr. Angus McBryde orthopedists. These were the doctors that the hospital sent me to. I went on my own to Dr. David Minter at the Sports Medicine Associates of Augusta, Georgia after talking to a co-worker of mine because I didn't have anyone to go to. Later, I went to the Miller Orthopedic Clinic in Charlotte, N. C.

When I first was hired for Richland Memorial Hospital, I remember giving the nurses a copy of my disability note at HealthWorks over at Baptist hospital from Dr. Jones about my disability ratings when I went for my pre-employment physical. I don't know if they had made a copy and put it in my folder or not.

I forgot to tell you that during the summer of 1998 after I was fired from Trident Regional Medical Center, I went to work at Hermina Traeye Memorial Nursing Home on Johns Island, S. C. I wasn't hired for nursing but the Nursing Director told me to give the medications to the patients. The cart was too heavy and it aggravated my already injured muscles. I only worked there 2 ½ days. I was terminated after developing severe pain on the left side of my neck going down my left shoulder and left side of my back. I never went back to inquire about the job that I was hired for because I left and came back home. The nursing home closed and I don't know if it ever opened back up.

Some years before I went to work at Trident Hospital, I was stopped at a light near the museum on Meeting Street in Charleston when some boys ran into the back of me. They drove away from the scene without giving me any information. I made a report with the policemen but I never heard any more from it. I went to St. Francis Hospital that morning and got checked out. I don't remember the year.

As for traffics tickets, I got one about two years ago for speeding while I was in Columbia. I also have gotten a ticket because my parking meter ran out before I could get out of the gym. While I was in school at USC, my so-called boyfriend ran up some traffic tickets on me when he was driving my car. These were made by him, not me.

Attorney Paula Stewart had my accident cases of 11/15/01 and 3/23/02, and then Michael Kelly took over. No one is handling the claims at present. PHTS never paid Dr. Jones any on my medical bills even though they gave him authorization to treat my back with the injury of 3/23/02.

Page 4

PHTS gave Dr. Jones permission to treat my neck injury of 10/24/02, but then they refused to pay him anything.

PHTS and Key Risk Management Services never paid Dr. Hook anything either.

I don't have my physician records concerning this accident of 10/23/03. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

P.S. I didn't know how far to go back to try to remember and to hunt through my papers. I am available to try to clarify some of the other questions that you asked. Please let me know what they are. I didn't include the rest of my pain medications with this letter because you told the secretary on 6/16/06 after the deposition that you didn't need them. If you decide you do need them, I will gladly send you a list.

(812)

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July 7, 2006

Michael E. Chase, Attorney
Turner Padgett Graham & Laney P.A.
P. O. Box 1473
Columbia, S. C. 29202

JUL 7 2006
1329.238

Re: Oral deposition of 6/16/06

Dear Attorney Chase:

Although I have not received the deposition yet, I remembered some more of the questions that needed clarifying. I don't know what number the questions are on the deposition, but I have given each a heading. They can be matched up with the questions on the deposition when it is available.

At the deposition, you stated that you were only interested in the accidents that I had had that I received medical attention for. Does this still hold true? If I remember any more questions that need clarifying before I receive the deposition, I will clarify them and bring the document to your office. Thank you.

Sincerely,



Gertrude Shiver
1026 Congaree Church Rd.
Gadsden, S. C. 29052
(803) 353-3892

CLARIFICATION TO SOME QUESTIONS OF THE ORAL DEPOSITION OF
6/16/06

EMPLOYMENT HISTORY

First and foremost, I was a servant of God (my first master) a very long time before I became an employee of Palmetto Health Richland (my second master). My first master has never released, discharge, or terminate me from this capacity.

Before I began, I know that my employment history does not look good; but I started off on the wrong foot. When I first entered nursing school at The University of South Carolina in 1978, there were quite a bit of black students in the program. I can't remember the exact number. The aim of some of the professors was to weed out some of them. A few of the white students were also weeded out. I made it through up until about two months or so of my senior year before graduation. There was an incident that happened at your client's place of business where the instructor claimed that I was going to make a medication error, but I was stopped. The patient had been on a ventilator and one of his medications supposed to have been on hold. My white instructor claimed that I had gotten some of the sounds of breathing and the heart mixed up. I was not supposed to give the medication, but I was preparing to do so. She embarrassed and humiliated me before the other students and nurses on the unit and afterward the nurses at your client's facility started making it hard for me during the rest of the time at my clinical site.

