THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

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S.C. SUPREME COURT

Opinion No. 5475 (S.C. Ct. App. filed March 22, 2017)

Sara Y. Wilson,

Respondent,

v.

Charleston County School District,

Petitioner,

APPENDIX VOLUME 1

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INDEX

Page

Appendix Volume 1
Record on Appeal 001

Appendix Volume 2
Brief of Appellant 500
Brief of Respondent 521
Reply Brief of Appellant 551
Published Opinion No. 5475, filed March 22, 2017 561
Petition for Rehearing 575
Order Denying Petition for Rehearing 588

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

Case No. 2012-CP-10-5429

Sara Y. Wilson, ... Appellant,

v.

Charleston County School District, ... Respondent.

RECORD ON APPEAL

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INDEX

Orders

Circuit court's order affirming the commission 1

Order denying appellant's Rule 59 motion 15

Pleadings and Motions

Appellant's Rule 59 motion 17

Return opposing the Rule 59 motion 25

Circuit Court Record

Appellant's brief to circuit court 32

Respondent's brief to circuit court 43

Reply brief to circuit court 56

Circuit court Record on Appeal 62

Hearing Commissioner's Decision on Ms. Wilson's Original Claim (November 29, 2007) 63

Appellate Panel's Decision on Ms. Wilson's Change of Condition Claim (July 18, 2012) 75

Notice of Ms. Wilson's Original Claim (Form 50 of August 9, 2006) 91

Notice of Ms. Wilson's Change of Condition Claim (Form 50 of January 6, 2009) 92

Hearing Request for the Change of Condition Claim, with attachments (Form 50 of March 29, 2011) 93

Letter of April 29, 2011 97

Deposition Transcript of Samiel H. Rosen, M.D. 99

Transcript of Single Commissioner's Hearing
(June 29, 2011) 125

Other Transcripts and Exhibits

Exhibit A to the Rule 59 return
(e-mail correspondence and the commission's file) 162

Certificate of Counsel 496

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
SARA Y. WILSON,	)	CASE NO. 12-CP-10-5429
EMPLOYEE/APPELLANT,	)	
vs.	)	**ORDER**
CHARLESTON COUNTY SCHOOL DISTRICT,	)	
EMPLOYER/SELF-INSURED CARRIER/RESPONDENT.	)	

FILED
2014 OCT -6 AM 9:36
JULIE J. ARMSTRONG
CLERK OF COURT
BY

This matter comes before the Court of Common Pleas for an appellate review of a decision of the South Carolina Workers' Compensation Full Commission WCC No. 0608517. The Employee/Claimant has appealed the Full Commission's decision finding that the Claimant has not proven a change of condition relative to her psyche and is further barred from bringing a psychological claim under the doctrine of res judicata.

The Employee/Claimant filed this appeal, arguing that res judicata was not applicable to the present claim and that a change of condition claim should not be strictly limited to the one year statute of limitations.

Counsel for both parties prepared briefs, and having reviewed the Commission's file as well as the supporting briefs submitted by the parties, this Court affirms in full the Order of the Full Commission, dated July 18, 2012.

FACTS OF THE CASE

The Claimant in this matter was a data entry clerk for Charleston County School District. She was initially injured on May 9, 2006, when two students were fighting and pushed into her, pinning her against a counter and injuring her neck and back.

The Claimant treated with various doctors for her neck and back and reached Maximum Medical Improvement on July 20, 2007. (Deposition of Dr. Aymond, p. 13). This matter went to a hearing on October 7, 2007, and the Claimant alleged permanent and total disability. On November 29, 2007, the Single Commissioner found that she was not permanently and totally disabled but had a 45% disability to her back relative to her neck and low back. The Form 19 paying this Order was filed on January 25, 2008.

On January 7, 2009, the Claimant filed a Form 50 not requesting a hearing but alleging a change of condition. Attached to this hearing request were two medical reports, neither of which indicated that the Claimant had sustained a change of condition in relation to her work injury. On March 29, 2011, the Claimant filed another Form 50, this time requesting a hearing on the change of condition claim. She attached the same two reports as had been attached to the January 7, 2009 hearing request and still did not attach a medical report indicating a change of condition.

At the hearing on June 29, 2011, the Claimant testified regarding her increased back pain, which is not the subject of this appeal. As far as the psychiatric treatment, which is the subject of this appeal, the Claimant indicated that she was in so much pain that she did not want to get up in the morning. She said that she did not go out with her friends anymore and that she felt helpless. She admitted that she was taking medications for depression and anxiety at the time of her first hearing. (Old APA 15, p.148-52).

The parties submitted the deposition transcript of Dr. Samuel Rosen at the change of condition hearing. In his deposition, Dr. Rosen reviewed his May 2008 report as well as the vocational assessment of Bill Stewart from September of 2007, which indicated that the Claimant had anxiety and depression and was getting medications and treatment for that problem and that it was related to the work injury. (Old APA 15, p.148-52). Dr. Rosen stated that the Claimant's depression and anxiety from her work injury existed in September of 2007, prior to the first hearing in this matter. He was asked "is it your opinion that Ms. Wilson had anxiety and depression from her work injury and required medication and treatment at least by September of 2007?" Dr. Rosen answered "[y]eah, that the work injury was causing some depression and anxiety by -- right." (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2). Of note, the Claimant did not allege psychological injuries or depression in the 2007 hearing. Dr. Rosen also testified that when he first saw the Claimant in May of 2008, she did not actually have endogenous depression, but that she did have endogenous depression at the time of his deposition, two and a half years after the statute of limitations had run on her change of condition claim. Dr. Rosen gave no indication that the Claimant had endogenous depression within a year after the last date of payment of compensation.

A review of the record from the first hearing indicates that the Claimant did not raise a psychological claim at that time. However, her vocational expert, William Stewart, did indicate that the Claimant had significant depression and anxiety related to the work injury. (Old APA 15). Mr. Stewart's report, dated September 6, 2007, states that "Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work." (Old APA 15, p.144). He also indicated that she required "medical psychological care. . .including follow up office

visits and prescribed psychotropic medications for anxiety and depression." Id. Specifically, Mr. Stewart noted that the Claimant continued to require Lorazepam for depression and anxiety. (Old APA 15, p.146). Mr. Stewart also noted that the Claimant scored a "7" on the Beck Anxiety Inventory and the fact that it was not worse was because of the medications she was taking. (Old APA 15, p.149). Finally, Mr. Stewart concluded that the Claimant was incapable of working due to a combination of chronic pain and psychological overlay "because of these injuries." (Old APA 15, p.150).

STANDARD OF REVIEW

This is an appeal from a decision of the South Carolina Workers' Compensation Commission's Full Commission. Such appeals are governed by the South Carolina Administrative Procedures Act, S.C. Code Ann. § 1-23-310, et seq. Pursuant to S. C. Code Ann. § 1-23-380 (A)(6):

> (A)(6) The Court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact... The Court may reverse or modify the decision if substantial rights of the Claimant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:
>
> (a) in violation of constitutional or statutory provisions;
>
> (b) in excess of the statutory authority of the agency;
>
> (c) made upon unlawful procedure;
>
> (d) affected by other error of law;
>
> (e) clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or
>
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

See also Darden v. Witham, 263 S.C. 183, 209 S.E.2d 42 (1974) (In order for a court to hold that the judgment of the lower court resulted from an abuse of discretion, there must be a showing by the appellant that the conclusions reached were without reasonable factual support, resulted in prejudice to the right of the appellant, and, therefore, in the circumstances, amounted to an error of law). Based on these criteria, there is no basis for a reversal of the Full Commission's decision.

ANALYSIS

The Full Commission did not err in finding as a matter of fact and concluding as a matter of law that res judicata barred Claimant's psychological claim or that Claimant's change of condition had to occur with one year of the last date of payment of compensation and that Claimant failed to carry her burden of proof in this regard.

I. Res Judicata Bars Claimant's Stress Claim.

Claimant argues that the Commission erred in denying her change of condition claim based on res judicata because she experienced "some anxiety and depression" before her original award. This Court disagrees. The Commission, in fact, denied Claimant's change of condition claim because she had the opportunity to raise a psychological claim at the first hearing and chose not to do so.

a. Res Judicata does not require that a claim be previously litigated and lost.

Claimant argues that res judicata does not apply in the present claim because the issue of a psychological injury was not actually litigated in the first hearing. The doctrine of res judicata applies not only when the issues were actually litigated but, as Claimant cites in her brief, also

when the issues "might have been litigated." Price v. City of Georgetown, 297 S.C. 185, 189, 375 S.E. 2d 335, 338 (Ct. App. 1977).

In the present matter, Claimant certainly could have brought a stress claim at the initial hearing in October of 2007 and chose not to do so. Mr. Stewart's report, submitted by the Claimant at the first hearing on September 6, 2007, states that "Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work." (Old APA 15, p.144). She required "medical psychological care" and "psychotropic medications for anxiety and depression." Id. Claimant's current psychiatrist, Dr. Rosen, testified that the Claimant's depression and anxiety from her work injury existed in September of 2007, prior to the first hearing in this matter. (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2).

Our Supreme Court has made it clear that if a claimant could have brought a claim at the initial hearing and failed to do so, he cannot later bring a change of condition claim on the same issue. "In a reopening proceeding, the issue before the Commission is sharply restricted to the question of extent of improvement or worsening of the injury on which the original award was based." Krell v. South Carolina State Hwy. Dept., 237 S.C. 584, 587, 118 S.E. 2d 322, 324-25 (S.C. 1961). In Krell, the claimant filed a change of condition claim because of an alleged recurring hernia problem. The claimant alleged that the hernia was present at the time of the initial accident and had flared up. The Commission denied his change of condition claim in light of the fact that the record showed that the claimant had not alleged a hernia problem at the first hearing and therefore could not assert it at a change of condition hearing.

The present claim is precisely like Krell. The Claimant here filed a change of condition claim because of continuing anxiety and depression, which she claims had worsened. Evidence

from the Claimant's own vocational expert shows that she had anxiety and depression related to her work injury at the time of the first hearing, and she was even on medications for depression and anxiety. The testimony from the Claimant's current psychiatrist is that she suffered from work related depression and anxiety before the first hearing. The Full Commission properly denied the Claimant's change of condition claim in light of the fact that the record showed that Claimant had not alleged a psychological problem at the first hearing and therefore she could not assert it at a change of condition hearing.

Importantly, the issue raised by Claimant is actually whether Claimant had enough of a psychological injury in the past to rise to the level of an injury that might have been litigated at the time of the first hearing. In other words, the Claimant's appeal is a factual one. The Commission is the finder of fact. Lowe v. Am-Cam Transport Services, Inc., 283 S.C. 534, 324 S.E.2d 87 (Ct. App. 1984; S.C. Code Ann. § 42-17-50 (1985)). A finding of fact made by the Commission may only be overturned if there is not substantial evidence to support it. S.C. Code Ann. § 1-23-380 (1986); see also Robbins v. Walgreens & Broadspire Servs., Inc., 375 S.C. 259, 264, 652 S.E.2d 90, 93 (Ct.App.2007). In the present claim, the evidence presented from the Claimant's own vocational expert and chosen psychiatrist is more than sufficient to establish substantial evidence. Therefore, the findings of the Full Commission on this matter are affirmed.

Claimant argues that the Commission's findings are mostly negative (e.g., "no doctor has opined that the Claimant did not have work related depression prior to the October 2, 2007 hearing." Finding of Fact 21 of the Full Commission Order) and that as a result the factual findings are not strong enough to hold up on appeal. This Court disagrees. The Full Commission order does rely on evidence of prior depression in the report of Claimant's own vocational expert and the deposition testimony of Claimant's psychiatrist. (Findings of Fact 19 and 20 of the Full

Commission Order). The point of the negative findings is that Claimant has presented no evidence to the contrary; in addition, it would remain Claimant's burden to prove depression, or if res judicata were somehow inapplicable, depression with a change of condition within one year of the last date of payment of compensation. These findings simply point out that Claimant has not carried her burden.

b. Continuing Jurisdiction Over a Matter Does Not Eliminate the Doctrine of Res Judicata.

Claimant makes an argument based on Cromer v. Newberry Cotton Mills, 201 S.C. 349, 23 S.E.2d 19 (1942), that the Commission has continuing jurisdiction over every case and therefore can change an award at any time. This Court disagrees.

In Cromer, the employer argued that since the claimant had been provided with an award relative to his disability, the Commission could not later come back and pay him an increased disability amount under the doctrine of res judicata. Id. at 21. The Court simply held that the Commission has the power under the change of condition statute, Section 46 (now S.C. Code Ann. § 42-17-90), to increase or diminish a prior award. However, because the Commission may hear a change of condition claim does not mean that commissioners are rehearing issues that could have been heard before. The whole point of a change of condition claim is that something the Commission decided initially has changed; therefore, the issues are different. The real question Claimant raises is whether a claimant may raise a new issue at a change of condition hearing that *could have been raised* at the first hearing. In Cromer, the claimant was not attempting to raise an issue that could have been previously raised. He simply argued that the condition that he had at the first hearing had changed.

Further, the Supreme Court heard Krell nineteen years after Cromer and found res judicata applicable in that workers' compensation claim. As discussed above, the facts of Krell are much more applicable to the present claim. In fact, the Court in Krell actually cited Cromer for the proposition that the Commission, and not the appellate court, is the ultimate finder of fact. Krell at 323-324.

Claimant argues that Krell is inapplicable to the present claim because the case involved a hernia, which comes on suddenly. However, there is no indication in Krell that its holding is limited to hernia claims. In addition, many claims, except for repetitive trauma claims by definition, have injuries that come on suddenly. The only question for this prong of res judicata is whether the issue is one that *could have been litigated* before. As stated above, there is substantial evidence to support that it could have, and under the substantial evidence standard, this Court affirms the findings of the Commission.

c. Res Judicata is a Bar to Claimant's Claim.

Claimant first argues again that res judicata is inapplicable because the issues here were not litigated and lost. As discussed above, this Court disagrees.

Claimant next argues that her claim is similar to Mungo v. Rental Uniform Services of Florence, 383 S.C. 270, 678 S.E.2d 825 (Ct. App. 2009), Estridge v. Joslyn Clark Controls, 325 S.C. 532, 482 S.E.2d 577 (Ct. App. 1997), and Clark v. Aiken County Gov't., 366 S.C. 102, 620 S.E.2d 99 (Ct. App. 2005). This Court finds these cases distinguishable from the present claim.

Mungo and Estridge both held that a claimant may raise the issue of depression at a change of condition hearing when the symptoms of depression prior to the first hearing were "mild, undiagnosed, and untreated." Mungo at 284; Estridge at 581. That is not the case in the present claim. The Claimant's vocational expert concluded that the Claimant was incapable of

working due to a combination of chronic pain and psychological overlay "because of these injuries." (Old APA 15, p.150). More importantly, he noted that she required "medical psychological care. . .including follow up office visits and prescribed psychotropic medications for anxiety and depression." Id. Specifically, he noted that Claimant *continued* to require Lorazepam for depression and anxiety. (Old APA 15, p.146). In other words, Claimant did not have a "mild, undiagnosed, and untreated" psychological condition. In fact, according to the Claimant's own expert, she was being treated for depression and anxiety and continued to need that treatment.

In Clark, the court simply found that the claimant's condition following his back surgery was not ripe for review at the first hearing because he did not know how well he would recover. The fact that his condition later worsened was the subject of a new hearing. Clark at 102-103. That case is wholly unrelated to the present facts where the Claimant had a documented psychological condition prior to her first hearing, was receiving medication for that condition, and chose not to raise the issue at all.

For the reasons set forth above, the decision of the Full commission is affirmed in full.

II. The Timing for a Claimant to Experience a Change of Condition is Unquestionably One Year.

Although this Court's conclusion in Section I disposes of this appeal, this Court addresses the timeframe in which a workers' compensation claimant must experience and prove a change of condition in order to have a compensable change of condition claim. Claimant argues that the Commission erred in finding that Claimant's change of condition claim had to occur within one year of the last date of payment of compensation. This Court disagrees. The Claimant makes three sub-arguments that amount to a policy argument that a claimant should have no limitations

on when a change of condition may occur. The clear law is simply not in line with this suggested policy argument and would require a legislative amendment.

S.C. Code Ann § 42-17-90 states in pertinent part:

> Upon its own motion or upon the application of any party in interest on the ground of a change in condition, the Commission may review any award and on such review may make an award ending, diminishing or increasing the compensation previously awarded, subject to the maximum or minimum provided in this Title, and shall immediately send to the parties a copy of the order changing the award. No such review shall affect such award as regards any moneys paid and *no such review shall be made after twelve months from the date of the last payment of compensation pursuant to an award under this Title.*
>
> (emphasis added)

Regulation 67-602 (C) provides:

> In a claim involving a change of condition, the moving party must attach to the hearing request form a medical report(s) *indicating a change in the claimant's condition.*
>
> (emphasis added)

A regulation, which is a "legislative rule," is one which, generally, has the force of law and becomes an integral part of the statute. Faile v. South Carolina Employment Sec. Commission, 230 S.E.2d 219 (1976). The general rule in South Carolina Worker's Compensation cases regarding statutory construction and interpretation is that the cardinal rule is to ascertain and give effect to the intent of the legislature. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Charleston County Sch. Dist. v. State Budget and Control Bd., 313 S.C. 1, 437 S.E.2d 6 (1993)). "If a statute's language is plain, unambiguous, and conveys a clear meaning 'the rules of statutory interpretation are not needed and the court has no right to impose another meaning.'" Wigfall, 354 S.C. at 109, 580 S.E.2d at 105 (2003) (citing

Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000)). The courts are further bound by precedent to strictly construe statutes in derogation of the common law. Id. (citing Gilfillin v. Gilfillin, 344 S.C. 407, 544 S.E.2d 829 (2001)). "Workers' compensation statutes provide an exclusive compensatory system in derogation of common law rights." Id. (citing Caughman v. Columbia YMCA, 212 S.C. 337, 47 S.E.2d 788 (1948)). "As such, when reading a workers' compensation statute we strictly construe its terms, leaving it to the legislature to amend and define its ambiguities." Id.

Claimant cites Allen v. Benson, 236 S.C. 22, 112 S.E.2d 722 (1960) to demonstrate that the Supreme Court has been receptive to lengthening the time in which a change of condition must occur. This Court disagrees with Claimant's interpretation. The Supreme Court, in Allen, simply found that it would be unfair to prejudice a Claimant by requiring that the *actual hearing* on his change of condition claim be heard within one year of the last date of payment of compensation and noted that it was enough that the "application for review" be filed within one year. Id. at 31, 726. The claimant must request a hearing or "review" within a year of the last date of payment of compensation with medical proof of a change of condition; Allen stands for the proposition that the claimant will not be held responsible if the hearing itself does not take place within that year. Allowing a claimant to file a Form 50 not requesting a hearing within a year of the final payment of compensation and then to wait an additional two years to request an actual review or hearing, and for that entire time to be included in the window for a change of condition, would mean that S.C. Code Ann § 42-17-90 loses all meaning. This Court finds that this is not what the Supreme Court intended in Allen when the claimant actually requested a hearing and experienced a change within the statute of limitations but simply did not have his hearing date until after that year had expired.

Further, the Claimant argues that there should be no set time limit on a change of condition because that could encourage unscrupulous employers to delay allowing a claimant to return to a physician. This Court disagrees. A claimant in such circumstances would have protection under other laws such as waiver or estoppel. See Hoke v. Cherokee County, 216 S.C. 376, 585 S.E.2d 330 (1950); Lovell v. C. A. Timbes, Inc., 263 S.C. 384, 210 S.E.2d 610 (1974).

Claimant also states as a matter of policy that there should be some laxity in the time limit for a change of condition claim in a case where a claimant's family doctor notices issues of depression and refers her out within the one year statute but where a psychologist cannot diagnose depression until after the one year has passed. Those hypothetical facts are not before this Court. The facts in the present claim are that Claimant was treating for depression and anxiety before her first hearing, (Old APA 15, p.148-52), her psychiatrist opined that the depression existed with treatment required prior to the first hearing, (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2), and her psychiatrist opined that her depression became endogenous by two and a half years after the one year change of condition time limit had run. Id. It is Claimant's burden to prove that her change of condition occurred within the one year time period, and Claimant has presented no evidence whatsoever to that effect. Claimant argues that if her depression and anxiety were starting or beginning to worsen during the one year time period that should be enough to establish a change of condition. However, Claimant has presented no evidence to this effect either. The only evidence in the record is that Claimant experienced depression and anxiety related to her work injury before the first hearing that became endogenous by two and a half years after the change of condition statute had run. Claimant indicates that she is not alleging that there should be no limit on the statute of limitations in workers' compensation

claims, but she essentially asks this Court to find that the one year statute is inapplicable. This Court is unwilling to make this finding.

The Claimant also argues that if a claimant takes too long to bring a change of condition claim, the remedy is the doctrine of laches. Under the clear statutory language of S.C. Code Ann § 42-17-90, and for the reasons stated above, this Court disagrees. Respondent argues in the alternative that the doctrine of laches would be applicable in the present claim, but since this Court finds that Claimant failed to prove her case under the doctrine of res judicata, or that any alleged change of condition occurred within one year of the last date of payment of compensation, this Court does not need to reach a decision on the issues of laches.

For the foregoing reasons, the decision of the Full Commission is affirmed in full.

CONCLUSION

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that the Full Commission Order, dated July 18, 2012, is fully affirmed.

IT IS SO ORDERED!