My instructor had tried to prevent me from graduating, but there was no university policy to assist her and I don't think that there was anything legally she could have done to prevent me from graduating. In the end, I think that there were about six black students including myself that graduated. Since she couldn't do anything against me to prevent me from graduating, I believe she and some of the nurses started to black ball me. While I was in school, I used to work as a nurse tech at Baptist Hospital. After word about this incident got out into the nursing community and I didn't know who else knew about it, my head nurse at Baptist called me to the hospital one day and fired me. I don't remember her giving me any reason why she fired me. After this, I was afraid and I didn't know where to look for work. One of my instructors had recruited me to work at the VA Hospital. After going there, I found out that as a new graduate that I really didn't like their military style of nursing and this type of environment. Then there was some jealousy with some of the black nurses assistants.

After leaving the VA hospital, I went to Providence Hospital to work. There was also some resentment toward me there because I had previous worked there during the summer as a nurses' tech while I was in school. The head nurse was also prejudiced against me and she didn't like the fact that I was a black registered nurse. I don't think that she had her bachelor's degree. I can't remember the exact circumstance, but

something happened and she busted me back down to a nurse's tech. She subsequently terminated me. Also as a new graduate, sometimes I was overloaded with patients and these patients weren't easy patients to take care of. I don't think I had less than ten patients to take care of at one time. The floor that I was assigned to when I first was hired at Providence Hospital was a dumping ground for all the rest of the floors. I remembered having up to twelve patients to provide nursing care to plus all of the other things that I had to do within an eight hour shift. After some of the nurses saw that I couldn't take care of these many patients with all of the things that were going on, some of the charge nurses started giving me up to six patients to provide care to. It wasn't an easy floor that I was working on. I believe that the head nurse got in trouble with administration after she had fired me.

After having been terminated from Providence Hospital, I didn't know what to do or where to go to find work. One of the black nurses that I met at Providence Hospital took me down to Orangeburg hospital but they weren't hiring. My cousin, who is a nurse, took me down to Charleston, but I really didn't want to work down there. After this, I started making plans to get out of this type of environment in South Carolina and to go up North to find work. In addition, I was tired of hearing my oldest sister Sarah's mouth about me finishing college and not working and about me not speaking proper English. Another black nurse at Providence Hospital, who had befriended me while I was there, talked me out of leaving the state. She took me down to Beaufort to Beaufort Memorial Hospital because she thought that this would be a better environment for me. This was her home town. After I had been hired at this hospital, I found out that there was some resentment toward me by some of the nurse's assistants and some of the black LPN's. Beaufort Memorial Hospital had recently let some of their workers go before I came, and they had hired me. I don't know the status of the people that they had let go, but I think that they may have been nursing assistants. All types of patients were on this unit including pediatrics. This was a large unit and it wasn't an easy unit to work on either. I believe that I was the only black RN on this unit even though I was a fairly new graduate.

The Director of Nursing had a military background. They had hired a white nurse as the head nurse and she harbored some resentment toward me. She was having some difficult times trying to manage the floor as well as some personal problems with her child. I remembered working over my quitting time one night to get the next shift started. The next day that I came back to work, they had already fired me and I can't remember what the exact circumstances were. I wasn't guilty of what they had accused me of. I believe that I had signed the form because of how they were treating me in the office. Subsequently, the Director of Nursing sent me over to the psychiatrist, but I wasn't crazy. I only went to the psychiatrist one time and I never went back. After I couldn't find any work in Beaufort, I went over to Charleston where I was hired at Charleston Memorial Hospital. I was placed on a smaller unit at Charleston Memorial Hospital.

Still, I was the only black RN on this floor. I think I was the only registered nurse besides the head nurse. This unit was more specialized and there wasn't a mixture of all kinds of patients. There were mostly orthopedics, genitourinary, and gynecological patients. Even though I had grown professionally and I was more assertive, I still was missing something in my professional life. I had never really had a black professional mentor. After working at Charleston Memorial Hospital for a number of years, I heard that there was a dynamic black nurse at Trident Regional Medical Center. So I went there in 1988, and I was hired. I didn't want to quite Charleston Memorial Hospital, so I went on a nursing pool where I was working every other weekend. After this, I was working I believe one weekend out of the month.

After I fell at Trident Regional Medical Center in 1995, I wasn't able to continue working full time at Trident Regional Medical Center and one weekend out of the month at Charleston Memorial Hospital. Dr. Crouch had given me an excuse for a while but I still wasn't able to go back. Since I wasn't able to go back to work at Charleston Memorial Hospital on the nursing pool and keep my end of the bargain, I was terminated.

It was after the patient had hurt my back at Trident Regional Medical Center on October 11, 1997, that my job termination began after I had worked at this facility for a number of years. This was the last worker's compensation injury that I had had at Trident Regional Medical Center. It started on December 24, 1997. (See "The Fall of a Nurse" Chapter 3, starting at page 16.) The hospital had a four step termination policy which they had included in their handbook. First there was an oral warning, a written warning, suspension, and then termination. When I found out what they were doing to me even though I had a worker's compensation injury, I reported the hospital to the Worker's Compensation Commission. After that, Lynda Adams, the Cardiac Coordinator placed me on suspension for about a month, and then she fired me by mail.

Later on, Trident Hospital reported me to the State Board of Nursing. Around May 30, 2000, Patricia Wark, the attorney that I had obtain to help me tried to railroad me into loosing my license along with the Nursing Board Attorney. After I had the run in with Commissioner Ann Mickle and Attorney E. Douglas Pratt-Thomas on April 12, 2000, for the refileing of my worker's compensation case of 1994, I had written a letter to Governor Hodges about what was going on. Around October 6, 2000, I received a letter from the State Board of Nursing that the complaint against me had been dismissed. (See The Fall of a Nurse, Chapter 6 & 7.)

After I was fired from Trident Regional Medical Center, I was hired at Hermina Traeye Memorial Nursing Home to do some work on the computers. The Nursing Director put me on the medication cart instead to give the medications to the residents. The cart was too heavy and it only aggravated my already injured muscles. I only worked there for about 2 ½ days. I was terminated after developing severe pain on the left side of my neck going down my left shoulder and left side of my back. I was sent to one of the Urgent Care offices on Savannah Highway for treatment where I received some medication for

my muscles and I believe some pain medications. I never went back to check on the computer job.

After I returned home, I couldn't find a job. Finally, I was hired with Florence Nursing Service. I was sent to various nursing homes in different places to work. I was doing pretty well with this until the work slacked up. They started giving the best assignments to some of the other workers. Then they didn't have any assignments for me at all. I believe I went nearly six months without any work. One day the director of Ridgeview Manor called and told me that she needed me to work. I told her that I was still on the Registry at Florence Nursing Service and that I wasn't supposed to take an assignment from a work site on my own that I had previously visited. She told me that that was all right that she needed me to work. I went there to work and I was given some part time hours. I worked mostly on night shift, 12 hours from 7 p. m. to 7 a.m. I don't remember the director ever giving me a job application to fill out. The work there wasn't too bad and there were only a few total care patients. There wasn't too great a risk of me reinjuring myself. Sometimes, I would have to help the nursing assistants turn the patients. Most of the patients were up walking around. I had to give the medications, do the treatment, and make out the work assignments.

I worked at Ridgeview Manor while I was continuing my education at Midlands Technical College in Health Information Management. A new head nurse that had come had changed the working hours. When I finished school and started working at Richland Memorial Hospital in September of 2000, she still let me continue to work. My hours at Richland Memorial Hospital were from 3 p. m. to 11:30 p. m. I was supposed to have been at Ridgeview Manor at 11 p.m. I had gotten permission from the head nurse to come in late. She knew that I was working at Richland Memorial Hospital in my new field but she let me continue to work anyway. Ridgeview Manor had started taking in more total care patients by now and they had built a new wing. After there was a change in the administration, one of the white LPN's started complaining about me coming in late and that she had to stay late until I got there. Later on, my position was taken away from me and given to someone else and I was placed on the prn pool. I worked at Ridgeview Manor until the end of December of 2000, because I was needed for the holidays.

After I was placed on the prn pool, I went by the nursing homes a number of times requiring about the schedule and to see if any spots were open for night shift. This was the only shift that I really wanted to work and that I could work without interfering with my full time job at Palmetto Health Richland. In addition, I called many times to the head nurse and administration, but there was no work available for me. I finally stopped calling and going and I started looking for another part time job at the hospital because of the low salary that I was receiving.