J.C. Nicholson, Jr.
Judge, Ninth Judicial Circuit

Charleston, South Carolina

Dated: 10/3/14

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO. 2012-CP-10-~~8372~~ 5429

FILED
2014 OCT 30 PM 1:59
JULIE J. ARMSTRONG
CLERK OF COURT
BY

Sara Y. Wilson
PLAINTIFF(S)

Charleston County School District
DEFENDANT(S)

Submitted by:

Attorney for : ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court: This matter came before this Court on Plaintiff's Motion to Reconsider, filed on October 22, 2014. After reviewing Plaintiff's Motion and accompanying legal memorandum, this Court hereby DENIES Plaintiff's Motion to Reconsider.

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.
Additional Information for the Clerk :

INFORMATION FOR THE PUBLIC INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
N/A		$

If applicable, describe the property, including tax map information and address, referenced in the order:
N/A

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details.**

Circuit Court Judge

2117
Judge Code

10/29/14
Date

For Clerk of Court Office Use Only

This judgment was entered on the day of , 20 and a copy mailed first class or placed in the appropriate attorney's box on this day of , 20 to attorneys of record or to parties (when appearing pro se) as follows:

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Sara Y. Wilson, Appellant, v. Charleston County School District, Respondent.	)	Case No. 2012-CP-10-5429 **MOTION TO ALTER OR AMEND AND FOR RECONSIDERATION**

This motion is made pursuant to Rules 52 and 59 of the South Carolina Rules of Civil Procedure. It is also made pursuant to the Supreme Court's decision in *Elam v. South Carolina Department of Transportation*, which instructs that a Rule 59(e) motion is not only a vehicle to ask a circuit court to "alter or amend" a judgment, but it is also as a vehicle to seek "reconsideration." See 361 S.C. 9, 21-22, 602 S.E.2d 772, 778-79 (2004).

Rule 59(b) specifies that this motion may not be made later than 10 days after the moving party receives written notice that the court's judgment has been entered. The appellant received that notice on October 10, 2014. This motion is accordingly timely.

(ABBREVIATED) BACKGROUND

This is a workers' compensation appeal that this court agreed to decide without a hearing. The parties submitted written briefs, and Sara Wilson, who was the losing party at the commission, also submitted a "record" that contained some of the pertinent orders and documents from below.

The underlying controversy centers around whether Ms. Wilson has a compensable workers' compensation claim called a "change of condition." The commission held that she did not.

The accident that Ms. Wilson suffered at work injured her back and her neck. Ms. Wilson received an award for these injuries, and the award was paid in January of 2008.

About a year later, Ms. Wilson brought a second claim, commonly called a "change of condition" claim, alleging that although her injuries had initially improved following her surgery in 2007, she subsequently experienced increasing chronic pain and that this pain eventually caused significant (and disabling) injury-related depression.

The employer in this case is the Charleston County School District. The School District defended Ms. Wilson's change of condition claim in two ways.

First, the School District said that Ms. Wilson should have brought a claim for her depression at the time of her original award. This argument relies on the premise that Ms. Wilson's injury-related depression was really not "new," even though Ms. Wilson said that it was.

Second, the School District argued that Ms. Wilson's claim was not timely. There were multiple aspects of this argument, but its central thesis was that even though Ms. Wilson had filed her claim within the appropriate deadline, she did not request a hearing until much later.

A hearing commissioner disagreed with both of these arguments, but the School District asked the full commission to review that decision and the commission's appellate panel reversed. The panel only reached the School District's first argument. It did not offer any opinion on the suggestion that this claim was untimely. See (R.pp.13-28) (the order).

This court has entered an order that affirms the commission's decision.

ARGUMENT

Ms. Wilson understands that the court has deliberated on this matter and has rendered its decision. She nevertheless respectfully submits that the court may have overlooked or misapprehended some points in reaching that decision. In addition to the arguments from her principal brief and her reply brief, Ms. Wilson would direct the court to four (4) specific items.

1. The order recites that the court reviewed "the commission's file." This *may* be incorrect.

The order recites that the court reviewed "the commission's file." **Attachment A**, p.1. This may be inaccurate. Ms. Wilson is not aware of the commission's file being submitted for review.

Ms. Wilson filed a principal brief, a reply brief, and a record. This record contained selected documents from the commission's file that Ms. Wilson believed to be pertinent to the issues she raised on appeal. These filings were submitted to the court. They were also filed with the clerk.

The School District filed a written brief with the court. Then, at the court's invitation, both parties submitted proposed orders. Unless Ms. Wilson is mistaken, these were the only documents submitted to the court for its consideration.

This point is not material to the *analysis* in the court's order. The order makes sixteen (16) references to documents that are in the commission's file, but only one of those references relates to something that was not included in Ms. Wilson's record, and this particular reference is not critical to the issues in question. See **Attachment A**, p.2 (the citation to Dr. Aymond's deposition).

But the broader point *is* material because it will define the field of documents that may be included in the record to the Court of Appeals. If the only documents that the court reviewed are the documents that the parties submitted, the court should delete the reference to the commission's file and say that it reviewed the parties' briefs, Ms. Wilson's record, and the parties' proposed orders.

2. The only evidence that Ms. Wilson had injury-related depression at the time of her first award is a vocational evaluation that the original commission *rejected* as inconsistent and less persuasive.

In affirming the commission's finding that Ms. Wilson had injury-related depression at the time of her original award, the court may have overlooked that the principal evidence offered to

support this finding is a vocational evaluation — not a medical evaluation — and that the commission specifically rejected this evaluation when it issued Ms. Wilson's original award.

The vocational evaluation begins on page 143 of the record and it ends on page 152. This document is the critical element of the School District's argument that Ms. Wilson was experiencing injury-related depression at the time of her original award and that Ms. Wilson should have brought a claim for a psychiatric injury at that time.

This document is also the critical document cited in the court's order. Twelve (12) of the order's sixteen (16) citations are direct references to this document, and three (3) of the remaining four (4) citations are indirect references to this document. These "indirect" references relate to the deposition of Ms. Wilson's treating psychiatrist. When the School District deposed Ms. Wilson's psychiatrist, it presented the vocational evaluation to him and asked him to offer an opinion based on the assumption that the evaluation was accurate. See (R.pp.40, 44).

The problem is that the commission specifically rejected this vocational evaluation when it issued Ms. Wilson's original award. The award was issued in November of 2007, and in that award, the original hearing commissioner noted that this vocational evaluation said Ms. Wilson's depression was related to her injury even though Ms. Wilson said that it was not. The original commissioner also found that this report (which was not authored by a *medical* doctor) was internally inconsistent. Instead of relying on this evaluation, the commission chose to rely on a different assessment; the one that the School District procured from David Price. (R.p.10). The commission specifically found Mr. Price's assessment to be more persuasive and more "in line" with the medical evidence. *Id.* In affirming the commission, this court's order is relying on evidence that the commission rejected in 2007 as thin and unsubstantial.

The evaluation reveals the reasons for this rejection. On one hand, it notes that Ms. Wilson's depression and anxiety test scores reflect only a "minimal level of depression" and a "minimal-mild level of anxiety." (R.p.149). But then, the evaluation offers a view that Ms. Wilson has a serious psychiatric condition and will never be able to return to gainful employment. *Id.* The evaluation opines that Ms. Wilson's score on her "life situation survey" was reflective of someone with an "overall relatively good quality of life." *Id.* But these things — mild depression, permanent and total disability, and a good quality of life — do not seem to go together. The evaluation finds Ms. Wilson to be forthright and honest about her injuries, see (R.p.148), but then the evaluation opines (without any explanation) that Ms. Wilson's "mild" depression is *not* related to her husband's death, even though Ms. Wilson says that it *is*. This is why the commission rejected the evaluation. It gives too many mixed signals.

3. The order says that this case involves a question of fact, but the commission's decision is not written with the level of detail and specificity that the law requires for the case to be fact-driven.

Ms. Wilson continues to firmly believe that the commission's order is written in a way that effectively says Ms. Wilson's claim is barred because she had some level of depression at the time of her original award and because she (supposedly) has not offered any evidence that her depression began within a year of that award. Her argument on appeal has been that these notions are not compatible with the correct legal standard for judging a change of condition claim.

These are legal issues, not factual issues, but the order treats the case as though it is fact-driven and affirms the commission's finding that Ms. Wilson had a compensable psychiatric injury at the time of her original award and that she should have made a claim for such an injury at that time.

In making this holding, the court may have overlooked that the commission must provide factual findings that are detailed and specific, and that the commission has to explain the reasoning behind its findings. If the commission disagrees with a party's argument, it is incumbent on the commission to explain why. See, e.g. *Pack v. State Dep't of Transp.*, 381 S.C. 526, 535, 673 S.E.2d 461, 466 (Ct. App. 2009) (remanding the denial of a brain injury for lack of explanation); see also *Drake v. Raybestos-Manhattan, Inc.*, 241 S.C. 116, 127 S.E.2d 288 (1962) (observing generally that the commission's findings must be detailed and specific).

The commission's decision does not do any of this heavy lifting. For example, the commission never explains why it is choosing to rely on a vocational evaluation that was previously rejected as unreliable. The decision treats the evaluation as authoritative, even though the original commission shunned it.

This lack of explanation permeates the commission's order. The commission never explained why it disagreed with Ms. Wilson's argument that her 2007 depression was related to her husband's death. The commission also never explained why it rejected Ms. Wilson's argument that the pain and depression she began experiencing in 2008 was remarkably different from the pain and depression she was experiencing in 2007. Ms. Wilson said that her previous episodes were situational depression and that she had never been in counseling or referred to a psychiatrist until after her original hearing, but the commission's order is silent on this argument. It adopts the previously-spurned vocational evaluation — without explanation — and it leaves the analysis at that.

The commission's order never attempted to explain how its findings are consistent with the testimony from Ms. Wilson (and her doctors) that she improved following surgery and that her present problems appeared later. It never tried to explain how the finding that Ms. Wilson has

always had a compensable psychiatric condition is consistent with the fact that Ms. Wilson's actual "injury" was to her spine and her neck. It also never explains the fact that the doctors the School District provided for Ms. Wilson never sent her to a psychiatrist for any mental treatment.

The commission did not have to resolve these questions in a certain way, but the commission was required to grapple with them, to reach a decision, and to explain why it reached that decision. The School District wants this case to be viewed as fact-driven because the standard of review for factual issues is deferential, but the reality is that the commission's order is not specific-enough for the case to be fact-driven. Instead of explaining why Ms. Wilson's theory of the case was not persuasive, the commission's order just ignored it.

4. The court should remove the timeliness argument from the order. It is not necessary to the decision and it was not reached by the commission.

Section II of the order begins by noting that it is not necessary to reach the timeliness issue. Then, the order reaches the issue anyway and says that Ms. Wilson's argument is a policy argument that there is no limitation on when a change of condition must occur. **Attachment A**, pp.10-11.

Nobody is arguing that the time limit is endless, and the principal defect with the School District's argument is that the Supreme Court has already held that as long as a change of condition claim is *filed* within the deadline, the request is timely. See *Allen v. Benson Outdoor Advertising Co.*, 236 S.C. 22, 29-31, 112 S.E.2d 722, 725-26 (1960). *Allen* does not talk about when a claimant must request a hearing. The School District is misrepresenting the issue in question and the law.

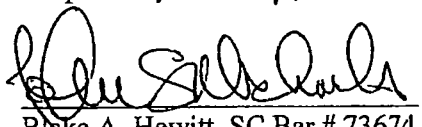
Either party can request a hearing in front of the commission. See S.C. Code Ann. § 42-17-20. If the School District was itching to defend this claim, it could have asked the commission to hear the case at any time. If the School District was concerned about having timely testimony from

a doctor, it could have deposed Ms. Wilson's psychiatrist at any time. Instead of doing this, the School District adopted the creative theory that Ms. Wilson had a psychiatric condition that was present from the beginning and that because a doctor has not specifically identified Ms. Wilson's depression as beginning and worsening between specific dates, the claim is not compensable. This theory is fine if the goal is to craft an inventive way to deny compensation for depression that clearly appears to be related to Ms. Wilson's injury, but it is not an argument about the timeliness of Ms. Wilson's claim. The timeliness analysis is unnecessary and incorrect.

CONCLUSION

The appellant respectfully requests that the court grant reconsideration, withdraw its previous order, and substitute a new order that follows the reasoning articulated in the appellant's written briefs. In the event that the court is resolute in its decision to affirm, the court should amend its previous order to clarify that the court did not review the commission's entire file and to remove section II of the order, which is not necessary to the case's disposition.

Respectfully submitted,



October 20, 2014

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
SARA Y. WILSON,	)	CASE NO. 12-CP-10-5429
	)	
EMPLOYEE/APPELLANT,	)	
	)	**RESPONDENT'S REPLY TO APPELLANT'S MOTION TO ALTER OR AMEND AND FOR RECONSIDERATION**
vs.	)	
	)	
CHARLESTON COUNTY SCHOOL DISTRICT,	)	
	)	
EMPLOYER/SELF-INSURED CARRIER/RESPONDENT.	)	
	)	
	)	

This matter came before the Court of Common Pleas for an appellate review of a decision of the South Carolina Workers' Compensation Full Commission WCC No. 0608517 dated July 18, 2012. The Employee/Appellant appealed the Full Commission's finding that the Employee/Appellant had not proven a change of condition relative to her psyche and was further barred from bringing a psychological claim under the doctrine of res judicata.

This Court filed an Order affirming the Full Commission in full on October 6, 2014, and according to the Employee/Appellant, she received this Order on October 10, 2014. On October 20, 2014, the Employee/Appellant filed a Motion to Alter or Amend and for Reconsideration. The Employer/Respondent submits this Reply in support of its position.

I. SIMPLY THAT THE ORDER RECITES THAT THE COURT REVIEWED THE COMMISSION'S FILE HAS NO BEARING ON THIS MATTER.

The Employee/Appellant argues that the Circuit Court's Order indicates that the court reviewed the Commission's file and makes references to documents the court may not have actually had. First, Employer/Respondent will agree that it is unclear whether the court had

possession of the entirety of the Commission's file, though that was certainly the belief of the attorney for the Employer/Respondent before proposed orders were submitted based on emails with this court's office and the attorney for the Employee/Appellant. (See Exhibit A). To avoid any further confusion, the Employer/Respondent has attached all documentation that has been submitted to the Commission at both hearings, to include all deposition transcripts. In contemplating the Employee/Appellant's motion, the court will now have access to the entirety of the Commission's file.

In addition, Employee/Appellant points out a reference in the court's Order to the deposition of Dr. Aymond, noting that the court may not have actually been provided with this deposition. However, the reference to Dr. Aymond's deposition, found on page 2 of the Order, may also be found on page 9 of the Full Commission Order. In other words, the court certainly had a reference to this testimony, and that reference was "material to the *analysis* in the court's order." (See page 3 of Employee/Appellant's motion).

Notwithstanding these issues, at this juncture, the court has now unquestionably been provided with all the materials cited in the Order. In reviewing those documents, the Employer/Respondent is confident that the court will only have more evidence to support its decision to affirm the findings of the Full Commission and deny the Employee/Appellant's motion.

II. THE FACT THAT THE COMMISSION'S FIRST ORDER FOUND THE CLAIMANT'S VOCATIONAL ASSESSMENT UNPERSUASIVE HAS NO BEARING ON THE DOCTRINE OF RES JUDICATA.

The Employee/Appellant continues to argue that the Commission should not have barred her psyche claim under the doctrine of res judicata because the only evidence presented at the

first hearing of depression was the Employee/Appellant's vocational assessment, which the Commission found to be unreliable. This argument misunderstands the doctrine.

The doctrine of res judicata acts as a bar to parties to litigate issues that "might have been litigated" by the parties previously. Price v. City of Georgetown, 297 S.C. 185, 189, 375 S.E. 2d 335, 338 (Ct. App. 1977). The doctrine does not require that the party at first hearing present substantial evidence to support its position; the court merely needs to recognize that this issue *might* have been litigated before.

Simply because the commissioner at the first hearing found inconsistencies in the report, the Employee/Appellant recommends that this court entirely ignore the references to her *own expert's opinion* citing that she "is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work" and noting that she required "medical psychological care" and "psychotropic medications for anxiety and depression." (Old APA 15, p.144). Simply because the commissioner found the Employee/Appellant's expert's report to be flawed does not negate the fact that it is evidence, *presented by the Employee/Appellant* at the first hearing, that she suffered from work related depression and was receiving medication for it.

Further, even if this court agreed to completely disregard this documentation, that in no way resolves the issue of whether the Employee/Appellant *might have litigated* the psyche issue at the first hearing. At the second hearing, the parties presented uncontroverted evidence from the Employee/Appellant's psychiatrist, Dr. Rosen, who testified that the Claimant's depression and anxiety from her work injury existed in September of 2007, *prior to the first hearing* in this matter. (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2). As a result, even disregarding the evidence submitted by the Employee/Appellant at the first hearing, the only

evidence in the record is that the Employee/Appellant had work related depression at the time of the first hearing, and thus with or without the vocational expert's report, that issue certainly might have been litigated at the first hearing, and the doctrine of res judicata barred her from raising the issue at the second hearing.

III. THIS APPEAL DOES INVOLVE SOME QUESTIONS OF FACT AND THE COMMISSION'S ORDER PROVIDES SUFFICIENT SUPPORT FOR THOSE FINDINGS.

The Employee/Appellant argues again that the issues on appeal here are primarily legal and that if the issues are factual, the Commission's Order is not detailed enough to support the findings. These questions are well covered in the court's order. Here, the Employer/Respondent simply reiterates that the issue that the Employee/Appellant raised in her brief was whether she had *enough* anxiety at the first hearing to rise to the level of something that might have been litigated. In Employee/Appellant's motion, her argument is that she may have been depressed at the first hearing, but it was related to her husband's death. Either way, that argument raises a factual question that must be addressed, and again, the Commission is the finder of fact, and as such its findings must be upheld unless there is not substantial evidence to support them. Lowe v. Am-Cam Transport Services, Inc., 283 S.C. 534, 324 S.E.2d 87 (Ct. App. 1984; S.C. Code Ann. § 42-17-50 (1985); S.C. Code Ann. § 1-23-380 (1986); see also Robbins v. Walgreens & Broadspire Servs., Inc., 375 S.C. 259, 264, 652 S.E.2d 90, 93 (Ct.App.2007).

The Employee/Appellant next argues that the Commission's findings lack sufficient explanation. This is erroneous. It is axiomatic that in her workers' compensation claim the claimant has the burden of proving a change of condition for the worse by a preponderance of the evidence. S.C. Code Ann. § 42-17-90. What the Full Commission order does, with specificity, is point out that the Employee/Appellant failed to carry that burden. The requirement of an order

denying a change of condition claim is not that the findings of fact detail why a claimant has not sustained a change of condition, but rather why a claimant has not carried his or her burden of proof by a preponderance of the evidence. The Full Commission Order does this thoroughly by pointing out that the only evidence in the record indicates that the Employee/Appellant did suffer from work related depression at the time of the first hearing and chose not to raise that issue. As a result, again, the Employee/Appellant's motion should be denied.

IV. THERE IS NO ERROR IN THE CIRCUIT COURT DECIDING THE TIMELINESS ISSUE AS AN ADDITIONAL SUSTAINING GROUND.

The Employee/Appellant argues that the court should not have reached the issue of timeliness in its order because it was unnecessary. There is no authority cited for this argument because it is well established that appellate courts may reach issues of dicta or additional sustaining grounds, which are not necessary for the ultimate decision. S. Carolina Pub. Serv. Auth. v. Carolina Power & Light Co., 244 S.C. 466, 479, 137 S.E.2d 507, 512 (1964) ("additional sustaining grounds are permitted to be filed under Rule 4, Section 7, of the Rules of this Court").

Under various precedents, including S. Carolina Pub. Serv. Auth., this court may affirm the commission on appeal on any issues as long as the issue appears in the record below, even if the commission did not rule on it, indeed, even if it was not raised to the commission. See also I'On, L.L.C. v. Town of Mt. Pleasant, 338 S.C. 406, 419-20, 526 S.E.2d 716, 723 (2000). In the present claim, a review of the record below reveals that the Employer/Carrier did raise this argument at both the Single Commission and Full Commission levels, and Allen v. Benson, 236 S.C. 22, 112 S.E.2d 722 (1960) is actually cited in Conclusion of Law number 2.

The Employee/Appellant goes on to again argue that a change of condition claim (and not an actual request for a hearing) need only be filed within the one year deadline, but this issue has been adequately addressed in the court's order, and since no new arguments were raised on that issue in the motion, those arguments do not need to be rehashed here.

However, the Employee/Appellant does indicate that had the Employer/Respondent wished to have this issue heard earlier, it could have requested a hearing. This is patently false. First, it is the Employee/Appellant's claim, and it is her burden to timely make her claims. Secondly, the Workers' Compensation Commission is actually quite strict about what issues an employer/carrier may and may not raise. An employer/carrier may not request hearings on denied claims, which would include denied change of condition claims. There are technically no issues in dispute in these matters until the claimant raises them, and any request for a hearing from the defense on these issues borders on frivolous.