It was sometimes in 2001 that I obtained a second job in the Trauma Registry at Palmetto Health Richland. After I fell out of the chair and the chair fell on top of my back on

March 23, 2002, I was out sick. When I came back, I felt that I was unable to work full times in the Medical Records Department and work those hours in the Trauma Registry. I was waiting a while until I thought my body was better and I could safely return to the Trauma Registry. When I felt that I was ready to return to the Trauma Registry, Alice Ammons, the trauma program coordinator wouldn't let me come back.

I had needed to work prn to help with the salary that I was making in the Medical Records Department because I had to pay my own medical bills. The administration in medical records and the hospital were punishing me for not following their worker's compensation policy and going over to HealthWorks for my medical care. Dr. Durkin, the medical director over HealthWorks told me on several occasions that I could go to any doctor that I wanted to but Worker's Compensation was not going to pay for it.

When I found out about Clinical Support and the sitting jobs, I went and did my paper work, but they never called me. I went back to check on the job more than once, but they still didn't give me an assignment. In 2005, I went to the Clinical Support office again and reapplied for some sitting assignments, and they finally let me do some.

At the present time, I continue to work in the Medical Records Department full time, and some prn hours in Clinical Support. I thought by working in the Medical Records Department, there would be a very low chance of me reinjuring myself since I already had some injuries to my back, feet, neck, and cervico-thoracic area. I had not been practicing nursing anymore since I left Ridgeview Manor and I lacked the minimum of 960 hours required for my license renewal. In April of 2006, because of the Codes of Laws of South Carolina Sections 40-33-940 and 40-33-950, and Nursing Regulations R 91-21, I had to placed my nursing license on inactive status.

COMMITTING OF A CRIME

According to God's law, I committed a sin. According to man's law, I committed a crime. To this day, I still don't know why I did what I did because I had plenty enough money with me to pay for the small item that I took. I think it may have been a harbinger to my trial of life events to remind me and to teach me not to forget to trust and rely on God (my first master).

I was told when I finished the Pre-trial Intervention Program that this would be erase from my record and my record would be wipe clean, and that it would not come back up again. I told Attorney Chase that he wasn't suppose to ask me that question but Attorney Chase told me that I had to tell. I am not a bad person.

WITNESS TO THE ACCIDENT OF 10/23/03

These two coders didn't actually see me fall but they heard me fall. They are Mrs. Gloria Clark and Mrs. Linda Layman.

HEALTH INFORMATION MANAGEMENT SPECIALIST

(My main job)

I am a health information management specialist. This job is mostly a light duty job and it is mostly a sedentary job. The majority of my shift is spent at the desk inputting information into the computer. I usually file papers and sit at the computer. There is some stooping, bending, standing, lifting, pulling, pushing, shifting, and reaching up, especially when I have to place the charts that I have analyzed on the shelves. When I go down stairs to the basement to file loose materials, I have to stand on a step stool to reach the top shelves of the file shelves. There is some danger of falling because some of the step stools are ragged and some are bent. Sometimes, I have to use the step stools on second floor to reach the top shelves.

I analyze charts and input information in the computers. Some time I help out in the front area by answering the telephone and pulling the physician charts for them to sign. I work with the outpatients charts. The majority of the charts that I handle except when I am filing loose material in the inpatient charts, are not that thick. They are mostly outpatient's charts. Some of the chest pain units charts are thick, but they are not as thick as the inpatient's charts. Occasionally, I have some thick heavy charts to work with.

Sometimes when the first shift employee is absent, I have to go to the different areas pushing a buggy to pick up the charts. There are carts in the Medical Records Department where I can place the charts on and roll it to my work station or to the rows of shelves. The majority of the times, the carts are not available for me. Other employees are using the carts, and sometimes the employees in the basement take the carts. At other times Barrington Wint, the manager on second floor, takes the carts and fill them up with inpatients charts and place them at the inpatients analysts work stations. When the carts are not available for me, I have to make several trips to my work station carrying a small load of charts in my arms. After I finished them, I have to carry them in my arms and placed them where they need to go. At the present time, I work 10 hour shifts, four days a week because of the gas prices. My hours are from 3 p.m. until 1:30 a.m.