CONCLUSION

As discussed herein, this court's Order dated October 6, 2014 is correct as filed. In the event that this court did not have the complete file before October 6, the court has the entire file now and a denial of the Motion to Alter or Amend would simply affirm that the entire file supports the current Order as it stands. The court and the Commission's reliance on the Employee/Appellant's expert's opinion for this limited purpose is completely justified, but even beyond that, there remains substantial evidence that the Employee/Appellant might have litigated the psyche issue at the first hearing; therefore, her claim is still barred by res judicata. This appeal does involve questions of fact, and the Commission's finding need only support that the Employee/Appellant did not carry her burden of proof. Finally, there is no error in this court citing additional sustaining grounds for its decision, and the timeliness issue was more than adequately addressed in this court's order. Based

on the foregoing, the Employee/Appellant's Motion to Alter or Amend and for Reconsideration should be denied and the Order dated October 6, 2014 should stand.

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Dated: October 24, 2014

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Sara Y. Wilson, Appellant, v. Charleston County School District, Respondent.	)	Case No. 2012-CP-10-5429 **APPELLANT'S BRIEF**

FILED
2013 NOV -6 PM 2:14
JULIE J. ARMSTRONG
CLERK OF COURT

This is an appeal from the Workers' Compensation Commission. Sara Wilson asked the commission to modify her workers' compensation award because several of her health problems have allegedly gotten worse. This request is commonly called a "change of condition" claim.

This appeal concerns Ms. Wilson's claim that her mental health has deteriorated in the time since her original award. She says that her mild and periodic depression has become significant and severe, and she says that this has been caused by constant pain from her work-related back injury.

The commission denied Ms. Wilson's request, reasoning that because Ms. Wilson experienced some degree of anxiety and depression before her original award, her change of condition claim was barred by res judicata. The commission also reasoned that Ms. Wilson's depression had to worsen between specific dates in order to be compensable.

Neither conclusion is correct.

Res judicata would bar Ms. Wilson from re-trying a claim that she previously lost, but Ms. Wilson is not claiming that her injury has always affected her mental health—she is claiming things have changed. For that reason, res judicata does not apply.

Similarly, a change of condition does not have to run its course between specific dates. A change of condition can be caused by a minor problem that has turned or is still turning serious.

This Court should accordingly reverse the commission and remand this claim for further proceedings. The commission must decide this case under the proper standard. It cannot use a higher standard than the law requires.

BACKGROUND

In May of 2006, Sara Wilson injured her back while working for the Charleston County School District. The School District employed Ms. Wilson as an administrative clerk.

Ms. Wilson was injured as a bystander in a fight between two students. Ms. Wilson is slight in stature. She is roughly 4'10" tall and weighed approximately 115 pounds at the time of her injury. Ms. Wilson said that the fighting students were significantly larger than she was, and she was injured when she was shoved up against a countertop and suffered a herniated disc. In March of 2007, Ms. Wilson underwent surgery to remove the disc and fuse two of her vertebra together.

The original claim was processed quickly. The School District did not contest the claim's validity, and Ms. Wilson received an award from the commission in November of 2007. This award required the School District to pay Ms. Wilson weekly benefits for a period of time, and it also required the School District to provide future medical treatment for Ms. Wilson's injury.

Instead of making weekly payments, the School District paid Ms. Wilson's award in a lump sum. The School District sent the check to Ms. Wilson's lawyer in January of 2008.

Ms. Wilson brought her change of condition claim in January of 2009. A little over 2 years later, in March of 2011, Ms. Wilson requested a hearing on the claim. A hearing commissioner conducted the hearing in June.

Ms. Wilson said that her back injury was affecting her mental health; specifically, that the pain caused by the injury had increased and that this pain resulted in depression. Ms. Wilson

admitted that she had experienced some anxiety and depression in the past, but she claimed that her current condition was of a different character. For example, Ms. Wilson explained that while she had been depressed after her husband's death years earlier, she did not experience significant depression until after the pain caused by her work-related injury significantly increased. She pointed out that it was not until early 2008—which was after her original award—that her primary care physician referred her to a specialist for psychiatric treatment.

The hearing commissioner agreed with this argument. Relying on precedent, he held that a mental disorder can be a part of a change of condition claim as long as the mental disorder is connected to the original injury. As a result of this finding, the hearing commissioner concluded that Ms. Wilson was entitled to ongoing psychiatric care and temporary total disability benefits.

The School District appealed to the full commission, and an appellate panel of the commission heard the appeal in July of 2012.

The panel reversed the hearing commissioner's decision. The panel held that because Ms. Wilson had experienced some level of anxiety and depression before her original award, her change of condition claim was barred by res judicata. The panel also reasoned that Ms. Wilson's depression had to worsen between specific dates—January of 2008 and January of 2009—in order to be compensable.

The panel's order was dated July 18, 2012. Ms. Wilson initiated this appeal one month later.

ARGUMENT

The court should reverse the decision below, for two reasons. First, res judicata does not bar this claim. Put simply, the test for a change of condition is whether the claimant's condition has changed. A new symptom might emerge, or an old symptom might amplify. Either is acceptable.

The second reason the Court should reverse is that a change of condition claim is not tied to a specific date of diagnosis or worsening. As long as it is filed by the deadline, a change of condition can encompass a problem that is still in the process of turning serious.

I. Res Judicata Does Not Bar a Claim Just Because a Symptom Was Present at the Time of the Original Award.

The commission reasoned that res judicata barred Ms. Wilson's claim because she had experienced some anxiety and depression before her original award. This reasoning is not correct.

a. This is the first time Ms. Wilson has ever made a psychiatric claim, and res judicata generally requires that a claim have been previously litigated and lost.

Res judicata, or "claim preclusion," prohibits a second lawsuit that is based on the same claims and issues that were actually litigated or that might have been litigated in a previous lawsuit. *Price v. City of Georgetown*, 297 S.C. 185, 189, 375 S.E.2d 335, 338 (Ct. App. 1988). Claim preclusion generally requires that the current case have the same parties as the previous case, that the subject matter of the cases be the same, and that the issue in question have been decided in the previous matter. *Id.* at 449, 511 S.E.2d at 57. The Supreme Court has described that the primary purpose of claim preclusion is "to bring an end to litigation and prevent a defendant from being forced to defend the same action repeatedly." *Id.* at 449, 511 S.E.2d at 57.

The School District is not being forced to defend an action that it already defended. This is the first time Ms. Wilson has claimed that her back injury is affecting her mental health. Ms. Wilson's original filing—the notice of a claim that she filed with the commission in August of 2006—does not mention any claim for a mental injury. (R.p.29). In similar fashion, Ms. Wilson's award, which the commission issued in November of 2007, does not mention any claim for a mental

injury. Indeed, the commission's award recites that Ms. Wilson did not ask for anxiety treatment and believed that the anxiety she experienced at that time was due to the death of her husband. (R.p.7). Ms. Wilson is not re-litigating a claim that she previously brought and lost. This is a claim that she is making for the first time.

b. Because every change of condition award modifies the commission's original decision, res judicata does not apply to the commission in the same way that it applies to a court.

Although it is possible for res judicata to apply to a workers' compensation case, the Supreme Court has described that this application is different from the way res judicata applies to a decision from a court. The principal case exploring this distinction is *Cromer v. Newberry Cotton Mills*, 201 S.C. 349, 354-56, 23 S.E.2d 19, 21-22 (1942).

Cromer explains that in a court case, the court's judgment is generally conclusive once a term of court has adjourned. This finality is what gives the court's judgment preclusive effect.

Cromer recognizes that the commission operates differently. The commission has continuing jurisdiction over every case and is allowed to review every award based on the request of either party or on the commission's own motion. See S.C. Code Ann. § 42-17-90 (Supp. 2012). The only limit on this review is that it occur within 12 months of the last payment of compensation. *Id.*

This distinction is important. It recognizes that *every* change of condition is going to involve modifying the commission's original findings. A court could not do this. No rule allows it.

The commission is not a court, and the reason that the change of condition process exists is so that the commission can alter an award despite that fact that it appears, on its face, to be final. A change of condition cannot be barred just because it involves something that was not a part of the first award. Unlike a court, the commission may change an award if the circumstances justify it.

c. A proper application of these principles and of precedent illustrates that res judicata does not bar Ms. Wilson's claim.

South Carolina courts have honored these principles as they have applied res judicata to change of condition claims.

Courts have not allowed a claimant to use a change of condition claim to re-try an issue that the claimant lost during the original case. This is what happened in *Owenby v. Owens Corning Fiberglas* and *Mead v. Jessex*. In both cases, the driving consideration was that the commission had already decided, in the first award, that the symptoms in question were not related to the claimants' injuries. Barring an appeal, that finding was conclusive. *Mead*, 382 S.C. 525, 532-34, 676 S.E.2d 722, 726-27 (Ct. App. 2009); *Owenby*, 313 S.C. 181, 183, 437 S.E.2d 130, 131-32 (Ct. App. 1993).

This reasoning is correct. A change of condition claim is not a vehicle for rehashing an issue that the claimant has already litigated and lost.

But if the alleged change of condition involves an issue that the claimant has *not* raised before, and if the allegation is that the effects of the claimant's injury have truly changed, there is no procedural bar to the claim. This is what happened in *Estridge v. Joslyn Clark Controls* and *Mungo v. Rental Uniform Service of Florence*. Both of these cases involved significant physical injuries, and both of these cases involved a change of condition based on the claim that as time lapsed, the physical injury began to significantly affect the claimant's mental condition.

In both cases, the Court of Appeals reversed the commission's finding that the mental claim was barred. See *Mungo*, 383 S.C. 270, 678 S.E.2d 825 (Ct. App. 2009); *Estridge*, 325 S.C. 532, 482 S.E.2d 577 (Ct. App. 1997). There is little to no material difference between these cases and the circumstances of Ms. Wilson's case. In *Estridge*, the court noted that while there was *some* evidence

of psychological problems at the time of the original award, these problems might not have impacted the claimant's disability at that time. See 325 S.C. at 540, 482 S.E.2d at 581. In *Mungo*, the court noted that at the time of the original award, no physician had diagnosed the claimant with a significant psychological condition. The court also noted that the claimant had not alleged a mental injury in her original claim. See 383 S.C. 270, 282-84, 678 S.E.2d 825, 831-32. These claimants were not re-litigating issues that had already been decided. They were claiming that their physical injuries progressively caused them to have mental problems. The same is true of Ms. Wilson.

For some claimants, medical treatment may result in permanent relief. It is unfortunately also possible that pain can subside after surgery, return, and get worse. That is what Ms. Wilson is claiming. See *Clark v. Aiken County Gov't*, 366 S.C. 102, 620 S.E.2d 99 (Ct. App. 2005) (pain relapse after surgery supported change of condition claim). The commission may not summarily dismiss this claim just because Ms. Wilson experienced a little anxiety and depression before her original award. If that reasoning was valid, *Mungo*, *Estridge*, and *Clark* would have been decided differently. There is no procedural bar. The commission needs to decide this claim on the merits.

II. A Change of Condition Claim Is Not Tied to a Specific Date of Diagnosis. As Long as it Is Filed in the Proper Time, it Can Encompass a Problem That Is Still in the Process of Turning Serious.

The commission held that Ms. Wilson's depression had to worsen between specific dates—January of 2008 and January of 2009—in order to be compensable. This is not correct.

a. The purpose of the change of condition statute is to allow the commission to adjust an award based on any developments, positive or negative, in the claimant's condition.

Change of condition claims are authorized by section 42-17-90 of the South Carolina Code (Supp. 2012). The Court of Appeals has described that the purpose of this statute is to allow the

commission to decrease compensation when someone's condition has changed for the better, and to increase compensation when their condition has changed for the worse. See, e.g., *Estridge*, 325 S.C. at 537, 482 S.E.2d at 580 (citing the Supreme Court's decision in *Cromer*). The change of condition can be a physical change that impacts someone's earning capacity, a change in earning capacity even though someone's physical condition has not changed, or a change in the claimant's degree of disability even though his or her physical condition has not changed. *Gattis v. Murrells Inlet VFW No. 10420*, 353 S.C. 100, 115, 576 S.E.2d 191, 199 (Ct. App. 2003) (Stilwell, J., dissenting). The goal of this scheme seems relatively clear—to account for circumstances as they change over time. As the Court of Appeals observed in *Estridge*, some health problems take time to appear and develop into "full bloom." 325 S.C. at 540, 482 S.E.2d at 581.

b. As long as it is filed by the proper deadline, a change of condition claim can encompass a problem that is still in the process of turning serious.

Like all provisions of the Workers' Compensation Act, the change of condition statute is to be liberally construed in light of its intended purpose. One illustration of how this applies in practice arose out of the statute's requirement that the commission conduct its change of condition "review" not later than 12 months after the last payment of compensation. See Section 42-17-90(A).

The Supreme Court considered this part of the statute in *Allen v. Benson Outdoor Advertising Co.* The court observed that if this language was read literally, it would require the commission to hear these claims *and decide them* within the 12 month deadline. The court rejected this view, and in doing so, it noted the purpose of the statute, the liberal construction afforded to the statute, and the fact that other states had construed their statutes to require only that the claim be filed—not decided—within the 12-month deadline. See 236 S.C. 22, 29-31, 112 S.E.2d 722, 725-26 (1960).

This is but one example of a principle of reasonableness that runs though all of these cases. If the claimant brings a change of condition claim within the deadline and pursues the claim with reasonable diligence, the court has been receptive, as it was in *Allen*. If the claimant does not act with reasonable diligence, the court has not been receptive. See *Richey v. Dickinson*, 359 S.C. 609, 598 S.E.2d 307 (Ct. App. 2004) (not a change of condition case, but laches barred a claim when the claimant did not request a hearing for 11 years). One court even took judicial notice of the fact that some workers' compensation cases take years to develop. *Wilkins v. State Compensation Comm'r*, 198 S.E. 869, 872 (W. Va. 1938) (cited favorably in *Allen*, 236 S.C. at 30, 112 S.E.2d at 726). That court was doing nothing more than stating the obvious.

These principles should not be controversial. The claimant's condition might still be in the process of worsening as the 12 month deadline approaches, and there is no valid reason to preclude such a claim. As opposed to a change of condition that happens to be uncomplicated and routine, another claimant's condition might be less definitive and need more time to evolve.

c. The commission did not recognize these principles or apply them to the facts of Ms. Wilson's case.

The decision below gives no indication that it recognized or applied these principles to Ms. Wilson's claim. Instead, it recites things that were uncontested and then summarily ends the case.

For example, the commission recited that no doctor has opined that Ms. Wilson did not have work-related depression prior to her original award. (R.p.25, ¶21). Ms. Wilson never claimed that any doctor gave such an opinion, and as the *Estridge* and *Mungo* cases describe, the fact that Ms. Wilson had *some* depression at that time would not bar a change of condition claim if her depression was minor but subsequently became severe.

The commission also recited that no doctor had opined that Ms. Wilson's depression began after the date of her original hearing or got worse between January of 2008 and January of 2009. Again, this was not what Ms. Wilson alleged. When she initiated this claim in January of 2009, Ms. Wilson attached a medical report which described that her primary physician had referred her to a specialist for psychiatric treatment. (R.pp.32-34). This information was confirmed in a letter from Ms. Wilson's psychiatrist, and this letter indicated that this physician had been providing Ms. Wilson with psychiatric care since May of 2008—well in advance of the change of condition deadline. See (R.pp.35-36). It should not matter that this physician was not able to diagnose Ms. Wilson with a specific change of condition within a 12 month period. The important facts are that he believed Ms. Wilson needed this treatment and he opined that this treatment is connected to her work-related back injury. In order to deny this claim, the commission has to consider and reject this argument. The commission's decision gives no indication that it did either.

One of the side effects of tying these claims to hard deadlines would be that hard deadlines would allow an unscrupulous employer to manipulate a claim. Consider the case of an injured worker who does not have the means to independently secure an appointment with a doctor. If an unscrupulous employer continually denies authorization for a doctor's visit, that denial might prevent the injured worker from proving what is, in fact, a valid change of condition claim. By delaying treatment for months or years, an employer would be able to manufacture the argument that the change of condition should be denied because it is impossible for a doctor to make an after-the-fact determination about the exact moment the change of condition occurred.

This case does not involve such guesswork. The facts are relatively straightforward. Ms. Wilson did *not* make a mental claim at the time of her first award, and while one vocational expert

previously opined that Ms. Wilson's depression was related to her back injury, the hearing commissioner found that this vocational assessment was inconsistent and gave it little weight. (R.pp.7, 10). Ms. Wilson's depression worsened to the point that her physician referred her to a psychiatrist in May of 2008—barely after her first award—and Ms. Wilson has been receiving psychiatric treatment since that time. With the utmost respect for the commission, it must accept the argument that this is a change of condition claim or it must give a principled reason for denying it.

CONCLUSION

Res judicata does not prevent a change of condition claim when a minor problem that was present during the original award has gotten worse. Also, a change of condition claim is not tied to a specific date of diagnosis or worsening. The Court should reverse this case and remand it for additional proceedings.

Respectfully submitted,

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STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS NINTH JUDICIAL CIRCUIT CASE NUMBER: 12-CP-10-5429
Sara Y. Wilson, Appellant, vs. Charleston County School District, Employer/Self-Insured, Respondent.	)	**RESPONDENT'S BRIEF**

This matter was initially heard before the South Carolina Workers' Compensation Commission regarding a change of condition claim filed by the Claimant/Appellant. The Single Commissioner heard that issue on June 29, 2011 in North Charleston, South Carolina. In an Order dated November 14, 2011, the Single Commissioner made several findings relative to jurisdiction, the statute of limitations, Laches, and the claimant's claim for a change of condition regarding her psyche. Charleston County School District timely appealed those findings. The Full Commission's hearing then went forward on May 23, 2012, and in an Order dated July 18, 2012 the Full Commission reversed several findings of the Single Commissioner. In relevant part, the Full Commission found that the Claimant had not proven a change of condition relative to her psyche and was further barred from bringing a psychological claim under the doctrine of res judicata. The Claimant then appealed the decision of the Full Commission to this Court.

FACTS

The Claimant in this matter was a data entry clerk for Charleston County School District. She was initially injured on May 6, 2009, when two students were fighting and pushed into her, pinning her against a counter and injuring her neck and back.

The Claimant treated with various doctors for her neck and back and reached Maximum Medical Improvement on July 20, 2007. (Deposition of Dr. Aymond, p. 13). This matter went to a hearing on October 7, 2007, and the Claimant alleged permanent and total disability. On November 29, 2007, the Single Commissioner found that she was not permanently and totally disabled but had a 45% disability to her back relative to her neck and low back. The Form 19 paying this Order was filed on January 25, 2008.

On January 7, 2009, the Claimant filed a Form 50 not requesting a hearing, but alleging a change of condition. Attached to this hearing request were two medical reports, neither of which indicated that the Claimant had sustained a change of condition in relation to her work injury. On March 29, 2011, the Claimant filed another Form 50, this time requesting a hearing on the change of condition claim. She attached the same two reports as had been attached to the January 7, 2009 hearing request and still did not attach a medical report indicating a change of condition.

At the hearing on June 29, 2011, the Claimant testified regarding her increased back pain, which is not the subject of this appeal. As far as the psychiatric treatment, which is the subject of this appeal, the Claimant indicated that she was in so much pain that she did not want to get up in the morning. She said she did not go out with her friends anymore and that she felt helpless. She admitted that she was taking medications for anxiety at the time of her first hearing. (Old APA 15, p.148-52).

The parties submitted the deposition transcript of Dr. Rosen at the change of condition hearing. In his deposition, Dr. Rosen reviewed his May 2008 report as well as the vocational assessment of Bill Stewart from September of 2007, which indicated that the claimant had anxiety and depression and was getting medications and treatment for that problem and that it was related to the work injury. (Old APA 15, p.148-52). ***Dr. Rosen stated that the Claimant's***

depression and anxiety from her work injury existed in September of 2007, prior to the first hearing in this matter. He was asked "is it your opinion that Ms. Wilson had anxiety and depression from her work injury and required medication and treatment at least by September of 2007?" Dr. Rosen answered "Yeah, that the work injury was causing some depression and anxiety by -- right." (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2). Of note, the Claimant did not allege psychological injuries or depression in the 2007 hearing. Dr. Rosen also testified that when he first saw the Claimant in May of 2008, she did not actually have endogenous depression, but that she did have endogenous depression at the time of his deposition, two and a half years after the statute of limitations had run on her change of condition claim. Dr. Rosen gave no indication that the Claimant had endogenous depression within a year after the last date of payment of compensation.

A review of the record from the first hearing indicates that the Claimant did not raise a psychological claim at that time. However, her vocational expert, William Stewart did indicate that the Claimant had significant depression related to the work injury. (Old APA 15). Mr. Stewart's report dated September 6, 2007 states that "Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work." (Old APA 15, p.144). He also indicated that she required "medical psychological care. . .including follow up office visits and prescribed psychotropic medications for anxiety and depression." Id. Specifically, Mr. Stewart noted that the Claimant continued to require Lorazepam for depression. (Old APA 15, p.146). Mr. Stewart also noted that the Claimant scored a "7" on the Beck Anxiety Inventory and the fact that it was not worse was because of the medications she was taking. (Old APA 15, p.149). Finally, Mr. Stewart concluded that the Claimant was incapable of working due to a

combination of chronic pain and psychological overlay "because of these injuries." (Old APA 15, p.150).

LEGAL ARGUMENT

I. Res Judicata Bars Appellant's Stress Claim.

Appellant indicates that the Commission denied her change of condition claim based on res judicata because she experienced "some anxiety and depression" before her original award. This is not exactly correct. The Commission in fact denied Appellant's change of condition claim because she had the opportunity to raise a psychological claim at the first hearing and chose not to do so.

a. Res Judicata does not require that a claim be previously litigated and lost.

Appellant argues that res judicata does not apply in the present claim because the issue of a psychological injury was not actually litigated in the first hearing. Appellant actually cites the correct law on res judicata but fails to recognize it in her argument. The doctrine of res judicata applies not only when the issues were actually litigated, but, as Appellant cites in her brief, also when the issues "might have been litigated." Price v. City of Georgetown, 297 S.C. 185, 189, 375 S.E. 2d 335, 338 (Ct. App. 1977).

In the present matter, the Claimant certainly could have brought a stress claim at the initial hearing in October of 2007 and chose not to do so. Mr. Stewart's report, submitted by the Claimant at the first hearing on September 6, 2007, states that "Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work. (Old APA 15, p.144). She required "medical psychological care" and "psychotropic medications for anxiety and

depression." Id. The Claimant's current psychiatrist, Dr. Rosen, testified the Claimant's depression and anxiety from her work injury existed in September of 2007, prior to the first hearing in this matter. (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2).

Our Supreme Court has made it clear that if a claimant could have brought a claim at the initial hearing and failed to do so, he cannot later bring a change of condition claim on the same issue. "In a reopening proceeding, the issue before the Commission is sharply restricted to the question of extent of improvement or worsening of the injury on which the original award was based." Krell v. South Carolina State Hwy. Dept., 237 S.C. 584, 587, 118 S.E. 2d 322, 324-25 (S.C. 1961). In Krell, the claimant filed a change of condition because of an alleged recurring hernia problem. The claimant alleged that the hernia was present at the time of the initial accident and had flared up. The Commission denied his change of condition claim in light of the fact that the record showed that the claimant had not alleged a hernia problem at the first hearing and therefore could not assert it at a change of condition hearing.

The present claim is precisely like Krell. The Appellant here filed a change of condition claim because of continuing anxiety and depression. Evidence from the Appellant's own vocational expert shows that she had anxiety and depression related to her work injury at the time of the first hearing, and she was even on medications for depression. The testimony from the Appellant's current psychiatrist is that she suffered from work related depression before the first hearing. The Full Commission properly denied the Appellant's change of condition claim in light of the fact that the record showed that the Claimant had not alleged a psychological problem at the first hearing and therefore she could not assert it at a change of condition hearing.

Importantly, the issue raised by the Appellant is actually whether the Appellant had enough of a psychological injury in the past to rise to the level of an injury that might have been

litigated at the time of the first hearing. In other words, the Claimant's appeal is a factual one. The Commission is the finder of fact. Lowe v. Am-Cam Transport Services, Inc., 283 S.C. 534, 324 S.E.2d 87 (Ct. App. 1984; S.C. Code Ann. § 42-17-50 (1985). A finding of fact made by the Commission may only be overturned if there is not substantial evidence to support it. S.C. Code Ann. § 1-23-380 (1986); see also Robbins v. Walgreens & Broadspire Servs., Inc., 375 S.C. 259, 264, 652 S.E.2d 90, 93 (Ct.App.2007). In the present claim, the evidence presented from the Claimant's own vocational expert and chosen psychiatrist is more than sufficient to establish substantial evidence. Therefore, the findings of the Full Commission on this matter should be affirmed.

b. Continuing Jurisdiction Over a Matter Does Not Eliminate the Doctrine of Res Judicata.

Appellant makes an argument based on Cromer v. Newberry Cotton Mills, 201 S.C. 349, 23 S.E.2d 19 (1942) that the Commission has continuing jurisdiction over every case and therefore can change an award at any time. The argument implies that the Commission has free reign to change its prior Orders and therefore res judicata is basically inapplicable to Workers' Compensation claims. While the argument is a clever one, it misconstrues the law.

In Cromer, the employer argued that since the claimant had been provided with an award relative to his disability, the Commission could not later come back and pay him an increased disability amount under the doctrine of res judicata. Id. at 21. The Court simply held that the Commission has the power under the change of condition statute, Section 46 (now S.C. Code Ann. § 42-17-90), to increase or diminish a prior award. However, because the Commission may hear a change of condition claim does not mean that commissioners are rehearing issues that could have been heard before. The whole point of a change of condition

claim is that something the Commission decided initially has changed; therefore the issues are different. The real question Appellant raises is whether a claimant may raise a new issue at a change of condition hearing that *could have been raised* at the first hearing. In Cromer, the claimant was not attempting to raise an issue that could have been previously raised. He simply argued that the condition that he had at the first hearing had changed.

Further, the Supreme Court heard Krell nineteen years after Cromer and found res judicata applicable in that workers' compensation claim. As discussed above, the facts of Krell are much more applicable to the present claim. In fact, the court in Krell actually cited Cromer for the proposition that the Commission, and not the appellate court, is the ultimate finder of fact. Krell at 323-324.

c. Res Judicata is a Bar to Appellant's Claim.

Appellant first argues again that res judicata is inapplicable because the issues here were not litigated and lost. As discussed above under I.a., this is an incorrect statement of this doctrine.

Appellant next argues that her claim is similar to Mungo v. Rental Uniform Services of Florence, 383 S.C. 270, 678 S.E.2d 825 (Ct. App. 2009), Estridge v. Joslyn Clark Controls, 325 S.C. 532, 482 S.E.2d 577 (Ct. App. 1997) and Clark v. Aiken County Gov't., 366 S.C. 102, 620 S.E.2d 99 (Ct. App. 2005). Appellant's reliance on these cases is misplaced.

Mungo and Estridge both held that a claimant may raise the issue of depression at a change of condition hearing when the symptoms of depression prior to the first hearing were "mild, undiagnosed, and untreated." Mungo at 284 & Estridge at 581. That is not the case in the present claim. The Appellant's vocational expert concluded that the Claimant was incapable of working due to a combination of chronic pain and psychological overlay "because of these

...injuries." (Old APA 15, p.150). More importantly, he noted that she required "medical psychological care. . .including follow up office visits and prescribed psychotropic medications for anxiety and depression." Id. Specifically, he noted that the Claimant *continued* to require Lorazepam for depression. (Old APA 15, p.146). In other words, the Claimant in the present claim did not have a "mild, undiagnosed, and untreated" psychological condition. In fact, according to the Claimant's own expert, she was being treated for depression and continued to need that treatment.

In Clark, the court simply found that the claimant's condition following his back surgery was not ripe for review at the first hearing because he did not know how well he would recover. The fact that his condition later worsened was the subject of a new hearing. Clark at 102-103. That case is wholly unrelated to the present facts where the Appellant had a documented psychological condition prior to her first hearing, was receiving medication for that condition, and she chose not to raise the issue at all.

II. The Timing For a Claimant to Experience A Change of Condition is Unquestionably One Year.

The Commission was completely correct in finding that the Claimant's change of condition had to occur with one year of the last date of payment of compensation. The Appellant makes three sub-arguments that amount to a policy argument that a claimant should have no limitations on when a change of condition may occur. The clear law is simply not in line with this suggested policy argument and would require a legislative amendment.

SC Code Ann § 42-17-90. The statute says in pertinent part:

> Upon its own motion or upon the application of any party in interest on the ground of a change in condition, the Commission may review any award and on such review may make an award ending, diminishing or increasing the compensation previously awarded, subject to the maximum or minimum provided in this

> Title, and shall immediately send to the parties a copy of the order changing the award. No such review shall affect such award as regards any moneys paid and *no such review shall be made after twelve months from the date of the last payment of compensation pursuant to an award under this Title.*
>
> (emphasis added)

Regulation 67-602 (C) provides:

> In a claim involving a change of condition, the moving party must attach to the hearing request form a medical report(s) *indicating a change in the claimant's condition.*
>
> (emphasis added)

A regulation, which is a "legislative rule," is one which, generally, has the force of law and becomes an integral part of the statute. Faile v. South Carolina Employment Sec. Commission, 230 S.E.2d 219 (1976). The general rule in South Carolina Worker's Compensation cases regarding statutory construction and interpretation is that the cardinal rule is to ascertain and give effect to the intent of the legislature. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Charleston County Sch. Dist. v. State Budget and Control Bd., 313 S.C. 1, 437 S.E.2d 6 (1993)). If a statute's language is plain, unambiguous, and conveys a clear meaning "the rules of statutory interpretation are not needed and the court has no right to impose another meaning." Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000)). The courts are further bound by precedent to strictly construe statutes in derogation of the common law. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Gilfillin v. Gilfillin, 344 S.C. 407, 544 S.E.2d 829 (2001)). Workers' compensation statutes provide an exclusive compensatory system in derogation of common law rights. *See* Caughman v. Columbia YMCA, 212 S.C. 337, 47 S.E.2d 788 (1948). As such, when reading a workers' compensation statute we strictly

construe its terms, leaving it to the legislature to amend and define its ambiguities. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003).

The initial question in interpretation is whether the statute's directives are mandatory or discretionary. In Wigfall, the court interpreted the term "shall" to be mandatory. Id. South Carolina's Supreme Court has also held the word "must" to indicate the legislature's intent to enact a mandatory requirement. Collins v .Doe, 352 S.C. 462, 574 S.E.2d 739 (2002). In the present case, the word *must* was used in the sentence pertaining to attaching medical reports *"indicating a change of condition"* to the Form 50 in requesting a hearing for a change of condition within the one year time frame. The mandatory requirement under the statute is that this Form 50 be filed with the necessary record within the one year time limit. Failure to do so results in the expiration of the one year time limit in SC Code Ann § 42-17-90. It also means that the Workers' Compensation Commission has no jurisdiction to hear this matter under Regulation 67-602 (C).

Appellant cites Allen v. Benson, 236 S.C. 22, 112 S.E.2d 722 (1960) to demonstrate that the Supreme Court has been receptive to lengthening the time in which a change of condition must occur. This is incorrect. The Supreme Court, in Allen, simply found that it would be unfair to prejudice a Claimant by requiring that the *actual hearing* on his change of condition claim be heard within one year and noted that it was enough that the "application for review" be filed within one year. Id. at 31, 726. The Claimant must request a hearing or "review" within a year of the last date of payment of compensation with medical proof of a change of causation; Allen stands for the proposition that the claimant will not be held responsible if the hearing itself does not take place within that year. Allowing a claimant to file a Form 50 not requesting a hearing within a year of the final payment of compensation and then to wait an additional two years to

request an actual review or hearing, and for that entire time to be included in the window for a change of condition, would mean that S.C. Code Ann § 42-17-90 has lost all meaning. This is not what the Supreme Court intended in Allen when the claimant actually requested a hearing and experienced a change within the statute of limitations but simply did not have his hearing date until after that year had expired. The intention and spirit of the Court's decision in Allen should be honored in this matter.

The Appellant also argues that if a claimant takes too long to bring a change of condition claim, the remedy is the doctrine of Laches. Assuming momentarily that the claimant should be allowed to ignore the clear statutory law, the change of condition claim in this matter would actually be barred under the doctrine of Laches. Laches is neglect for an unreasonable and unexplained length of time, under circumstances affording the opportunity for diligence, to do what in law should have been done. Muir v. C.R. Bard, Inc., 336 S.C. 266, 519 S.E.2d 583, 598 (Ct. App. 1999).

To prevail on the defense of Laches, the party asserting the doctrine must prove (1) unreasonable delay by the adverse party, resulting in (2) material prejudice to the moving party. In the case of Richey v. Becton Dickinson, 359 S.C. 609, 598 S.E.2d 307 (Ct. App. 2004), the court first held that that the claimant could not adequately explain the lengthy delay in requesting a hearing by arguing that he could not find a good lawyer. Secondly, they found that the defendants were materially prejudiced because the delay made proximate cause difficult to ascertain.

In the present matter, the Claimant cannot even allege that that she delayed requesting a hearing because she was looking for an attorney. She has retained the same attorney since before the first hearing, so her excuse for her three year delay, which she never provided, cannot even rise to the level of the claimant's excuse in Richey. The fact that she still did not have a medical report

indicating a change of condition when she finally requested a hearing in March of 2011 only further shows that there was no excuse for this lengthy delay.

As to the second Laches requirement, the Defendant's prejudice in this matter is precisely the same prejudice as outlined in Richey. The two medical records attached to both Forms 50 are (1) a note showing an injection the Claimant received and (2) a report from Dr. Sam Rosen on May 18, 2008 indicating that the Claimant was concerned with her finances because her temporary total disability checks had stopped, but unlike at the time of the first hearing, he could not actually diagnose the Claimant with depression or recommend any medications. Not only is there no indication that the Claimant had sustained a change of condition in either report, there is no indication that the Claimant had any depression from her physical injury at that time. Dr. Rosen's deposition did not take place until June of 2011, requesting him to discuss his opinions in May of 2008. Dr. Rosen cannot be expected to have an independent recollection of that appointment or his impressions of the Claimant three years earlier, which are crucial in a psychological claim where diagnostic reports cannot be reviewed and relied upon.

Finally, the Appellant argues that there should be no time limit on a change of condition because that could encourage unscrupulous employers to delay allowing a claimant to return to a physician. To this argument, I would simply note that this is what the doctrine of Estoppel is meant to cover.

CONCLUSION

Based on the foregoing, the Employer/Self-Insured respectfully submits that the doctrine of res judicata is applicable to the present claim because the Claimant was suffering from work related depression and receiving medication for that depression at the time of the first hearing; thus this issue could have been litigated at the first hearing. Also, SC Code Ann § 42-17-90

creates a clear requirement that any change of condition must occur with twelve months of the last date of payment of compensation. Therefore, the decision of the Full Commission should be affirmed.

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Dated: March 7, 2014.

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Sara Y. Wilson, Appellant, v. Charleston County School District, Respondent.	)	Case No. 2012-CP-10-5429 **REPLY BRIEF**

Sara Wilson respectfully offers the following reply in support of her request that the Court reverse this case and remand it to the commission for additional proceedings.

A. Nobody is arguing that res judicata does not apply to workers' compensation cases. The point is that it applies differently (and more flexibly) than it would apply in circuit court.

Nobody is suggesting that res judicata does not apply to workers' compensation cases. This point should not be controversial. Everyone ought to agree that while res judicata *does indeed* apply, it applies in a way that is different from the way in which it would apply to a regular civil case.

In a civil case, the court's judgment is conclusive and cannot be modified absent a Rule 60 motion. See Rule 60, SCRCP. Achieving relief on such a motion generally requires the moving party to make a substantial showing.

Workers' compensation cases are different. The essential purpose of the change of condition statute is to empower the commission to modify an award—to amend the decision it already made—because the facts and circumstances which led to that award have changed. This is what Ms. Wilson alleged here. She claimed that her depression went from tolerable to disabling.

Ms. Wilson was able to locate four instances where appellate courts applied res judicata in workers' compensation cases. None were comparable to the present case. See **Attachment A.**

B. Nobody is arguing that there is an endless time limit for a change of condition claim, but it ought to be obvious that a change of condition need not run its course within the one year deadline.

Nobody is suggesting that there is an endless time limit for a change of condition claim, but at the same time, it ought to be obvious that a change of condition need not run its course during the one year deadline. Assume for a moment that Ms. Wilson's claim is valid. Now let us consider two different scenarios with respect the diagnosis of Ms. Wilson's psychological condition.

Under the first scenario, suppose that a physician was able to say with certainty that Ms. Wilson's psychological condition became compensable, which is to say that it began affecting her ability to work, on a specific date. Let us also assume that this date falls within the one year deadline.

Under the second scenario, suppose that Ms. Wilson's primary care physician (who is not a psychiatrist) observes Ms. Wilson's mental health deteriorating and refers Ms. Wilson to a specialist for psychiatric care. This referral comes within the one year deadline, but the diagnosis of a disabling condition does not come until later.

Is the School District really suggesting that these scenarios should be treated differently? They are not meaningfully distinguishable. Workers' compensation statutes are supposed to be read flexibly and in favor of awarding compensation. See, e.g., *Allen v. Benson Outdoor Advertising Co.*, 236 S.C. 22, 112 S.E.2d 722 (1960) (rejecting a strict reading of the change of condition statute). The School District's view of the law has the opposite effect.

C. If this is a fact-driven case, the Commission needed to engage in detailed fact finding and to explain its decision. If Ms. Wilson always had a diagnosed psychological injury, where is the medical evidence of that diagnosis?

The School District is trying to sell a more nuanced and fact-driven argument than it sold to the commission. It is also trying to give the commission's order more credit than it is due.

The School District says that the controlling issue is backward-looking. It says that the question is whether Ms. Wilson had a compensable depression claim at the time her original award.

The commission's analysis does not follow this reasoning. The commission's decision contains blanket findings; findings like "no doctor has opined that [Ms. Wilson] did not have work-related depression prior to [her original hearing]," and "no doctor has opined that [Ms. Wilson's] work-related depression began after [the relevant date] and worsened between [certain dates]." (R.pp.25-26, findings 21 & 22). This is not a nuanced order. It is written in broad absolutes.

The commission cannot have been viewing the law correctly if it made these sorts of findings. It does not matter whether Ms. Wilson had some degree of work-related depression prior to the first hearing, and it does not matter whether her work-related depression began between certain dates. The question is whether her mental condition has changed. The commission never made a finding about when Ms. Wilson's depression became disabling, and it never cited any medical evidence which suggests that this pre-existing depression had any significant level of severity. One searches in vain for an explanation of whether the commission believed that Ms. Wilson had compensable depression at the time of her original hearing, and one is also left wondering what facts would have led the commission to reach such a conclusion.

This sort of non-specificity is not unique to Ms. Wilson's case. In the last year-and-a-half, South Carolina's appellate courts have sent at least three cases back to the commission because the commission's findings were not sufficiently specific to allow the appellate court to resolve the appeal. See *Nicholson v. South Carolina Dep't of Social Servs.*, 405 S.C. 537, 748 S.E.2d 256 (Ct. App. 2013); *Burnette v. City of Greenville*, 401 S.C. 417, 737 S.E.2d 200 (Ct. App. 2012; *Canteen v. McLeod Reg'l Med. Ctr.*, 400 S.C. 551, 735 S.E.2d 246 (Ct. App. 2012). These cases have

differences from one another, but there is a common denominator that these cases share with Ms. Wilson's case. The law requires the commission to do more than make findings and give a result. The commission's findings must be cogent, they must be backed by evidence, and the commission's decision must demonstrate that the commission interpreted the law correctly.

With the utmost respect for the School District and the members of the commission's appellate panel, we know that this did not happen here. We know that Ms. Wilson did not suffer chronic depression as a result of her work-related injury at the time of her original claim. She did not have enough time. Ms. Wilson was injured in May of 2006. She had surgery in March of 2007, she improved after surgery, and she received an award from the commission in November of 2007. Surely the School District is not suggesting that Ms. Wilson developed prolonged (and worsening) depression during the eight months between her surgery and her award. Ms. Wilson's doctors said that she *improved* after surgery and that she did not relapse and deteriorate until later.

D. This case is materially different from *Krell*, and as Ms. Wilson's principal brief explained, the problem is not that the commission denied Ms. Wilson's claim, but that the Commission used an improper view of the law to do so.

Ms. Wilson would again direct the court's attention to three cases that she believes are fairly comparable to the present case. These cases are *Mungo v. Rental Uniform Service of Florence*, 383 S.C. 270, 678 S.E.2d 825 (Ct. App. 2009), *Clark v. Aiken County Gov't*, 366 S.C. 102, 620 S.E.2d 99 (Ct. App. 2005), and *Estridge v. Joslyn Clark Controls*, 325 S.C. 532, 482 S.E.2d 577 (Ct. App. 1997). The School District seeks to distinguish these cases by reciting that they involved "mild" and "undiagnosed" conditions, but the same is true in Ms. Wilson's case. It was not until *after* Ms. Wilson's original award that her primary physician viewed her depression as severe-enough to warrant treatment from a specialist. No medical evidence makes a previous connection.

The School District says that the present case is controlled by the Supreme Court's decision in *Krell v. South Carolina State Highway Department*, 237 S.C. 584, 118 S.E.2d 322 (1961).

Krell is a hernia case and is controlled by the hernia statute, which requires a work-related hernia to appear almost immediately after an injury in order to be compensable. If the hernia must appear immediately, it naturally follows that it going to be difficult (if not impossible) for a hernia to be part of a change of condition claim. Something cannot appear immediately yet also *not* appear until after the original award and within one year of the last payment of compensation.

If the commission is going to conclude that Ms. Wilson's depression has always been compensable, it needs to make that finding expressly and it needs to cite more than a vocational evaluation (which is not medical evidence) that the original hearing commissioner *rejected.* See (R.p.10, ¶19). This evaluation observed that Ms. Wilson was a motivated and credible person with an outstanding work ethic. (R.p.58). This is substantially different from Ms. Wilson's testimony about her present condition. See (R.pp.87-88). The commission must issue an order which shows that it judged this case according to the proper standards. The present order does not.

Respectfully submitted,

March 14, 2014

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Attorneys for Appellant

Attachment A

List of Appellate Decisions Applying Res Judicata to a Workers' Compensation Case

Mead v. Jessex, Inc.,
676 S.E.2d 722, 382 S.C. 525 (Ct. App. 2009)

Johnson v. Greenwood Mills, Inc.,
317 S.C. 248, 452 S.E.2d 832 (1994)

Owenby v. Owens Corning Fiberglas,
313 S.C. 181, 437 S.E.2d 130 (Ct. App. 1993)

Krell v. South Carolina State Highway Dep't,
237 S.C. 584, 118 S.E.2d 322 (1961)

*Note: This list does not include decisions where the application of res judicata was rejected. Such decisions include *Estridge v. Joslyn Clark Controls*, *Mungo v. Rental Uniform Service of Florence*, *Clark v. Aiken County Government*, and several other cases.