MY SITTING JOB

(My second job)

Since I was made to pay my own medical bills related to these workers compensation injuries including this one of 10/23/03, I had to find another second job. In addition, the insurance that I have is not adequate. It punishes me for going to my own doctors. I was not allowed to go back to my second job in the Trauma Department after I fell out of the chair with my worker's compensation injury of 3/22/02. My job in the Trauma Department was just right for me. I had checked on some other jobs since that time, but this sitting job was the only one that I was able to get. This job is dangerous for me within itself, especially when I have to handle the combative patients and the confused patients that are in restraints. It is also dangerous for me when there is some lifting, pulling, and turning the heavy patients.

I have not been hurt as of yet because the nurses and techs that I have come into contact with have been understandable when I tell them that I have problems with my neck, back, and shoulder. I don't know how long this is going to last. Sometimes, the patients are combative and they try to leave their rooms and the hospital. I have to try to prevent them from leaving the hospital until someone else comes to help me. I am working this job and I hope that I don't get hurt. I do all right when the patients are not that bad or total care patients. Sometimes, I have to watch the babies that have been abused but they are all right to work with. I only work about four hours when I do work. Mostly, I sit and prevent the patients from pulling out there IV's and other tubes. I help them walk to the bathroom. Also, I help them with their bathing and feedings. I really need another desk job, but I have not found one. I have tried to get one in the admission office, but I have not heard anymore from that.

HOW THE ACCIDENTS HAPPEN AT TRIDENT REGIONAL MEDICAL CENTER

Please see, "The Fall of a Nurse" Chapter 1-3, pp 1-26.

AUTOMOBILE ACCIDENT OF 11/25/2000 **(Underinsured and uninsured motorist coverage with Travelers' Insurance Company)**

My Attorney, Barry George, who had been handling my automobile accident case of 11/25/2000, with Driver's Choice Insurance Company lied to me and misled me into settling my claim with Travelers Insurance Company and I didn't know that I was settling the claim with Travelers. He settled it for only a \$1000.00. He had the form covered up and he didn't explain anything to me or tell me that I was settling the claim with Traveler's Insurance Company. When I found out that he had lied to me, I sent the \$1000.00 back to the Attorney for Travelers Insurance Company, but he would not accept

(820)

it. Attorney George would not accept the \$1000.00 back either. Also, he had told me to lie on the deposition and I didn't know at the time that he was telling me to lie, nor did I know his motive for telling me to lie on the deposition.

I didn't know of any attorney who would be willing to sue Attorney George on my behalf. I think that the statute of limitation has run. I did report him to the Lawyer Disciplinary Board but the complaint was dismissed by an Assistant Disciplinary Counsel C. Tex Davis, Jr. He left me having to pay for the rest of my medical bills and the reimbursement to Blue Cross and Blue Shield Insurance Company and Marsh-Seabury and Smith, formerly Maginnis and Associates under subrogation. (See "The Fall of a Nurse," Chapter 13, pp. 129- 135. p. 142. Appendix A.)

LIVING CONDITION

Presently, I am living in a ragged mobile home. I have some funds which I can borrow against to build me a nice home, but I don't have anyone to help me or to guide me. I am not a business person. In addition, I don't have an attorney to help me and I don't know of any one who would be willing to help me. I don't know what home builders to trust since there are some unscrupulous people who like to take advantage of single women. Also, I didn't want to start building a home and I didn't have enough money to quite finish it and I loose my job. Consequently, I would loose the house and my land. Since the State of South Carolina is a "right to work state," there is lot of fear among the workers of this state. There was more fear created when the General Assembly of South Carolina passed the at-will employment bill No.H3448 and Governor Mark Sanford signed it into law on March 15, 2004.

Also, I have some health problems after all these workers' compensation injuries. I don't know when it may be necessary for me to have some surgery on my spine, and I will have to use up all of my savings and retirement funds to pay off my debts and medical bills.

NOT ACCEPTING THE \$7, 500 FOR THE INJURY TO MY RIGHT SHOULDER AND RIGHT FOOT

When I told you that I didn't accept the above offer for the injury to my right shoulder and right foot for the worker's compensation injury of January 1995, it was the principle of the matter. In addition, this offer wasn't acceptable to me. Furthermore, I was speaking on behalf of my first master. I belong totally to my first master, especially my left foot and my body is worth more than that to my first master. I can't be compensated for the members of the right side of my body and not the left side, especially my left foot.