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	IN THE COURT OF COMMON PLEAS FOR THE NINTH JUDICIAL CIRCUIT
Sara Y. Wilson, Appellant, v. Charleston County School District, Respondent.	)	Case No. 2012-CP-10-5429 **APPELLANT'S RECORD ON APPEAL**

INDEX

Orders

Hearing Commissioner's Decision on Ms. Wilson's Original Claim
(Order of November 29, 2007) 1

Appellate Panel's Decision on Ms. Wilson's Change of Condition Claim
(Order of July 18, 2012) 13

Pleadings and Motions

Notice of Ms. Wilson's Original Claim
(Form 50 of August 9, 2006) 29

Notice of Ms. Wilson's Change of Condition Claim
(Form 50 of January 6, 2009) 30

Hearing Request for the Change of Condition Claim, with attachments
(Form 50 of March 29, 2011) 31

Letter of April 29, 2011 35

Transcripts

Deposition Transcript of Samiel H. Rosen, M.D. 37

Transcript of Hearing of June 29, 2011 63

DECISION AND ORDER
BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC FILE NUMBER 0608517

SARA Y. WILSON,

Claimant,

vs.

CHARLESTON COUNTY SCHOOL DISTRICT,

Employer/Self-Insured

HEARING:	Hearing held in North Charleston, South Carolina on October 2, 2007.
APPEARANCES:	Leslie M. Whitten, Esquire on behalf of the Employer/Carrier.
	Tiffany R. Spann-Wilder, Esquire on behalf of the Employee/Claimant.
PURPOSE OF HEARING:	To determine issues presented on the Forms 50 and 51 and the Form 21.
DECISION AND ORDER BY:	Andrea Pope Roche, Commissioner.
DATE FILED:	November 29, 2007

STIPULATIONS

At the call of the case, the parties stipulated as follows:

1. That both the Claimant and the Defendants were subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act.

2. That jurisdiction and sufficiency of the notice of the hearing were admitted.

3. That, at the time of the injury, the average weekly wage being earned by the Claimant was the sum of $556.37, resulting in a compensation rate of $370.93.

4. That venue for this hearing was proper in Charleston County, South Carolina, pursuant to stipulation by the parties.

APA SUBMISSIONS

The following APA submissions were submitted on behalf of the Employee/Claimant:

APA	Name of Provider	Date of Report	No. Pages
(4)	Roper Hospital	5/9/06	35-42
(5)	W. Pettigrew Clare	5/12/06-9/12/06	43-46
(6)	Doctor's Care	5/20/06-5/31/06	47-51
(7)	Tri-county Radiology	5/25/06	52-53
(8)	Private Therapy Services	6/13/06-8/15/06	54-76
(9)	Dr. Blake Dennis	6/16/06-7/18/06	77-84
(10)	Dr. Robert Alexander	7/27/06-11/17/06	85-107
(11)	Charleston Neuroscience Inst.	1/16/07	108-109

(12)	Dr. James Aymond	1/16/07-9/14/07	110-122
(13)	James Island P.T.	4/27/07-6/8/07	123-137
(14)	Dr. Robert Brabham	2/14/07-2/15/07	138-142
(15)	Dr. William Stewart	9/6/07	143-152
(16)	Dep. William Dixon	1/23/07	25
(17)	Dep. Sara Wilson	1/23/07	56
(18)	Dep. of Dr. Aymond	9/11/07	18

The following Exhibits were submitted on behalf of the Employee/Claimant:

Exhibits on behalf of Employee/Claimant:

Charleston City Police Department Incident Report; Claimant's personnel records; records from South Carolina Retirement Systems; miscellaneous documents, including handicap pass and flight information

The following APA submissions were submitted on behalf of the Employer/Carrier:

APA	Name of Provider	Date of Report	No. Pages
(1)	Dr. Alexander	11/16/2006	1-2
(2)	Dr. Aymond	7/20/07	3
(2)	David Price	2/19/07 - 8/30/07	4-13

The following Exhibits were submitted on behalf of the Employer/Carrier:

Exhibits on behalf of Employer/Carrier:

Dr. Aymond's deposition; records from claimant's personnel file; payroll records for claimant

CLAIMANT BIOGRAPHICAL

DATE OF BIRTH:	[redacted]/1943
SEX:	Female
MARITAL STATUS:	Widow
EDUCATION:	High school, plus college credit in typing and computers
WORK HISTORY:	Customer service, cashier, phone operator, and secretary

STATEMENT OF THE CASE

The above case came to be heard before the undersigned Commissioner in North Charleston, South Carolina, on October 2, 2007 pursuant to notice timely and properly given to all parties of record. The Employer/self-insured filed a Form 21 on December 19, 2006 requesting a hearing to determine whether temporary total disability benefits could be terminated on the basis that the Claimant had reached Maximum Medical Improvement. The Employer/self-insured asserted the Claimant had reached Maximum Medical Improvement pursuant to the report of Dr. James Aymond dated November 16, 2006 and his deposition dated September 11, 2007. The Claimant agreed that she had reached Maximum Medical Improvement but asserted that she was permanently and totally disabled as a result of her injury in combination with her pre-existing psychological problems. The Claimant further alleged that she has sustained injuries to her neck and lower back as a result of her work injury.

EVIDENCE OF THE CASE

The Claimant was the only witness to testify at the hearing. The Claimant has done many sedentary jobs in the past, such as bookkeeping, typing, working on a computer and

working as a customer service representative and telephone operator. She has a high school education and also attended college for two years, taking classes in computers and typing. She testified that she was injured at work on May 9, 2006, while working as a data entry clerk at James Simons Elementary School. Two students were fighting in her office, and she got caught in the middle of it and ended being pushing into nearby counter tops.

The medical records reveal that the Claimant initially treated with Doctor's Care, (APA 6) who referred her to Dr. Blake Dennis. (APA 9). Dr. Dennis ordered an MRI of the cervical spine and indicated that surgery might be an option for the Claimant, but that the Claimant was not interested in surgery. (APA 9, p. 84). Dr. Dennis eventually referred the claimant to Dr. Alexander, who gave the Claimant injections in her neck. (APA 10).

The Claimant indicated that she was not improving in her treatment with Dr. Dennis and Dr. Alexander, so per the request of the Claimant, she was sent for a second opinion to Dr. Stovall on November 13, 2006 who indicated that the claimant had reached Maximum Medical Improvement from a conservative treatment standpoint. (APA 3, p. 6). He indicated that surgery might be an option but that the claimant was not interested in surgery. (APA 3, p. 6). On November 16, 2006, Dr. Alexander agreed that the Claimant was at Maximum Medical Improvement from a conservative standpoint (APA 1, p.1) and, on November 17, 2006, he assigned the Claimant an 8% rating to the whole person relative to the cervical spine. (APA 1, p.2).

The Claimant then went on her own to Dr. James Aymond on January 16, 2007, complaining of continued neck pain and also alleging pain in her lumbar spine. (APA 12, 116). Dr. Aymond ordered a MRI for the claimant's lumbar spine and recommended an anterior cervical discectomy and fusion at the C6-7 level. (APA 12, 117). He did perform

this surgery and then sent the Claimant for physical therapy for both her neck and lower back. (APA 12). On July 20, 2007, Dr. Aymond opined that the Claimant was at Maximum Medical Improvement for her cervical spine and assigned her a 23% rating to the whole person relative to the cervical spine. (APA 12, 121). He gave her restrictions of lifting no more than 20 pounds and avoiding repetitive overhead activities. (APA 12, 121). He noted that the Claimant was doing "very well." (APA 12, 121). He also stated that she could contact his office for lumbar injections if she had worsening symptoms. (APA 12, 121).

In his deposition on September 11, 2007, Dr. Aymond testified that he had not seen the Claimant since July 20, 2007 and that she had not contacted his office for another appointment. (Deposition of Dr. Aymond, p. 11, lines 6-12). Dr. Aymond believed that the Claimant's lower back symptoms were related to her work injury (Deposition of Dr. Aymond, p. 12), but he further indicated that the Claimant had reached Maximum Medical Improvement regarding her lower back and assigned her a 5% rating to the whole person relative to the lumbar spine. (Deposition of Dr. Aymond, p. 13). He indicated that she should not perform repetitive bending and twisting. (Deposition of Dr. Aymond, p. 13, lines 1-5).

At the hearing, the Claimant admitted that she can stand for at least an hour without any problem and that she can sometimes sit for an hour or more. She testified that the pain level in her neck can sometimes be 9 out of 10 and that her lower back pain can be 6 out of 10. However, upon review of the report from David Price, the Claimant previously indicated her pain at its worst would be 6 or 7 out of 10, and this only occurred a couple of times a month. (APA 3, p. 11). The Claimant admitted at the hearing that her pain had not increased since her evaluation with David Price. The

Claimant also told David Price that she only took her breakthrough pain medication a couple of times per month. (APA 3, p. 11).

The Claimant also admitted that she did not want the injections to her lower back at this point because her pain was not bad enough to warrant them. She also testified that she had significant difficulty working after her injury. However, she admitted that the time she worked was prior to her surgery and that her surgery helped her a great deal.

She further admitted that she has not asked for any treatment for anxiety and that she only had an increase in her medications because of the death of her husband, but not due to this accident.

The Claimant was evaluated by Dr. William Stewart for a vocational assessment on September 6, 2007. (APA 15). Dr. Stewart administered a test to the Claimant to evaluate her reading and math levels. The test revealed that the Claimant has about an 11th grade reading level and a 12th grade math level. (APA 15, p. 148). In contrast to the Claimant's testimony about the cause of her psychological problems, Dr. Stewart indicated that the Claimant had psychological overlay due to her chronic pain and inability to work. (APA 15, p. 144). Dr. Stewart ultimately concluded that the Claimant is incapable of returning to the sedentary and light levels of work she has done in the past (APA 15, p. 151), but he acknowledged that her work restrictions are sedentary to light restrictions. (APA 15, p. 151). The Claimant also submitted a vocational assessment from Dr. Robert Brabham, dated February 15, 2007, but this assessment was done prior to the Claimant's cervical fusion and was not updated. (APA 14).

The Employer/self-insured submitted a vocational assessment from David Price. (APA 3). Mr. Price acknowledged the Claimant's continued complaints of pain (APA 3,

p.11), but he also noted that the Claimant's only restrictions limited her to light work. (APA 3, p.12). The Claimant's former occupation as a data entry clerk is actually classified as sedentary work, which is of course a lighter category than the Claimant's restrictions. (APA 3, p.12). Mr. Price also noted that the he would support the Claimant's decision to retire because she told him that she is "happy with [her] retirement." (APA 3, p.12). However, he would also support a decision to return to work should she choose to do so. (APA 3, p.13).

Based upon the stipulations of the parties, the testimony and evidence received and produced at the hearing, as well as my personal observation of the witnesses, the undersigned Commissioner finds the following facts based upon the preponderance of the evidence:

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That all parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act.

2. That, at the time of her injury, the claimant earned an average weekly wage of $537.87, resulting in a compensation rate of $370.26.

3. That the Claimant was previously paid temporary total disability benefits at a compensation rate of $335.26.

4. That employer/self-insured will pay the Claimant the difference in the underpayment of past temporary total disability benefits.

5. That the Claimant sustained an admitted injury by accident to her neck on May 9, 2006.

6. That Dr. Aymond determined the Claimant had reached maximum medical improvement regarding her cervical spine as of July 20, 2007 and assigned a 23% rating to the whole person relative to the cervical spine.

7. That Dr. Aymond also opined that the claimant's lower back problems arose from her work related injury in his deposition of September 11, 2007.

8. That, in his deposition, Dr. Aymond opined that the claimant had reached Maximum Medical Improvement to her lower back and assigned a 5% rating to the whole person relative to the lumbar spine.

9. That the last appointment that claimant had with Dr. Aymond for her neck or lower back prior to his deposition was July 20, 2007.

10. That the Claimant reached Maximum Medical Improvement to her neck and lumbar spine by July 20, 2007.

11. That the Claimant's injury to her lumbar spine is related to her work-related injury of May 9, 2006.

12. That the Claimant has sustained 45% disability to her back due to her cervical and lumbar injuries.

13. That the Employer/self-insured may stop payment of temporary total benefits.

14. That the Employer/self-insured is entitled to credit for overpayment of temporary total disability benefits paid since the date of maximum medical improvement, July 20, 2007.

15. That the Claimant is not permanently and totally disabled.

16. That based on the medical records and testimony, the claimant improved after her cervical fusion.

17. That the claimant's lumbar pain is not enough for her to request the injections as recommended by Dr. Aymond.

18. That the claimant's work restrictions are compatible with her prior employment.

19. That I find David Price's vocational assessment to be more persuasive than William Stewart's assessment. Mr. Price's assessment is much more in line with the medical evidence than then report of Dr. Stewart. Furthermore, I find Dr. Stewart's assessment to be internally inconsistent. Dr. Brabham's assessment is given little weight as it was prepared for a different forum and was prepared before the Claimant had surgery.

20. That although Dr. Alexander's restrictions were argued at the hearing, these restrictions were prior to the claimant's surgery that relieved her pain.

Based upon the above Statement of the Case, Evidence of the Case, and the Findings of Fact, the following Conclusions of Law are made:

CONCLUSIONS OF LAW

The following sections of the South Carolina Code of Laws give the appropriate definitions and provisions of the South Carolina Workers' Compensation Act as applicable to this case:

1. S.C. Code Ann. § 42-1-160 defines injury by accident;

2. "Maximum medical improvement" (MMI) is term used to indicate that workers' compensation claimant has reached such plateau that in physician's opinion

there is no further medical care or treatment which will lessen degree of impairment. Lee v. Harborside Café, 564 S.E.2d 354, 350 S.C. 74 (Ct. App. 2002).

3. S.C. Code Ann. § 42-9-10 defines when compensation is to be paid for permanent and total disability;

4. S.C. Code Ann. § 42-9-30 sets forth compensation to be paid for scheduled disability to the back;

5. S.C. Code Ann. § 42-15-60 and Dodge v. Brucolli, 514, S.E. 2d 593 (S.C. App. 1999) define medical care and treatment to be provided.

Based upon the above Statement of Case, Evidence of the Case, Findings of Fact, and Conclusions of Law, the following Order is made:

ORDER

Based on the foregoing, it is hereby:

ORDERED, ADJUDGED, AND DECREED that the employer/carrier shall be entitled to stop payment of temporary total disability benefits as of July 20, 2007 and shall be entitled to a credit for all weekly benefits paid subsequent to July 20, 2007 as against any permanent partial disability; it is further

ORDERED, ADJUDGED, AND DECREED that the employer/carrier shall pay the Claimant for a period of 135 weeks at the weekly rate of $370.93, which represents 45% permanent partial disability or loss of use of the back; it is further

ORDERED, ADJUDGED, AND DECREED that employer/self-insured will pay the Claimant the difference in the underpayment of past temporary total disability benefits paid at a compensation rate of $335.26.

No hearing costs or penalties are assessed in this matter.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

Andrea Pope Roche
Commissioner

Columbia, SC

Dated: 11/21/07

CERTIFICATE OF SERVICE

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

This 29th day of November, 2007

By Barbara Cheselow

Administrative Assistant to the Commissioner

RECEIVED

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

WCC FILE 0608517

SARA Y. WILSON,
Claimant,

vs.

CHARLESTON COUNTY SCHOOL DISTRICT,
Employer/Self-Insured,

Appellate Panel Review
Columbia, South Carolina
May 23, 2012

Appellate Panel Decision & Order filed

on 7/18, 2012.

AFFIRMED IN PART/REVERSED IN PART

Tiffany R. Spann-Wilder of The Spann-Wilder Law Firm, L.L.C., on behalf of Claimant.

Leslie M. Whitten, of Young Clement Rivers LLP, on behalf of Employer/Self-Insured.

STATEMENT OF THE CASE

The above case was heard before Commissioner Derrick L. Williams in North Charleston, South Carolina, on June 29, 2011 pursuant to notice timely and properly given to all parties of record. On November 14, 2011, Commissioner Williams issued the following Findings of Fact and Rulings of Law:

FINDINGS OF FACT

1. The South Carolina Workers' Compensation Commission has jurisdiction over this claim with venue being proper in Charleston County, State of South Carolina. The Claimant was a covered employee and the employer was a covered employer. The employee/employer relationship existed at the time of the Claimant's injury by accident.

2. This claim was heard before the undersigned Commissioner on June 29, 2011, in accordance with notices timely and properly served upon all parties of interest.

3. The Claimant sustained an admitted injury to her neck and back and was previously awarded 45% to the neck and back by Commissioner Roche.

4. I do not find that the statute of limitations had run on the filing of the change of condition claim, for either the neck/back or the Claimant's psychological condition. All of the Claimant's pleadings were sufficient and were timely filed under the Act. Defendants' argument as to non-compliance with Reg. 67-602(C) are not persuasive. Neither do I find that the doctrine of laches applies, as there is no prejudice to the Defendants and the Claimant has not "slept on her rights." "Laches is neglect for an unreasonable and unexplained length of time, under circumstances affording opportunity for diligence, to do what in law should have been done." Muir v. C.R. Bard, Inc., 336 S.C. 266, 296, 519 S.E.2d 583, 598 (Ct. App. 1999). "Under the doctrine of laches, if a party who knows his rights does not timely assert them, and by his delay, causes another party to incur expenses or otherwise detrimentally change his position, then equity steps in and refuses to enforce those rights." Id. at 296, 519 S.E.2d at 599. "The party asserting laches has the burden of showing negligence, the opportunity to act sooner, and material prejudice." Id. at 297, 519 S.E.2d at 599.

5. Based on the evidence as a whole, I find the Claimant has not met her burden of proving a compensable change of condition to her neck/back. Dr. Aymond disavows his questionnaire in his deposition, and when reading his deposition in full, he completely contradicts his questionnaire. Moreover, based on a complete review of the medical evidence, I do not find a physical change of condition has been proven under § 42-17-90 or the case law. However, the Claimant is still entitled to ongoing medical care for her neck and back under the original order of the case and should maintain treatment pursuant to that.

6. Based on the evidence as a whole, I find the Claimant has proven a change of condition for her psychological issues. The case of Estridge v. Joslyn Clark Controls, Inc., 352 S.C. 532, 482, S.E.2d 577 (Ct. App. 1997) stands for the proposition that if a workers' compensation claimant's mental condition is causally connected to original, compensable physical injury, and is newly manifested symptom of original injury which has caused worsening of condition, mental condition **can be considered in change of condition proceeding**. Clearly, based on the reports and the deposition of Dr. Rosen, Claimant has proven her change of condition for her psychological condition. The change of condition

became apparent by Dr. Rosen's May 16, 2008 report, which was Claimant's first visit to him.

7. Claimant is entitled to additional medical treatment with Dr. Rosen for her psychological condition.

8. Claimant is entitled to Temporary Total Disability benefits from May 16, 2008 to the present and continuing.

CONCLUSIONS OF LAW

Accordingly, as provided in §42-17-40, South Carolina Code of Laws, 1976, As Amended, it is the determination of this Commission as follows:

1. Under §42-1-130, the Claimant was a covered employee at the time in question.

2. Under §42-1-140, the Defendant/Employer was a covered Employer under the Act.

3. Under §42-1-140, average weekly wage is defined.

4. Under §42-17 -90, the Claimant suffered a compensable injury to her psyche as a result of an overlay of her original injuries to the neck and back on May 9, 2006 arising out of her employment with Charleston County School District.

5. Under §42-15-60, the Claimant is entitled to have ongoing medical care for her psyche to be provided by Dr. Samuel Rosen as the authorized physician.

ORDER AND AWARD

Based on the above findings of fact and conclusions of law, it is hereby,

ORDERED, ADJUDGED AND DECREED, the Claimant's psyche is a compensable injury and the Defendants are to provide Claimant with medical treatment for her psyche from Dr. Samuel Rosen;

ORDERED, ADJUDGED AND DECREED, Claimant's additional neck and back care be provided under the original order of the case as outlined by Commissioner Roche;

ORDERED, ADJUDGED AND DECREED, that Claimant is paid temporary total disability benefits from the date of her change of condition, May 16, 2008 and continuing until she reaches Maximum Medical Improvement (MMI) at the rate of $370.93;

ORDERED, ADJUDGED AND DECREED, that all other issues are held in abeyance;

AND IT IS SO ORDERED!!!

3

Within the statutory period, counsel for both Charleston County School District and the Claimant each filed a Form 30, Application for Review in the case setting forth the appeal grounds, copies of which were furnished to all interested parties, prior to oral argument presented before the Appellate Panel on May 23, 2012. All proffered testimony had been taken. Such, together with all documentary evidence, has been delivered by oral argument to the individual members or the Appellate Panel and has since been under study and consideration.

In its appeal, Charleston County School District respectfully submits the following:

1. Whether the Commissioner erred in Finding of Fact #4, specifically whether the Commissioner erred in finding that the statute of limitations had not run in this matter, that the claimant was compliant with Regulation 67-602 (C), and that the doctrine of Laches was inapplicable to the present claim?

2. Whether the Commissioner erred in Finding of Fact #6, specifically whether the Commissioner erred in failing to find that the claimant could have brought her psychological claim at the first hearing and thereby waived her rights to any arguments regarding a change of condition?

3. Whether the Commissioner erred in Finding of Fact #7, specifically whether the claimant is entitled to additional medical treatment with Dr. Samuel Rosen?

4. Whether the Commissioner erred in finding that the claimant is entitled to temporary total disability benefits from May 16, 2008 to the present and continuing under Finding of Fact #8?

5. Whether the Commissioner erred in Conclusion of Law #4 finding that the claimant has sustained a compensable injury to her psyche?

6. Whether the Commissioner erred in Conclusion of Law #5, finding that the claimant is entitled to ongoing medical care for her psyche?

7. Whether the Commissioner erred in the Order and Award, finding that the claimant's psyche is a compensable injury and that the Defendants are to provide the claimant with medical treatment to her psyche from Dr. Samuel Rosen?

8. Whether the Commissioner erred in finding that the claimant is to be paid temporary total benefits from May 16, 2008 and continuing?

In her appeal, Claimant respectfully submits the following:

1. Did the Commission err in Finding of Fact # 5 finding that the Claimant had not sustained a physical change of condition to the neck/back? The medical evidence supports that the physical condition of the claimant did in fact change regarding her back and conditions as a result of her neck surgery – namely, denervation, which has been the source of the claimant's constant and unending pain.

STANDARD OF REVIEW

When reviewing evidence in the award of the single commissioner, the Appellate Panel makes its own findings of fact and reaches its own conclusions of law either consistent or inconsistent with those of the single commissioner. S.C. Code Ann. § 42-17-50 (1985); *Lowe v. Am-Can Trans. Servs., Inc.*, 283 S.C. 534, 324 S.E.2d 87 (Ct. App. 1984). The final determination of witness credibility and the weight to be accorded evidence is reserved to the Appellate Panel. *Shealy v. Aiken County*, 341 S.C. 448, 535 S.E.2d 438 (2000). An award of benefits may not rest on surmise, conjecture, or speculation but, rather, must be founded on evidence of sufficient substance to afford it a reasonable basis. *Linen v. Ruscon Constr. Co.*, 286 S.C. 67, 332 S.E.2d 211 (1985).

EVIDENCE OF THE CASE

The Claimant in this matter was a data entry clerk for Charleston County School District. She was initially injured on May 6, 2009, when two students were fighting and pushed into her, pinning her against a counter and injuring her neck and back. She had an anterior cervical discectomy and fusion at the C6-7 level with Dr. Aymond. Dr. Aymond released her on July 20, 2007, with a 23% rating to the whole person and restrictions of lifting no more than 20 pounds and avoiding repetitive overhead activities. He later assigned a 5% rating for the low back. This matter went to a hearing on October 7, 2007, and the Claimant alleged permanent and total disability. On November 29, 2007, the Single Commissioner found that the Claimant was not

permanently and totally disabled but had a 45% disability to her back relative to her neck and low back. The "certified correct" Form 19 showing payment of this Order was filed on January 25, 2008. An amended Form 19, signed by the Claimant, was filed on May 7, 2008.

On January 7, 2009, the Claimant filed a Form 50 not requesting a hearing, but alleging a change of condition. Attached to this hearing request were two medical reports, one an injection report and the other indicating a visit with Dr. Rosen. On March 29, 2011, the Claimant filed another Form 50, this time requesting a hearing on the change of condition claim. She attached the same two reports as had been attached to the January 7, 2009 hearing request.

At the hearing on June 29, 2011, the Claimant testified that she was experiencing increased back pain since the initial hearing in this matter. She indicated that she was in so much pain that she did not want to get up in the morning. She said she did not go out with her friends anymore and that she felt helpless. She admitted that she was taking some medications for anxiety at the time of her first hearing but denied that the medications were related to her work injury and testified instead that they were related to the death of her husband, four years prior to the hearing in October of 2007, despite the report of her vocational expert. (Old APA 15, p.148-52). The Claimant also denied that she was particularly upset about her temporary total disability checks stopping, even though that was specifically laid out in the report of Dr. Rosen, her chosen physician. (APA 6, p. 77).

In response to a questionnaire from the Claimant's attorney on May 3, 2011, Dr. Rosen responded "yes" to questions about whether the Claimant had depression related to her chronic pain from her work injury. (APA 6, p.99-100). This letter did not address when the Claimant's depression, related to the work injury, started. In Dr. Rosen's deposition, he reviewed his May 2008 report as well as the vocational assessment of Bill Stewart from September of 2007, which

indicated that the Claimant had anxiety and depression and was getting medications and treatment for that problem and that it was related to the work injury. (Old APA 15, p.148-52). Dr. Rosen stated in his deposition that the Claimant's depression and anxiety from her work injury existed in September of 2007, prior to the first hearing in this matter. He was asked "is it your opinion that Ms. Wilson had anxiety and depression from her work injury and required medication and treatment at least by September of 2007?" Dr. Rosen answered "Yeah, that the work injury was causing some depression and anxiety by -- right." (Transcript of Dr. Rosen's deposition p. 17, line 22 – p.18, line 2). The Claimant did not allege psychological injuries or depression in the 2007 hearing, though she did allege that she was permanently and totally disabled as a result of her injury in combination with her pre-existing psychological problems. Dr. Rosen also testified that when he first saw the Claimant in May of 2008, she did not actually have endogenous depression, but that she did have endogenous depression at the time of his deposition, two and a half years after the statute of limitations had run on her change of condition claim. Dr. Rosen gave no testimony that the Claimant had endogenous depression within a year after the last date of payment of compensation.

A review of Dr. Rosen's medical records (APA 6) as well as his deposition testimony reveals that Dr. Rosen never ordered the Claimant out of work. In his initial report of May 16, 2008, he indicated that she had been unable to work due to back pain, but he did not indicate that she was not or should not be working relative to depression. (APA 6, p. 77-79). He did not mention work one way or the other in any of his subsequent medical records. In his deposition, Dr. Rosen testified "to my knowledge [the Claimant] was not able to work" in September of 2007, but he never testified that he wrote her out of work or intended to write her out of work for her psychological injuries. (Transcript of Dr. Rosen's deposition p. 7, lines 20-23).

A review of the record from the first hearing indicates that the Claimant did not raise a psychological claim at that time. However, her vocational expert, William Stewart did indicate that the Claimant had significant depression related to the work injury. (Old APA 15). Mr. Stewart's report dated September 6, 2007 states that "Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work." (Old APA 15, p.144). He also indicated that she required "medical psychological care. . .including follow up office visits and prescribed psychotropic medications for anxiety and depression." Id. Specifically, Mr. Stewart noted that the Claimant continued to require Lorazepam for depression. (Old APA 15, p.146). Mr. Stewart also noted that the Claimant scored a "7" on the Beck Anxiety Inventory and the fact that it was not worse was because of the medications she was taking. (Old APA 15, p.149). Finally, Mr. Stewart concluded that the Claimant was incapable of working due to a combination of chronic pain and psychological overlay "because of these injuries." (Old APA 15, p.150).

The medical records regarding the Claimant's physical injuries reveal that the Claimant initially treated with Doctor's Care, (APA 6), who referred her to Dr. Blake Dennis. (APA 9). Dr. Dennis ordered an MRI of the cervical spine and indicated that surgery might be an option for the Claimant, but that the Claimant was not interested in surgery. (APA 9, p. 84). Dr. Dennis eventually referred the Claimant to Dr. Alexander, who gave the Claimant injections in her neck. (APA 10).

The Claimant indicated that she was not improving in her treatment with Dr. Dennis and Dr. Alexander, so, per the request of the Claimant, she was sent for a second opinion to Dr. Stovall on November 13, 2006 who indicated that the Claimant had reached Maximum Medical

Improvement from a conservative treatment standpoint. (APA 3, p. 6). He indicated that surgery might be an option, but that the Claimant was not interested in surgery. (APA 3, p. 6). On November 16, 2006, Dr. Alexander agreed that the Claimant was at Maximum Medical Improvement from a conservative standpoint (APA 1, p.1) and, on November 17, 2006, he assigned the Claimant an 8% rating to the whole person relative to the cervical spine. (APA 1, p.2).

The Claimant then went on her own to Dr. James Aymond on January 16, 2007, complaining of continued neck pain and also alleging pain in her lumbar spine. (APA 12, 116). Dr. Aymond ordered a MRI for the Claimant's lumbar spine and recommended an anterior cervical discectomy and fusion at the C6-7 level. (APA 12, 117). He did perform this surgery and then sent the Claimant for physical therapy for both her neck and lower back. (APA 12). On July 20, 2007, Dr. Aymond opined that the Claimant was at Maximum Medical Improvement for her cervical spine and assigned her a 23% rating to the whole person relative to the cervical spine. (APA 12, 121). He gave her restrictions of lifting no more than 20 pounds and avoiding repetitive overhead activities. (APA 12, 121).

In his deposition on September 11, 2007, Dr. Aymond testified that he had not seen the Claimant since July 20, 2007 and that she had not contacted his office for another appointment. (Deposition of Dr. Aymond, p. 11, lines 6-12). Dr. Aymond believed that the Claimant's lower back symptoms were related to her work injury (Deposition of Dr. Aymond, p. 12), but he further indicated that the Claimant had reached Maximum Medical Improvement regarding her lower back and assigned her a 5% rating to the whole person relative to the lumbar spine. (Deposition of Dr. Aymond, p. 13). He indicated that she should not perform repetitive bending and twisting. (Deposition of Dr. Aymond, p. 13, lines 1-5).

The Claimant's first visit with Dr. Aymond after the October 7, 2007 hearing was on November 13, 2007. (APA 1, p.6). She complained of neck pain, and he prescribed Zanaflex and indicated that she would remain on the same restrictions. Id. On December 7, 2007, Dr. Aymond noted the Claimant's continued low back pain and noted that her "previous MRI. . .revealed very minimal changes." (APA 1, p. 7). In his deposition taken on June 21, 2011, Dr. Aymond testified that the MRI referenced was from January of 2007 and that he did not request a new MRI because she had "no neurological changes that [he] felt would be necessary to have a new or updated MRI scan." (Dr. Aymond's June 21, 2011 deposition transcript, p. 8).

Dr. Aymond saw the Claimant again on October 21, 2008, at which time he once again noted that she was having continuing "intermittent lower back discomfort," that "this [was] not a new problem for her," and that she remained "at maximum medical improvement and with the same previously noted impairment rating." (APA 1, p. 8).

On May 8, 2009 (more than a year after the last date of payment of compensation), the Claimant returned to Dr. Aymond with complaints of left shoulder pain and left upper extremity dysesthesias, so Dr. Aymond ordered an updated MRI, which was completed on May 11, 2009. (APA 1, p. 10-11). Dr. Aymond reviewed the MRI on May 18, 2009 and noted "no evidence of disc degeneration or caudal to the level of her surgery." (APA 1, p. 12). He then ordered an electrical study, which revealed "evidence of sensory neuropathy affecting the median and ulnar sensory nerves of the left upper extremity." In his deposition, Dr. Aymond stated that he not seen any evidence that would lead him to believe that the Claimant's arm issues would be related to her neck. (Dr. Aymond's June 21, 2011 deposition transcript, p. 13).

In response to a questionniare from the Claimant's attorney on May 3, 2011, Dr. Aymond responded "yes" to a question about whether the Claimant's low back injury had worsened, and

he also responded "yes" to a question about whether the Claimant's left arm pain and denervation was related to her neck, though there was no indication of when these things occurred. (APA 1, p.16-17).

During his deposition, Dr. Aymond was taken through his medical records regarding the Claimant, and then he indicated that he changed his opinion in reference to the lower back. He stated that though she may have complained more of pain in her lower back, she had "not sustained any different condition." (Dr. Aymond's June 21, 2011 deposition transcript, p. 16-17). As to the cervical spine, Dr. Aymond indicated that he could not provide any opinion as to whether the Claimant sustained any sort of physical change of condition to her neck since 2007. (Dr. Aymond's June 21, 2011 deposition transcript, p. 17). No other doctors have given any opinions in this matter as to whether or not the Claimant sustained a physical change of condition to her back or her neck in the year after the Form 19 was filed on January 24, 2008.

FINDINGS OF FACT

IT IS FOUND AS A FACT THAT:

1. That all parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act;

2. That the Claimant injured her low back and neck in an admitted accident on May 9, 2006;

3. That the Claimant was previously awarded 45% disability to her back in the Workers' Compensation Commission's Order dated November 29, 2007;

4. That Dr. Aymond initially completed a questionnaire indicating that the Claimant sustained a change of condition to her back, though he did not address when the change occurred;

5. That Dr. Aymond was taken through his medical records in this claim in his deposition;

6. That Dr. Aymond noted in his deposition that the Claimant had no neurological changes after her MRI dated January of 2007 that would warrant a new lumbar MRI;

7. That, in his deposition, Dr. Aymond reversed his prior opinion in the questionnaire regarding a change of condition to the lumbar spine and opined that there was no medical evidence that the Claimant had sustained a physical change of condition to her lumbar spine since her January of 2007 MRI, done before the first hearing in this matter;

8. That no doctor has opined that the Claimant sustained a physical change of condition to her lumbar spine between January 25, 2008 and January 25, 2009;

9. That the Claimant has not carried her burden of proving a change of condition to the lumbar spine;

10. That Dr. Aymond noted in his deposition that the Claimant's cervical MRI taken on May 18, 2009 showed "no evidence of disc degeneration or caudal to the level of her surgery" and that the subsequent electrical study revealed "evidence of sensory neuropathy affecting the median and ulnar sensory nerves of the left upper extremity;"

11. That, in his deposition, Dr. Aymond stated that he had not seen any evidence that would lead him to believe that the Claimant's arm issues would be related to her neck;

12. That, in his deposition, Dr. Aymond reversed his prior opinion in the questionnaire regarding the Claimant's condition to the cervical spine and indicated that he could not provide an opinion on her denervation and that he never provided any opinion regarding a change of condition to her cervical spine;

12

13. That no doctor has opined that the Claimant sustained a physical change of condition to her neck between January 25, 2008 and January 25, 2009;

14. That the Claimant has not carried her burden of proving a change of condition to the cervical spine;

15. That the Claimant was sent a check paying this Order, even if she did not deposit the check due to an appeal, and the Form 19 indicating this was filed with the Workers' Compensation Commission on January 25, 2008;

16. That the last date of payment of compensation to the Claimant in this matter was January 25, 2008 at the latest;

17. That the Claimant was required to bring a claim for a change of condition, if any, by January 25, 2009, and that any change of condition claimed must have occurred by January 25, 2009;

18. That the Claimant did not allege a psychological condition at the first hearing in this matter on October 2, 2007;

19. That the Claimant's vocational expert, William Stewart, indicated in his report in September of 2007 that the Claimant had anxiety and depression and was getting medications and treatment for that problem and that it was related to the work injury;

20. That Dr. Rosen opined on page 17 of his deposition that the Claimant's depression and anxiety from her work injury existed in September of 2007, prior to the first hearing in this matter;

21. That no doctor has opined that the Claimant did not have work related depression prior to the October 2, 2007 hearing;

13

22. That no doctor has opined that the Claimant's work related depression began after October 2, 2007 or worsened between January 25, 2008 and January 25, 2009;

23. That the Claimant has not carried her burden of proving a change of condition or a new injury to the psyche;

24. That the Claimant had pre-existing depression for her work related injury by September 2007 and could have raised the psyche as an issue at the October 2, 2007 hearing, but did not; and

25. That the Claimant is barred from bringing a claim for depression or psychological injuries at this time under the doctrine of res judicata.

CONCLUSIONS OF LAW

The following sections of the South Carolina Code of Laws give the appropriate definitions and provisions of the South Carolina Workers' Compensation Act as applicable to this case:

1. Section 42-1-160 of the South Carolina Code of Laws (1976, as amended) is applicable in defining "injury and personal injury;"

2. Section 42-17-90 of the South Carolina Code of Laws (1976, as amended) is applicable in determining whether a change of condition claim has been timely filed, as well as the time in which a change of condition must have occurred;

3. Allen v. Benson, 236 S.C. 22, 112 S.E.2d 722 (1960) is applicable in determining whether a change of condition claim has been timely filed as well as the time in which a change of condition must have occurred;

4. Owenby v. Owens Corning Fiberglass, 313 S.C. 181, 437 S.E. 2d 130 (S.C. App. 1993) and Krell v. South Carolina State Hwy. Dept., 237 S.C. 584, 118 S.E. 2d 322 (S.C.

14

1961) are applicable in determining what issues may and may not be raised in a change of condition claim under the doctrine of res judicata;

5. Robbins v. Walgreens and Broadspire Services, Inc., 375 S.C. 259, 652 S.E.2d 90 (Ct. App. 2007) is applicable in determining the Claimant's burden of proof in a change of condition claim, including the requirement of a physical change of condition;

6. Section 42-15-60 of the South Carolina Code of Laws (1976, as amended) is applicable in determining the period of time in which medical treatment and supplies shall be furnished;

7. Section 42-9-30 of the South Carolina Code of Laws (1976, as amended) is applicable in determining the amount of compensation and period of disability for certain injuries; and

8. Section 42-17-40 of the South Carolina Code of Laws (1976, as amended) is applicable in governing the conduct of hearings and rendering of awards.

ORDER

Based on the foregoing, the Single Commissioner's order is **AFFIRMED IN PART AND REVERSED IN PART.**

It is hereby:

ORDERED, ADJUDGED, AND DECREED that Single Commissioner's Order finding that the Claimant has not carried her burden of proving a change of condition to her neck or back is affirmed;

IT IS FURTHER ORDERED that the Single Commissioner's Order finding that the Claimant sustained a change of condition relative to her psychological issues is reversed;

IT IS FURTHER ORDERED that the Claimant could have brought a psychological claim at the October 7, 2007 hearing and did not; therefore her change of condition claim for psychological injuries is now barred under the doctrine of res judicata;

IT IS FURTHER ORDERED that the Employer/Self-Insured is not responsible for any medical treatment to the Claimant's psyche and only continues to be responsible for medical care to the neck and back under the Order of November 29, 2007;

IT IS FURTHER ORDERED the Claimant is not entitled to any further temporary total disability or permanent disability benefits since she has not proven a change of condition within one year of the last date of payment of compensation.

No hearing costs or penalties are assessed in this matter.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

By: _____

Commissioner Andrea C. Roche

CONCURRING:

_____

Commissioner T. Scott Beck

_____

Commissioner Melody L. James

CERTIFICATE OF SERVICE

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

This 18 day of July 2012

By Valerie D Keller

Administrative Assistant to the Commissioner

Leslie M Whitten

Tiffany R. Spann-Wilder

16

P.O. Box 1715 ■ 1612 Marion Street
Columbia, South Carolina 29202-1715

Carrier File # _____
Carrier Code # _____

Sara Y. Wilson _____ _____ Charleston County School District
Claimant's Name SSN Employer's Name

_____ Charleston, SC _____ 75 Calhoun Street Charleston, SC 29401
Address City State Zip Address City State Zip

_____ (843) _____ Charleston County School District c/o The Schaffer Companies
Home Phone # Work Phone # Insurance Carrier

Tiffany R. Spann-Wilder, Esquire (843)266-7792
Phone #

Complete each information blank. To request a hearing, check box 13. b., indicate the kinds of benefits claimed by checking the box(es) at lines 6, 7, and 8 and file this form in duplicate. A claim for workers' compensation benefits is made based on the following grounds:

1. a. The claimant sustained an accidental injury to the right arm, right shoulder, neck, back, right leg, left leg on May 9, 2006 *in* Charleston County, State of South Carolina.
1. b. Describe briefly how the accident occurred claimant was shoved forward into a counter by two (2)fighting students.
2. Both the employee and the employer were subject to the South Carolina Workers' Compensation Act at the time of the injury.
3. The relationship of employer and employee existed at the time of the injury.
4. At the time of the injury the employee was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on May 9,2006 in the following manner: verbally communicated to William Dixon, Principal
[x] 6. Due to injury, the claimant is in need of (check one):
[x](a) medical examination and treatment for all injuries listed above.
[x](b) additional medical examination and treatment for all injuries listed above.
[x] 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: To be determined.
[x] 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one)
[ ](1) General Disability: [ ] Total [ ](2) Specific Disability: [ ] Total
[ ] Partial [ ] Partial
Body part(s) affected are: To be determined.
[ ] 9. Due to the injury, the claimant has a serious body disfigurement consisting of _____.
10. a. At the time of the injury, the claimant was paid weekly wages of $ to be determined ; Form 20 Requested; and demands accounting of days worked and wages earned as provided by law.
10. b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident. Employer herein: to be determined.
11. a. Further grounds of claim: To provide all benefits under the Act-to include UTICA Language and Lump Sum Payment.
11. b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident: **Roper Hospital, 316 Calhoun Street, Charleston, SC 29401; Doctor's Care, 1851 Sam Rittenberg Blvd., Charleston, SC 29407; Dr. W. Pettigrew Clare, Sr., 114 Ashley Avenue, Charleston, SC 29401; Dr. R. Blake Dennis, 615 Wesley Drive, Suite 100, Charleston, SC 29407; Dr. J. Robert Alexander, 2145 Henry Tecklenburg Drive, Ste. 220, Charleston, SC 29414; Private Therapy Services, 815 Savannah Highway, Suite 101, Charleston, SC 29407.**
11. c. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe: _____.
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
[X] 13. a. **I am filing a claim. I am not requesting a hearing at this time.**
[ ] 13. b. **I am requesting a hearing.**

Tiffany R. Spann-Wilder August 9, 2006
Signature of Claimant/Representative Date

Refer to R. 67-205, R.67-206, R.67-207, and R.67-601 through R.67-615. Questions about the use of this form may be direct to the Commission's Judicial Department.