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9/15

Furthermore, I think the sequelae of my high blood pressure and rapid heart rate may have come about because of the injury to my chest area.

Attorneys Thomas White and E-Douglas Pratt-Thomas drew up an order which Commissioner Bryan Lyndon issued and Attorney White made me sign which deliberately got ride of my claims and injuries of 1994 and the rest of my injuries for the claim of 1995. (See "The Fall of a Nurse" Appendix A.)

Commissioner Ann M. Mickle had wanted to clinch up all of my claims including the one to my back that Commissioner Atkins had left open if I had accepted the \$7, 500 for my right shoulder and right foot. (See the Fall of a Nurse, Chapter 6, pp. 47- 53.) She was very eager to do this. I could never bring these injuries up again to the Commissioner. Both of my feet are flat because the ligaments and tendons dropped in my feet after falling on the concrete floors at Trident hospital with the accident of January 1995. She was very angry with me for some reason. She was acting illegally and unethical toward me.

With all of the falls that I have had, I have never broken a bone that I know of. Although my bones have been bruised, they have never been broken. It is always my tendons, ligaments, muscles, and joints and spine that are affected. My shoulder area is half of my chest. It contains a lot of tendons and ligaments and joints. Included along in this area are a lot of the major blood vessels. Furthermore, I think what is happening to me is not about money. I think that this is a religious experience that I am going through.

When the General Assembly of the State of South Carolina was dividing up my first master's creation and assigning a monetary value to each member, they ignored the tendons, ligaments, and I believe the joints. The State of South Carolina needs to recognize these important members of God's Creation and assign a monetary value to them. The \$7,500 is not enough for the members of my first master's creation. I have trouble with my tendons, ligaments, and joints.

HEALTHWORKS (Punishment)

It was on November 11/15/2001, with the injury to my left Achilles tendon, left heel, and foot that the Supervisor, Barrington Wint, called around and told me to go to HealthWorks for my on-the-job injury. He told me that this was the place that I had to go. He did not send me to the Emergency Room. Since that time, HealthWorks is also indicated in the Worker's Compensation Illness/Injury Policy and Procedure of Palmetto Health Richland for the injured worker to go to for care. HealthWorks is staffed with occupational health nurses and nurse practitioners. The only physician that I ever saw was Dr. Martin Durkin who only came there on Wednesdays for a few hours. He is the medical director for HealthWorks and a neurologist.

There, I meet Barbara Griffin, the occupational health nurse who gave me an ice pack and told me to take some over the counter medication for pain. I was sent back to work. On Friday morning, 11/16/2001, I fell up the steps at home and hurt my left elbow. I called back to HealthWorks where I had to return to see Coleen Collins, the nurse practitioner. She really wasn't directing my care nor did she give me anything strong for the pain. I made some visits to her and then she turned me loose with the problems that I was still having from the injury to my left foot, Achilles tendon, and left heel. Later on, I returned to see Dr. Durkin when I was having some neurological symptoms (See "The Fall of a Nurse," Chapter 8, pp 67-69, 71-73, 76.) Later on, I found out that Dr. Durkin was only the medical director of HealthWorks and I don't think he was competent to take care of an orthopedic injury.

When I fell out of the chair and hurt my back on March 23, 2002, I was told by the Emergency Room Physician at Baptist Hospital to follow up with my private physician and not to go back over to HealthWorks. I told him about the injury to my Achilles tendon, heel, and foot. I had had two accidents at Palmetto Health Richland within four months time. The Administrations in the Trauma Department, Medical Records Department, Dr. Durkin, and the occupational health nurses and nurse practitioners at HealthWorks were angry with me for not following their policy and procedure and going over to HealthWorks for care for my back. Therefore, they would not pay me for the days that I was out sick. Attorney Paula Stewart was helping me with my first and second claim. PHTS had authorized treatment for my back at Charleston Spine and Physical Medicine if I would relinquish my right to mileage. I did this by filling out a form and returning it to Attorney Paula Stewart. I only relinquish my rights if they would pay for my treatment. They never did pay for my treatments. I believe Dr. Durkin was being vindictive toward me. In addition, I was being mistreated by the nurses.

I have some herniated discs in my spine. Under the Nurse Practice Act, the Nurse Practitioner is not allowed to give injections in the joints and the spine. This is the physician's domain. At the time of the accident of 3/23/02, I only knew of two offices that did injections in the spine beside the anesthesiologist at the hospitals. They were the Southeastern Spine Institute, LLC, formerly the Caroline Spine Institute, and Charleston Spine and Physical Medicine. Both of these offices are located in Charleston, S. C.

After my Worker's Compensation accident of October 11, 1997, I was sent to Carolina Spine Institute after visiting Trident Industrial Medicine and Trident Sports Medicine. There, I had met Dr. George Warren who was taking care of me. He claimed that it was my muscles that were giving me the problems. After I had some physical therapy, he turned me loose in 1998 with a herniated disc in the lumbar area of my spine. At this time, I didn't know that I had a herniated disc, but I was continuously having pain and I was hearing a crunching sound in my back. I had had some neurological problems with my leg (See "The Fall of a Nurse," Chapter 3, pp13-14, 17-18.)

When I visited Dr. James C. McIntosh's office and he found out what Dr. Warren had done, his office called back to the Carolina Spine Institute for me to return there for continued treatment. All of the doctors at Carolina Spine Institute refused to see me. They stated that I had to return to Dr. George Warren. I didn't want to go back to Dr. Warren, so Dr. McIntosh's office called and got me an appointment at Charleston Spine and Physical Medicine. I have been going there ever since for some injections to be given in my back and problems with my spine.

I believed that Dr. Durkin and Coleen Collins were negligent in the treatment of my left foot. According to Section 42-15-70 of the Codes of Laws of South Carolina, there is no medical malpractice. Nothing is said about the nurses and nurse practitioners. In addition, I think that there may have been a violation of MER 81-110. I believed that I had a cause of action. Dr. Durkin is not qualified to give injections in the joints or spine. The injured worker is not always referred out to a specialist. At other times, they are not referred out in a timely manner. Unfortunately, Attorney Michael Kelly wasn't interested in helping me and I couldn't find any one else. I haven't been able to establish and keep a lasting relationship with an attorney. Because of a lack of legal representation and the statute of limitation, I am unable to seek redress from Coleen Collins, nurse practitioner for her treatment of my left foot for the accident of November 15, 2001.

In Section 42-15-60 of the Codes of Laws of South Carolina, there is mention of a physician other than provided by the employer to provided medical care to the injured employee. Nothing is said about the nurse practitioner caring for the injured worker. Since the Emergency Room physician had told me to follow up with my private physician and not to go over to HealthWorks, I followed his instructions. He did not tell me to go to the nurse practitioner or to Dr. Durkin. If I had gone over to HealthWorks, than I would be following up with the nurse practitioner since that is the person that was offered to me for care. The nurse practitioners are no substitute for a physician. In addition, Palmetto Health Richland HealthWorks knew about my prior disability to my back, especially Dr. Durkin. Dr. Durkin wasn't qualified to give injections in my spine. I think Palmetto Health Richland should be punished for not providing a physician for my care, and refusing to pay for a physician that I found on my own.

RELIEF

When I told you that I wanted you to pay me for chronic pain, I was thinking about Palmetto Health Richland and the Worker's Compensation Laws of South Carolina and not focusing on my first master and his laws.

Since the General Assembly forgot about the tendons, ligaments, and joints of the human body, and they didn't assign a monetary value to them; I thought I could only claim pain. I don't have a disability rating for these organs. In addition, I have not finished treating

(828)

with Dr. Brandt yet. Since I am a damage servant for my first master, and I wasn't provided with a physician by Palmetto Health for my care, I need to be compensated for more. My knees and hands are what I use in my prayers and supplications to my first master. I have trouble kneeling down to pray because of the pain in my knees.

Palmetto Health and its Insurance Carrier, Key Risk Management Services, need to pay all of my medical bill, my physicians' bills and some of my future earning capacity. They need to pay for my physical therapy for my left leg and foot. They need to pay for the injections to my side, back, and chest area. They need to reimburse Blue Cross and Blue Shield and Companion Health Care for paying for my medical treatment. In addition, they need to pay for my surgery.

In January of 1995, when I fell at Trident Hospital, I injured my chest area. Subsequently, I was having perineum pain and my breasts became swollen. I had to have some surgery on my uterus. I developed some adhesions which I didn't know that I had until I fell on October 23, 2003. After which, I was having a lot of lower abdominal pain and side pain. Dr. Albert E. Odom, Ob-gyn subsequently found a cyst on my left ovary and some abdominal adhesions. I need to have the rest of the adhesions removed. Sometime they interfere with me having a bowel movement.