WCC Form # 50. Rev. Date 9/90 **Employee's Notice of Claim and/or Request for Hearing.**

South Carolina Workers' Compensation Commission
1612 Marion Street • P.O. Box 1715
Columbia, SC 29202-1715
(803) 737-5723
www.wcc.sc.gov

WCC File #: 0608517
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Sara Wilson SSN:
Address:
City: Charleston State: SC Zip:
Home Phone : Work Phone ( )

Employer's Name: Charleston County School District
Address: 171 Church Street, Ste. 140
City: Charleston State: SC Zip: 29401-3136
Insurance Carrier: Charleston County School District

Preparer's Name: Tiffany R. Spann-Wilder Law Firm: The Spann-Wilder Law Firm, LLC Preparer's Phone#: (843) 266-7792

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and File this form in duplicate.
A claim for Workers' compensation benefits is made on the following grounds: **Date of Injury or Illness: May 09, 2006**
■ **Injury** ☐ **Illness** ☐ **Repetitive Trauma**

1a. The claimant sustained an injury to Right Arm/Shoulder, Neck/Back, Right Leg, Left Leg, Psyche on May 09, 2006 in Charleston County, State of South Carolina.
1b. Body part(s) affected are: Psyche, Neck, Back, Both Shoulders/Arm & Both Legs
Briefly describe how the accident occurred: Shoved forward into a counter by 2 fighting students.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of the injury.
4. At the time of the injury the employee was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on May 09, 2006 in the following manner: verbally communicated to William Dixon (James Simmons Elementary), Principal
[x] 6. Due to injury, the claimant is in need of (check one):
[x](a) medical examination and treatment for all injuries listed above.
[x](b) additional medical examination and treatment for all injuries listed above.
[x] 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: To be determined.
[x] 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one)
[ ](1) General Disability: [ ] Total [ ](2) Specific Disability: [ ] Total
[ ](3) Wage Loss [ ] Partial [ ] Partial
[ ] 9. Due to the injury, the claimant has a serious body disfigurement consisting of
10. a. At the time of the injury, the claimant was paid weekly wages of $ to be determined ; Form 20 Requested; and demands accounting of days worked and wages earned as provided by law.
10. b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident. Employer herein; to be determined.
11. a. Further grounds or unusual aspects of claim: To provide all benefits under the Act-to include UTICA Language and Lump Sum Payment.
11. b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident:
Dr. Samuel Rosen, 198 Rutledge Avenue, Ste. 8 Charleston, SC 29403;
Dr. Andrew Geer, 2095 Henry Tecklenburg Dr. Charleston, SC 29407
Charleston Neuroscience Institute Imaging, 582 Long Point Road, Mt. Pleasant, SC 29464;
Doctor's Care West Ashley,1851 Sam Rittenberg Blvd., Charleston, SC 29407;
James Island Physical Therapy, 325 Folly Road, James Island, SC 29412;
Private Therapy Services, 815 Savannah Hwy., Ste. 101, Charleston, SC 29407;
Dr. J. Robert Alexander, 180 Wingo Way, Ste. 106, Mt. Pleasant, SC 29464;
Dr. James K. Aymond, 2093 Henry Tecklenburg Drive, Charleston, SC29414;
Dr. W. Pettigrew Clare, Sr., 114 Ashley Avenue, Charleston, SC 29401;
Dr. R. Blake Dennis, 615 Wesley Drive, Ste. 100, Charleston, SC 29407;
Dr. Don O. Stovall, 2880 Tricom Street, North Charleston, SC 29406.
11. c. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe: 45% impairment to spine (inclusive of back & neck)
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
[X] 13. a. **I am filing a claim. I am not requesting a hearing at this time.**
[ ] 13. b. **I am requesting a hearing. A $25 fee is required.**
14. **Estimated time needed for hearing: 30 minutes**

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

Preparer's Signature | Attorney Title | tiffany@spannwilderlawfirm.com Email | January 6, 2009 Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

WCC Form # 50
Revised 9/07

Employee's Notice of Claim and/or Request for Hearing

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
ww.wcc.sc.gov

WCC File #: 0608517
Carrier File #:
Carrier Code #:
Employer FEIN #:

Claimant's Name: Sara Y. Wilson SSN:
Address:
City: Charleston State: SC Zip:
Home Phone: Work Phone: (843) 805-6713

Employer's Name: Charleston County School District
Address: 75 Calhoun Street
City: Charleston State: SC Zip: 29401
Insurance Carrier: Corval Corporation

Preparer's Name: Tiffany R. Spann-Wilder, Esq. Law Firm: Spann-Wilder Law Firm Preparer's Phone #: (843) 266-7792

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.
A claim for workers' compensation benefits is made based on the following grounds: Date of Injury or Illness: 5/9/2006
[X]Injury [ ] Illness [ ] Repetitive Trauma

1a. The claimant sustained an injury to right arm, shoulder, neck/back, right/left leg, psyche on 05/09/2006 in Charleston county, state of South Carolina.
1b. Body part(s) affected are: right arm, shoulder, neck/back, right/left leg, psyche.

Briefly describe how the accident occurred. Two fighting students shoved claimant into a counter.

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.

3. The relationship of employer and employee existed at the time of injury.

4. At the time of the injury the claimant was performing services arising out of and in the course of employment.

5. Notice of the accidental injury was given to the Employer on 5/9/2006 in the following manner:
Oral to William Dixon

X 6. Due to injury, the claimant is in need of (check one):
x (a) medical examination and treatment for: all injuries listed above
x (b) additional medical examination and treatment for: all injuries listed above

x 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
To be determined

x 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
[ ](1) General Disability: [ ] Total [ ](2) Specific Disability: [ ] Total
[ ] (3) Wage Loss [ ] Partial [ ] Partial

9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of $To be determined; Form 20 requested, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Employer herein; All others to be determined

11a. Further grounds or unusual aspects of claim:
To provide all benefits under SCWCC Act to include payment in a lump sum & the inclusion of Utica-Mohawk Language

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident: Dr. Samuel Rosen, 2093 Henry Tecklenburg Dr., Charleston, SC; Dr. Andrew Geer, 2095 Henry Tecklenburg Dr., Charleston, SC; Charleston Neuroscience Institute Imaging, 582 Long Point Rd., Mt. Pleasant, SC 29464; Doctors Care, 1851 Sam Rittenberg Blvd, Charleston, SC; James Island Physical Therapy, 325 Folly Rd., James Island, SC 29412; Private Therapy Services, 815 Savannah Hwy, Ste. 101, Charleston, SC; Dr. J. Robert Alexander, 190 Wingo Way, Ste. 106, Mt. Pleasant, SC; Dr. James K. Aymond, 2093 Henry Tecklenburg Dr., Charleston, SC; Dr. W. Pettigrew Clare, Sr., 114 Ashley Ave., Charleston, SC; R. Blake Dennis, 615 Wesley Dr., Ste. 100, Charleston, SC ; Dr. Don O. Stovall, 2880 Tricom St., N. Charleston, SC; Carolina Neurological Clinic, 125 Doughty St., Ste. 460, Charleston, SC 29403.

11c. To the best of your knowledge, did you have any prior permanent disability? ___If yes, describe:

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

13a. **I am filing a claim. I am not requesting a hearing at this time.**

X 13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: 1.5 hours

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

Tiffany R. Spann-Wilder — Attorney — tiffany@spannwilderlawfirm.com — 03/29/2011
Preparer's Signature — Title — Email — Date

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-515. Questions about the use of this form may be directed to the Commission's Claims Department.

WCC Form # 50
Revised 9/07

50

Employee's Notice of Claim and/or Request for Hearing

INITIAL APPOINTMENT

SARA Y. WILSON

May 16, 2008

HISTORY: This is the first psychiatric contact for this 64-year old widowed female who was referred among others by her doctor, Dr. Oliverio. She has had persistent problems with chronic pain and associated anxiety and depression. She was doing generally well in all respects until May of 2006. She was working at her job (data technician at James Simmons Elementary School). Two "boys" were horse playing initially although the horse play got a bit out of hand. As they began to come closer to her vicinity, she tried to get out of the way, but "the next thing I knew I was screaming"; she was in fact knocked by these boys across a counter. The workup immediately following showed some blood in her urine and eventually hematoma. This resolved itself. Unfortunately, within a few days, she began experiencing increasing pain both in her back and neck. This led to an evaluation including a MRI and x-rays and referral to Dr. Dennis and orthopedic surgeon who did another MRI and found the she'd hernia a cervical disc. Attempts to manage the pain with physical therapy and other pain management technique (Dr. Alexander) were unsuccessful and in March of 2007 under the care of Dr. Aymond, she had a surgical fusion of her neck. Although this helped her neck pain to some degree, her low back pain persisted until today. In fact there is apparently a bulging disc but she had considerable daily pain. It is made worse by most types of activities. Sitting long periods of time, bending, lifting, etc. all create serious problem for her. She, therefore, cannot drive and certainly has been unable to work. Her hopes to go back to work two or three hours a day turned out to be impossible as they could not accommodate these hours and she finally had to go out on disability and workman's compensation. Unfortunately in December for reasons that are somewhat unknown, the checks stopped coming and in addition to her chronic pain and impairment in her lifestyle, she now has serious financial difficulties and stress. She is quite depressed and anxious about what the future (and present for that matter) holds for her. She had hoped that she could retire at age 65 and continue to teach or interact with kids on a part-time and/or volunteer basis. She finds herself very restricted in her social life.

She does have associated endogenous depressive symptoms mostly of decreased energy, concentration, interest in activities and social withdrawal. Her appetite is generally okay.

She's not been suicidal and certainly not a danger to anyone else.

She has had some anxiety problems in recent months and at times can be quite anxious and have palpitations, but no frank panic attacks or anxiety attacks.

Her past psychiatric history includes a depressive episode following the death of her husband in 2003. They had been happily married for 39-years. Her treating physician at the time put her in the hospital for a couple of days and started her on Prozac which either was helpful or time itself was helpful and she was returned to full function. She had an ~~eastinkable~~ episode that may have been anxiety related in 2005. The workup was negative and while in the office of Jervey she was

Type copy

tearful and upset. He placed her on Zoloft 100 mg eventually given. After a few months, this was tapered to 25 mg and as noted above by the time of the incident at the school, she was once again back to her normal self.

There's no history of alcohol or drug abuse. No history of other mood disorders. No history of other psychiatric disorder.

FAMILY AND SOCIAL HISTORY: She was born and raised in Charleston. She has a high school degree plus college courses. She has worked in data technician with the school district for many years retiring because of her disability in September of 2006.

Her father died at age 60 of a stroke, her mother died at age 82 of sepsis. The patient is the second of four children. She does have one brother with an alcohol problem. Otherwise her family history is negative for psychiatric illness or alcoholism.

PAST MEDICAL HISTORY: She is currently under the care of Dr. Oliverio. HER ALLERGIES INCLUDE CILLINS, SULFA. She is intolerant of Demerol unless she gets Phenergan with it or Aspirin. Her current medications include Librax about once a day, Lorazepam 1 mg usually just once a day (although she's approved to take up to three a day), Micardis 40 mg a day, Nexium 40 mg a day, Premarin 0.9 mg daily and Xanaflex 2 mg (usually about once a day). She has hypertension, hypercholesterolemia, irritable bowel and the pain as noted above. Surgeries are limited to hysterectomy, cholecystectomy and C-sections. She does not smoke.

MENTAL STATUS: She is alert, cooperative and pleasant. Sensorium is clear. She's well oriented. Her memory is intact for recent and long-term events. Speech is normal. Her affect is mildly to moderately depressed, perhaps mildly anxious at times. She is not suicidal. There is no psychosis. No thought disorder. Insight and judgment are generally intact.

IMPRESSION: 1. Adjustment disorder with mixed emotion. 2. Anxiety disorder NOS. 3. Depressive disorder NOS.

PLANS: It does not appear that she has a clear endogenous depression. Hopefully we will be able to manage without antidepressants at this point. I have suggested because of her tension and chronic pain that she consider switching to Valium (Rx 5 mg tablets #30 with two refills to one-half to one every four hours if needed for anxiety or pain), this would be in place of the Librax, Ativan and Xanaflex.

Should she have persistent bowel symptoms, perhaps a small dose of Bentyl would suffice. Hopefully Dr. Oliverio will agree with the current plans.

We will discuss counseling options over the next several weeks. I will plan to see her again in two weeks. She will call me if needed in the meantime.

Samuel H. Rosen, M.D.

SHR/ac

Cc: Robert R. Oliverio, Jr, M.D., Lowcountry Medical Associates, 615 Wesley Drive Suite 300 Charleston SC 29407

The Spann-Wilder Law Firm, LLC

Tiffany R. Spann-Wilder, Esquire
tiffany@spannwilderlawfirm.com

2131 Dorchester Road (29405)
Post Office Box 70488
North Charleston, SC 29415
(843) 266-7792 • (800) 866-3830
(843) 266-7797 (fax)

April 29, 2011

BY WAY OF FAX 843-402-1961 @ & US MAIL
Dr. Samuel Rosen
2095 Henry Tecklenburg Drive, Suite 303
Charleston, SC 29407

RE: **Claimant:** **Sara Y. Wilson**
Employer: **Charleston County School District**
WCC No..: **0608517 (Date of Injury: May 9, 2006)**

Dear Dr. Rosen:

Please be advised that I represent Ms. Sara Wilson as a result of her work related accident on May 9, 2006. On or about November 29, 2007 the S. C. Workers Compensation Commission issued an Order finding that Ms. Wilson suffered a work related injuries to her neck and back. After that time, we filed a petitions (Amended Form 50's) alleging that Ms. Wilson's physical and psychological condition changed for the worse over time. In that regard, it is my understanding that you have been treating Ms. Wilson for psychological issues relating to her chronic pain and depression since 2008. In that regard, I would ask that you respond to the following questions: (Please check "yes" or "no" and provide an explanation if necessary)

1. That I have been providing ~~psychological counseling~~ Psychiatric Care to Ms. Sara Wilson since May 2008.

Yes ____ No ____

If YES, please list Diagnoses: Adjustment Disorder, Anxiety Disorder, Depressive Disorder (NOS)

2. To my knowledge, Ms. Wilson's past psychological history includes a depressive episode in 2003 following the death of her husband in which she was hospitalized. She was prescribed medication and returned to full function psychologically.

Yes ____ No ____

Explanation, if necessary: ____

3. That based upon my treatment, ~~psychological~~ testing and review of her records, Ms. Wilson suffers from psychological issues of depression relating to her chronic pain issues stemming from her workers' compensation case.

Yes ____ No ____

Explanation, if necessary: ____

S. Wilson Brief 99

Sara Wilson - page 2
Questionnaire

4. That in my medical opinion, Ms. Wilson's chronic pain and depression for which I have treated him since 2008 is "most probably and to a reasonable degree of medical certainty" [greater than a 50% probability] related to her workers' compensation injuries (neck, back & arm) at Charleston County School District.

✓ Yes ____ No

Explanation, if necessary: _____

_____

5. That Ms. Wilson's current psychological condition is a change in condition from the anxiety and single episode depression of her husband's death.

✓ Yes ____ No

Explanation, if necessary: _____

6. That Ms. Wilson's condition has plateaued; however, she still requires Psych. intervention psychological maintenance in the form of periodic counseling sessions and medications in order to effectively treat her condition and maintain her level of functioning at maximum medical improvement.

✓ Yes ____ No

Explanation, if necessary: _____

_____

5/3/11
DATE

Dr. Samuel Rosen
Adult Psychiatry

Should you have any questions or require any further information in these regards, please do not hesitate to contact me. With kindest personal regards, I remain,

Yours very truly,
THE SPANN-WILDER LAW FIRM, LLC

Tiffany R. Spann-Wilder

S. Wilson Brief 100

98

BEFORE THE SOUTH CAROLINA

WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO. 0608517

SARA Y. WILSON,

Employee/Claimant,

-versus-

CHARLESTON COUNTY SCHOOL DISTRICT,

Employer,

-and-

CHARLESTON COUNTY SCHOOL DISTRICT,

Carrier/Defendants.

DEPOSITION OF:
SAMUEL H. ROSEN, M.D.



DATE: Friday, June 24, 2011

TIME: 10:20 a.m.

LOCATION: Offices of Samuel H. Rosen, M.D.
2093 Henry Tecklenburg Boulevard
Suite 303
Charleston, SC 29414

REPORTED BY: JENNIFER M. HUGGINS,
Certified Shorthand Reporter

JENNIFER M. HUGGINS
Independent Contractor working in association with
Milligan Court Reporting
Telephone: (843)971-5867 Fax: (843)971-6509
E-mail: Milliganscc@comcast.net

(The reading and signing of the deposition by the witness is waived.)

(SAMUEL H. ROSEN, M.D., having been first duly sworn, testified as follows:)

EXAMINATION

BY MS. WHITTEN:

Q. Dr. Rosen, my name is Leslie Whitten. I'm an attorney for Charleston County School District at Young, Clement, Rivers downtown. And I just have a few questions for you regarding Ms. Wilson. I really don't think we will be here terribly long. I'm sure you've had your deposition taken numerous times, so if you could just do the usual rigamarole of your background, I would appreciate it.

A. Okay. My bachelor's degree is from Emory University, a medical degree from the University of Alabama in Birmingham. I did a short phase as a neurology resident, and then I did a psychiatry residency and chief residency at Washington University in St. Louis. I was in private practice there for three to four years and have been in practice here in Charleston since 1983.

Q. Okay. And when did you first meet Sara

Wilson?

A. She was seen initially on May 16th, 2008.

Q. Okay. And what were her issues on that day? Why was she seeing you?

A. Well, she had been referred by her physician, Dr. Oliverio, who continues as her physician. She had chronic pain problems and depression, so she was referred to me for the evaluation of the depression itself.

Q. Okay. And I see on that day, in the second sentence, I think of your report, that you mentioned persistent problems with chronic pain, associated depression. Are you able to say exactly when that anxiety and depression started?

A. Well, she has -- she has had anxiety and depression off and on for years, including before for the injury. There was a work-related injury that exacerbated it, and it is for that that I was seeing her.

Q. Okay. And I have handed you Dr. Bill Stewart's report.

MS. WHITTEN: For the record, this is the old APA Submissions 15, starting at page 159.

Q. Have you had a chance to review that

report?

A. I have.

Q. Okay. And if that report is accurate, do you believe that Ms. Wilson's anxiety and depression existed at least in September 2007 as it related to the work injury?

A. Yes.

Q. Okay. And according to this report, was Ms. Wilson on medication for depression and anxiety in September?

A. She was.

Q. And according to this report, was she seeking treatment for depression in September of '07?

A. From Dr. Oliverio.

Q. And according to your note, what changed between September of 2007 and when she first saw you in May of '08?

A. Well, it would be my understanding from the history that she had been seen initially for these problems by Dr. Oliverio. He felt things were not going well and wanted some additional help in treating the anxiety and depression.

Q. Okay. Any outside factors that it appears to have caused her to come see you in May

of '08 as opposed to earlier?

A. Outside factors?

Q. You know, I will just show you what I'm talking about. It's about three-fourths of the way down under the history on the first page of your report. It says, unfortunately in December, for reasons that are somewhat unknown, the checks stopped coming, and in addition to her chronic pain impairment and her lifestyle, she now has serious financial difficulties and stress.

A. Right.

Q. Are you aware of anything, other than the financial issue, that had changed between September of '07 and May of 2008?

A. Not that I'm aware of. Her inability to work is somehow a separate issue beyond just the finances. I mean, she had worked all of her life, so not being able to work certainly also plays a role.

Q. And to your knowledge, was she unable or able to work in September of '07?

A. To my knowledge, she was not able to work.

Q. Okay. Now, on the second page of your report, and for the record, this is page 78 of the

current APA's, under plans, it says, she does not appear to have clear -- and I apologize for my pronunciation -- endogenous depression.

A. Endogenous.

Q. Endogenous, thank you. What does that mean?

A. Depression exists is a generic term. People can be depressed about situations. Of course, she was to some degree. Endogenous depression is characterized by a set of symptoms, including poor sleep, appetite, energy, concentration and other symptoms. And if they exist as a group and are persistent over a month's time, we assume that there's a biochemistry that is also active in the depression.

Q. Okay. So what does that mean for Ms. Wilson? What are you saying is the cause for her depression?

A. Well, you know, at that time with that comment, I was thinking that the major depression or endogenous depression was not a major contributor. Since that time, you know, it has changed. The opinion has changed.

Q. Okay. And I'm just going to refer you to the report that you completed for

Ms. Spann-Wilder.

MS. WHITTEN: And for the record, this is page 99 of the current APA's.

Q. You indicate in that report that Ms. Wilson is depressed from her work injury, but you don't say one way or the other about when the depression started from the work injury. Do you have an opinion on that?

A. Yes. It is my opinion, to a reasonable degree of medical certainty, that although she had had depression and anxiety in the past, the work injury either exacerbated or caused the new episode to begin.

Q. And given that you didn't see her until May of 2008, do you have an opinion, to a reasonable degree of medical certainty, of when between the work injury and when she saw you that all of this started as far as the depression part of it?

A. Well, psychiatry, you know, we don't have the same type of projective evidence that perhaps orthopedists have. So we rely, you know, primarily on the patient's history. So her history was, you know, continuing depression and anxiety then, and over the course of time, with continued

disability or continued financial problems or continued pain, the depression worsened and she did have the endogenous symptoms we talked about before.

Q. Okay. But I guess my question is -- okay. I think we already established this, but according to at least the report from Bill Stewart, did she have anxiety and depression from the work injury in September of '07?