Since I have had all of these worker's compensation injuries, I can't obtain any better health insurance on my own. Companion Health Care is not adequate for my needs. I found some kind of a health plan, but it is not insurance. It is not all that good either and I thought that it would supplant my health insurance that I had at Companion. This was one of the plans that Palmetto Health offered me. The plan that Palmetto Health offered me punishes me for going to my own doctors, especially the doctors that are out of town. The prescription plans also punishes me for using brand name drugs that were prescribe for my heart.

I need some help in going to law school. Because of these worker's compensation injuries, my personal injuries cases have been ruined by the attorneys that I have hired or I can't find an attorney at all. I have not been able to establish a lasting relationship with any attorney. If I was an attorney, I would know what to do and I could file a law suit on my behalf to defend myself and to follow through on my claims. Thus, I would not be left to pay my own medical bills.

My attorneys ruined my personal injury case (automobile accident of April 29, 1997) because of the worker's compensation injuries. With my personal injury case (automobile accident of November 25, 2000) my attorney lied, misled, and tricked me into settling my underinsured and uninsured motorist claim with Traveler's Insurance Company. He told me to lie on the deposition and I didn't know what he was doing. Therefore, I was left to pay my own medical bills and to repay March-Seabury and Smith and Blue Cross and Blue shield under subrogation.

At the present time, I am going to loose my personal injury claim of August 13, 2003, where I fell at the Embassy Suite Hotel in Columbia and hurt my back. I had to receive medical attention for the fall. The attorney that I had at that time would not accept the claim and the other attorney would not accept it either. They don't want to accept my personal injury claims that are mixed with the worker's compensation injuries. As it stands, I want be able for the rest of my life to pursue any personal injury claims because of the prior worker's compensation injuries and the lack of legal representation. If I was an attorney, I could help myself and I wouldn't loose my personal injury claims, nor would I be messed up with my personal injury claims.

I need some help in getting the General Assembly of South Carolina to recognize the tendons, ligaments, and joints as compensable members of the body. Perhaps they can assign a general monetary value for all the ligaments, all of the tendons, and all of the joints. There would be three categories and a general monetary value set for each category.

I need another second job instead of my present sitting job where there is a less risk of me reinjuring my neck, shoulder, and back.

FORGOTTEN ACCIDENTS

I told you about this accident of 8/13/2003, when I left the brown envelope at your office on 6/23/06, and I don't know if you had seen the brown envelope or had a chance to read the book yet.

Because of the fall that I had on August 13, 2003, at Embassy Suite Hotel in Columbia, I had to go to see Dr. Hook about it. Also, I had to buy two supports for my back because of the fall. I think Dr. Jones had included this fall in his notes because I told him about it. I am going to loose this claim because of the statute of limitation and the lack of legal representation. The managers wouldn't let me fill out an accident form nor would they tell me the name of the insurance company for The Embassy Suite Hotel.

Around October of 1995, I fell at the apartment complex at 411 Meeting Street late one evening after dark where I injured my abdominal incision when my right foot got caught in a black drainage pipe that someone had left on the sidewalk. I fell on the concrete. I had some surgery on my uterus in June of 1995. I had developed some complications after my worker's compensation fall of January of 1995 at Trident Hospital. Aetna Insurance Company paid for my medications.

Deirdre Shivers
7-7-06

(826)

September 5, 2006

Attorney Michael Chase
Turner Padgett
P.O. Box 1473
Columbia, S. C. 29202

SEP 7 2006

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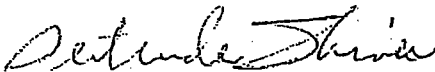
RE: Update

Dear Attorney Chase:

I had to end up going to the doctor for my fall of May 20, 2006, at Red Hill Baptist Church. In addition, I developed some moderate pain in my right wrist at work on Sunday, July 16, 2006, while using the hole puncher at Palmetto Health Richland. I am still under Dr. Frank Noojin's care.

While I was hunting through some papers of mine the other week, I found a copy of the Order that Commissioner Mickle had sent me regarding the refiling of my 1994-95 worker's compensation claim. A copy is enclosed. Thank you.

Sincerely,



Gertrude Shiver
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(803) 353-3892

(827)