A. Correct.

MS. WHITTEN: Okay. Actually, I think that's all I have, yeah.

EXAMINATION

BY MS. SPANN-WILDER:

Q. Dr. Rosen, good morning. I'm Tiffany Spann-Wilder, and I represent Sara Wilson in regards to this work injury. And I want to talk a little bit more about where psychiatry fits in versus treatment by medication for depression.

A. Well, in my approach to psychiatry, and I think more and more in the field, psychiatrists are the medication arm of treating psychological and psychiatric problems. So I think in response to your question, there's not a separation between the medication and psychiatric involvement. It is

part of our involvement.

Q. However, though, is it common for primary care physicians to provide medication for folks when there are minimal type symptoms that appear with depression?

A. Yes. And in fact, I would suspect that it would be easy to show that primary care physicians prescribe more antidepressants and mood medications than psychiatrists do just because of their volume of patients.

Q. And so in those regards, what changes or what things may happen that require someone to need more intervention, i.e., to sit and speak with a psychiatrist versus just being on medication?

A. Every primary care physician has a degree of comfort with the various problems that the patients have that they see. For example, a primary care physician might be very comfortable treating heart disease up to a very complex situation, and in others would feel very inadequate for that and would quickly refer patients with, you know, cardiac problems.

Likewise, in psychiatry, I think some primary care physicians feel quite competent to treat depression, anxiety or other psychiatric

problems pretty far into the first or second trial of antidepressants, for example. But when things are not going well or when it's beyond their comfortable level, that's where they refer to psychiatry.

Q. And based on the referral from Dr. Oliverio, is that your opinion that that treatment got to a place where he was no longer able to assist?

A. Yes.

Q. Okay. What are the current medications that you have prescribed for Ms. Wilson?

A. The medicine I'm primarily prescribing is the Cymbalta. Dr. Oliverio is continuing to prescribe, I believe, the Diazepam, which is a mild anxiety medication.

Q. At the point of Ms. Wilson first coming to see you, was she still on the Lorazepam?

A. Yes. On the Lorazepam?

Q. Yes.

A. It may be Diazepam. They're both Benzodiazepines, and I don't recollect which one. It wouldn't make much difference with what we're talking about.

Q. Okay. And that dosage, do you have

that?

A. Yeah. It is -- she was on Lorazepam 1 milligram she could take up to three times a day, and she was also on medicine, Librax, which has Librium in it, a Chlordiazepoxide, which is another Benzodiazepine.

Q. And the dosages that she was taking, are those considered a low dosage?

A. No. It is moderate.

Q. Moderate. What is the Cymbalta for now?

A. Cymbalta is an antidepressant, but it is used and certainly marketed as a help for pain and chronic pain.

Q. And so the prescription of the Cymbalta has a two-fold purpose for her?

A. That's correct.

Q. Has her dosage of Diazepam increased with Dr. Oliverio to your knowledge?

A. Well, she's now on Diazepam as opposed to Lorazepam, and the dose she's on now is 5 milligrams twice -- up to twice a day, which has not increased. I think that's the dose she's been on for a long time.

Q. When you talk about the endogenous

symptoms of depression, what are those that you have found in Ms. Wilson at this point?

A. Well, the last appointment was May 23rd, and according to my record, she was sleeping much more than normal. She had poor concentration, lack of interest and motivation, decreased socialization and decreased energy. Those would all be endogenous symptoms of depression.

Q. How often are you seeing her at this point?

A. About every -- well, it had been about every few weeks. There was a period of time from August 2010 until April of 2011 that I did not see her, and then I saw her in April, it looks like, and then May. And she was supposed to return in three or four weeks following the May 23rd appointment. So I don't know when her appointment is scheduled.

Q. Do you know why there was that break in treatment?

A. I suspect it may have to do with, you know, whether it was covered -- these visits would be covered or not.

Q. During that time, did you continue to refill medications, or was that reverted back to

Dr. Oliverio?

A. I think that would have been reverted back to Dr. Oliverio.

Q. Okay. And let's see. Just a second. In the questionnaire that you completed for me, I think it was question six, you indicated that her condition had plateaued, but that she continued to need psychological care?

A. Psychological? No, psychiatric.

Q. No. I'm sorry. And you corrected me and crossed those out. I'm sorry. At this point, do you foresee a termination of your services to her and just the maintenance with Dr. Oliverio?

A. Well, even at our last appointment, she wasn't doing well, and we talked about changing the medication. And given that this has been ongoing for months, it would be hard to make a prediction about when it might no longer be necessary.

Q. To the best of your ability and your medical opinion, you foresee ongoing treatment; is that fair?

A. Right. That's correct.

Q. And what wasn't working about the Cymbalta?

A. Well, I mean, if Cymbalta is an

antidepressant and she has pretty serious depression still ongoing, and the pain was still going, I would say it wasn't working.

Q. Have you changed the medication?

A. We talked about a change at her next appointment, if she wasn't doing better.

Q. And what would that go to?

A. Well, the medicine we were considering is Nortriptyline.

Q. And what would be the difference in that versus the Cymbalta?

A. Nortriptyline is a tricyclic antidepressant. It's been around for quite a long time. And in my opinion, I think it works as well or better than Cymbalta for treating depression and pain.

Q. And so it has that two-fold component as well?

A. Correct.

Q. Are these medications that will cause her to be -- or to sleep more and be lethargic?

A. Well, no, I would hope not.

Q. Okay. And I know you are a medical doctor. The conditions -- are you familiar at all with the medical conditions that she's been treated

for orthopaedically?

A. Familiar at all?

Q. In terms of -- not as a doctor, but just what her situation is?

A. I have some understanding, yes.

Q. Okay. And that she's undergone a cervical fusion --

A. Yes.

Q. -- in the past? And has some lumbar spine issues as well?

A. Yes.

Q. Are back problems and cervical issues common problems for pain?

A. Well, I would say yes, but certainly I think you-all have access to specialists.

MS. SPANN-WILDER: Yeah. All right. I don't think I have any other questions.

EXAMINATION

BY MS. WHITTEN:

Q. Okay. I just want to make one thing clear and then I think we're done, Dr. Rosen. I just want to understand, is it your opinion that Ms. Wilson had anxiety and depression from her work injury and required medication and treatment at least by September of 2007?

A. Yeah, that the work injury was causing some depression and anxiety by -- right.

Q. Okay. And then when she saw you in May of 2008, it wasn't endogenous, but it is now?

A. It wasn't -- right. It didn't appear to be endogenous then but that changed.

Q. Okay. And have all of your opinions today been to a reasonable degree of medical certainty?

A. Yes.

MS. WHITTEN: Okay. Thank you. That's all I have.

MS. SPANN-WILDER: Can we go off the record for a minute?

(A recess transpired.)

MS. SPANN-WILDER: I don't have any more questions.

(DFT. EXH. 1, Dr. Bill Stewart's Report, was marked for identification.)

(The deposition concluded at 10:42 a.m.)

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALTY CLINICS

September 20, 2007

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VOCATIONAL AND REHABILITATION EVALUATION

Sara Y. Wilson
[redacted]
Charleston, SC [redacted]

Charleston County

Date of Evaluation: 9/06/07
SSN:
DOB: [redacted]/43
Age: 63 years
Marital Status: Widow, one child age 36 years
Hand Dominance: Right

Telephone: [redacted]

Gender: Female Race: African American

REFERRAL

Ms. Sara Y. Wilson was referred for evaluation by attorney Tiffany Spann-Wilder, with Spann-Wilder Law Firm. The evaluation was requested to determine Ms. Wilson's vocational potential, ability to work/employability status and ability to earn/earnings capacity in light of her medical/orthopedic/surgical/psychological conditions. Ms. Wilson sustained significant work-related injuries to her neck/cervical spine, right arm, right side of her body, lower back and right leg, with chronic pain problems and psychological overlay (depression and anxiety), on 5/09/06 while employed as a data entry clerk with James Simons Elementary School in Charleston, SC, Charleston County School District in Charleston, SC. At the time of her injuries two male students were fighting, knocking Ms. Wilson into a marble top counter in the school's administrative/reception office.

Her diagnoses included herniated disc C6-7, marked degenerative disc disease C6-7 with bulging disc, cervical spondylosis C6-7, mild to moderate osteoarthritis of the facet joints L4-5 and L5-S1 levels, and chronic neck and right upper extremity pain with lower back pain (with aggravation of pre-existing lumbar scoliosis with muscular and buttocks pain).

DEPARTMENT OF NEUROPSYCHIATRY
AND BEHAVIORAL SCIENCE
3555 Harden Street Extension, Columbia, SC 29203
803-434-5250 FAX 434-4277

[redacted]

143

53

120

115

Appendix 118

And, based on clinical findings, review of medical/orthopedic/surgical records, and the results of testing during this evaluation it is felt that Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work.

After being injured, Ms. Wilson had to have surgery on her neck/cervical spine, anterior cervical diskectomy with osteophytectomy C6-7 level, anterior interbody fusion with tricortical iliac crest allograft, cervical plate fixation with DePuy Swift plating system/ interbody cervical fusion with plating and bone grafting C6-7 level on 3/28/07, performed by Dr. James K. Aymond, Orthopaedic Specialists of Charleston.

In addition, Ms. Wilson required medical pain management care, injection procedures in her neck/cervical spine, with Dr. J. Robert Alexander, Jr., Spine & Orthopaedic Specialists of South Carolina. Dr. Alexander also performed acupuncture in her right upper arm.

And, she has required, and continues to require medical psychological care with Dr. W. Pettigrew Clare, Sr., including follow-up office visits and prescribed psychotropic medications for anxiety and depression.

EVALUATION PROCEDURES

Clinical occupational and rehabilitation interview.
Behavioral observations.
Analysis of vocational or occupational factors, including age, education, training, and work experience in combination with the nature and degree of the medical/orthopedic/ surgical/psychological impairments, limitations, and restrictions.
Labor market access survey and analysis.
Ability to earn/earnings capacity assessment and analysis.
Vocational potential testing and assessment: Wide Range Achievement Test-Revised 4 (WRAT-R4), Penn Bi-Manual (Dexterity) Worksample, Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Life Situation Survey (LSS), Pain-Activity Scales/Drawings.
Review of orthopedic surgery records from Dr. James K. Aymond, Orthopaedic Specialists of Charleston.
Review of orthopedic records from Dr. R. Blake Dennis, Palmetto Orthopaedics of Charleston.
Review of orthopedic records from Dr. J. Robert Alexander, Spine & Orthopaedic Specialists of South Carolina.
Review of medical records from Dr. W. Pettigrew Clare, Sr.
Review of medical records from Doctors Care–West Ashley.
Review of medical/radiology/surgical records from Roper St. Francis Healthcare/Roper Hospital.
Review of medical/radiology records from East Cooper Regional Medical Center.
Review of radiology/MRI records from Charleston Neuroscience Institute Imaging.

Review of radiology/MRI records from Tri-County Radiology Associates.
Review of physical therapy records from Private Therapy Services.

STATEMENT OF UNDERSTANDING REGARDING CONFIDENTIALITY

Ms. Wilson was informed of her lack of confidentiality and privilege related to a workers' compensation matter. She stated she understood such, acknowledging she had been informed of that lack of confidentiality and privilege, at which point the evaluation began.

BACKGROUND INFORMATION

Ms. Wilson has a high school education, having finished in Charleston, SC in 1961. She attended Palmer College (now Trident Technical College – Palmer Campus) on a part-time basis for one year in about 1965-1966, studying basic office procedures, typing, filing etc. She attended the College of Charleston on a part-time basis for one semester in 1990, taking a course in college preparation/learning strategies and introduction to computers. She has not had any additional schooling or training, other than on the job orientations and experiences over the years.

Ms. Wilson's work history has consisted of her having worked as a data entry clerk with James Simons Elementary School in Charleston, SC, Charleston County School District 20 for almost twenty-one (21) years, from January 1986 until 5/09/06, the day she was injured in this work-related accident, then being retired on disability by her employer on 9/11/06 because of these work-related injuries and ongoing problems and limitations (having started out working as a substitute teacher, then working as a teachers aide with a kindergarten class, then as a resource aide in reading and math, then as a music class aide, then as a art class aide, then as a media center aide, then as a media clerk, then as a data entry clerk). In that job she earned approximately $13.80 per hour, and worked 40 hours a week, working 10-months a year (working extra hours during the other two months during the last four or five years of her employment with the School District, working a total of about 20 hours during those months). She performed a variety of job duties, including entering student data into a computer system, typing letters and correspondence, keeping attendance for the school, prepared reports concerning number of students in the school and average daily attendance (quarterly reports), entering discipline information into the computer system, preparing report cards (at one time), ordering school supplies and getting supplies to the teachers, requesting and sending out student records to and from other schools, calling parents and guardians when students were sick, checking in and giving out medications to students, attending and helping with the school improvement council meeting, etc. She had to file records and lift/move folders and files/records in file cabinets, etc.

Prior to this job, Ms. Wilson had worked as an office worker/cashier/customer service worker with a Sears department store for nine (9) years, from 1973 to 1982; as a directory assistance operator with Bell-South Telephone Company for six (6) years, from 1966 to 1972; and, as an office worker with the Federal Department of Commerce for one (1)

year (a job to prepare workers for the world of work). While she was still in high school she had worked as an office worker with a dentist.

Ms. Wilson's vocationally relevant work experience would be classified as ranging from sedentary to light (probably more in a light category because of lifting/moving/ distributing the school supplies and lifting/moving the student and school records/file boxes) from physical/exertional demand standpoints; and, as ranging from low semi-skilled to semi-skilled from skill level standpoints.

Because of these injuries and ongoing problems and limitations, Ms. Wilson has not been able to perform any kind of work or gainful employment since the day she was injured in this work-related accident. She described ongoing problems and limitations, and the reasons she has not been able to work, as including "my neck, can't sit, pain in my neck, typing I get stiff in my fingers and numb on me – can't stand very long, my legs hurt, hurts my lower back – pain, my neck, a hard pain."

Ms. Wilson continues to require prescribed medications for pain (Demerol), and for depression/anxiety (Lorazepam). In addition, she continues to use a prescribed Tens Unit, attaching a total of four electrodes on her neck and lower back. Side effects from her medications involve drowsiness.

Ms. Wilson has been released by Dr. Aymond, but still has her prescription for pain medicine filled by Dr. Aymond's office/nursing staff. The medication for depression/ anxiety, which she was on before this accident, is now being prescribed by Dr. Robert Oliverio (who replaced Dr. Clare when he retired (as her primary care physician) in December 2006).

She also continues to take over the counter medications for pain and stiffness (Extra Strength Tylenol). And, she uses a walking cane "for my leg (right leg), gives out on me." And, she continues to use a heating pad and ice pack for pain management purposes, placing them across her neck and lower back.

Ms. Wilson was in physical therapy in Charleston, SC, under orders from Dr. Dennis, before surgery for her neck, and Dr. Aymond, after her neck/cervical spine surgery and for her neck and lower back.

In an orthopedic surgery report dated 7/20/07, Dr. Aymond stated "...status post cervical fusion at the C6-7 level...continues to have some degree of lower back discomfort secondary to what was found to be mild to moderate osteoarthritis of the facet joints at L4-5 and L5-S1 level...remain on a lifting restriction of 20 lbs. or less and she should avoid repetitive overhead activities...rate her impairment to be 23% impairment of the whole person as it relates to her cervical disc altered motion segment integrity...have her notify us if she desires to proceed with facet injections performed in her lumbar spine..."

In a questionnaire dated 9/14/07, Dr. Aymond assigned a 5% whole person impairment for Ms. Wilson's lower back/lumbar spine. Dr. Aymond also indicated that Ms. Wilson will require possible facet injections, and assigned work restrictions of sitting for three hours, standing for two hours and walking for two hours.

When asked about her interests and future plans had she not been injured in this accident, Ms. Wilson stated "work until I was 65, 66 (years old), or past that."

Concerning her interests and future plans at this point in time, Ms. Wilson reported "no – I can't, hurting, can't walk, stand (that is, she can work on a reliable, sustained basis)."

Ms. Wilson's prior/past or other medical history had involved high cholesterol diagnosed in 2006, requiring a prescribed medication at this time; acid reflux since early 2000, requiring a prescribed medication at this time; anxiety since about 1992, following the death of her mother, getting better after that, and then getting worse again after the death of her husband, with depression, in 2003, requiring a prescribed medication at this time (Ativan); hypertension since about 1996, requiring a prescribed medication at this time; irritable bowel syndrome since about the 1990's, requiring a prescribed medication at this time; and, scoliosis of her mid spine, since birth. She had a benign lump removed from her left breast in 2005. She had surgery to remove her gallbladder in 2000. She had a partial hysterectomy in 1983 and another partial hysterectomy in 1989, requiring a prescribed hormone replacement medication at this time. She had a c-section in 1970.

ACTIVITIES OF DAILY LIVING

Ms. Wilson lives alone in her own home, which is located on a small lot. She was provided transportation to the evaluation by a friend. She does not drive, and has never had a driver's license.

Ms. Wilson's current daily activities involve her being at home mostly, doing some very light straightening up and cooking, washing/drying a few clothes, going to the grocery store with a friend, going to church on Sunday and occasionally during the week, listening to the radio and watching some television. She sends and receives e-mails from her daughter, who lives in Virginia. She has had to give up many activities because of these injuries, including regular housecleaning, vacuuming, taking down, cleaning/ washing and re-hanging curtains, bending over to get things from low cabinets, walking for exercise, and dancing with friends at private parties.

CURRENT INCOME/FINANCIAL STATUS

Ms. Wilson's income includes her workers' compensation benefits. She is also receiving disability retirement from her job. And, she is receiving her Social Security retirement benefits.

TOBACCO/ALCOHOL/DRUG USE
Ms. Wilson does not smoke. She does not drink alcohol. Nor does she use any kind of illicit/nonprescription drugs.

BEHAVIORAL OBSERVATIONS
Ms. Wilson is a rather small person, 4' 10" tall and 114 pounds. She was appropriately dressed and groomed.

She was oriented as to time, place, person and situation, but demonstrated concentration and attention span limitations because of her chronic pain problems and related problems/ limitations.

She was cooperative, but exhibited a rather flat affect and depressed mood during the evaluation. And, she appeared quite stressed and anxious because of her chronic pain problems, inability to work, and inability to be more productive.

She appeared uncomfortable, shifting/adjusting her weight in the chair she was sitting in, and changing positions from sitting to standing and moving about the room several times during the evaluation. She made slow, stiff, careful movements when changing positions from sitting to standing and starting to walk.

Overall, Ms. Wilson presented as a person who suffers from significant work stamina or endurance limitations.

Ms. Wilson is considered to be a motivated person with an **outstanding** work record and a strong work ethic, who wants to work and who would rather be working but was equally frustrated by her inability to do so. She was matter of fact and straightforward in describing her conditions, and did not tend to exaggerate or overstate her disabilities or situation. That is, her descriptions and allegations of her injuries and ongoing problems and limitations were consistent with the medical/orthopedic/surgical/medical psychological records.

TEST RESULTS AND INTERPRETATIONS
Wide Range Achievement Test-Revised 4 (WRAT-R4): On the WRAT-R4, Ms. Wilson had a reading score at the 11.6 grade level (30th percentile), and an arithmetic score at the 12.4 grade level (61st percentile). Her reading score is in the limited range of educational ability.

Penn Bi-Manual Dexterity Worksample: On the Penn Bi-Manual Dexterity Worksample, Ms. Wilson had an assembly time/score of 11' 27", a disassembly time/score of 10' 20", and a total time/score of 21' 47". All of these times/scores are below the 2nd percentile, reflective of slow work speed and pace and descriptive of a worker with no ability to successfully compete for, perform, and sustain sedentary and light jobs that require a fast paced/production rate work speed.

Beck Depression Inventory-II (BDI-II): Ms. Wilson had a total raw score of eight (8) on the BDI-II. This score is suggestive of a minimal level of depression. Item analysis revealed problems associated with loss of pleasure/getting very little pleasure from the things she used to enjoy, loss of energy, change in sleeping pattern, change in appetite, concentration difficulty, tiredness or fatigue, and loss of interest in sex.

Beck Anxiety Inventory (BAI): On the BAI, Ms. Wilson had a total raw score of seven (7). This score is suggestive of a minimal-mild level of anxiety. Symptoms/problems identified included numbness or tingling, feeling hot, wobbliness in legs, heart pounding or racing, unsteady, and nervous.

Life Situation Survey (LSS): Ms. Wilson had a total raw score of one hundred one (101) on the LSS. This score is suggestive of an overall relatively good quality of life. In response to a question concerning 'What would it take to make your life better?', she reported "finances, able to see my daughter and grandson more, pain free and continue to have faith that everything will get better. Continue to do my job. I would still be working if I was not injured. I enjoyed doing my job. I had to retire and was not able to enjoy the pleasures of retirement."

Overall, Ms. Wilson's scores on the BDI-II, BAI and LSS are reflective of a person who appears to be coping with her situation; however, this most probably relates, at least in part, to the prescribed medication she is on for depression/anxiety, and that medication should be continued. It is also felt that her strong religious faith and support of family and friends plays a significant part in her ability to cope/deal with her situation and disabilities.

Pain-Activity Scales/Drawings: Ms. Wilson identified aching pains in the back of her neck and in the back of both shoulders, numbness and cramping in her right arm and hand, a pressure feeling in her left hand, aching pains in her lower back and stiffness in her right leg/knee. She indicated that her worst symptoms/problems are in her neck, lower back and right arm. And, that she experiences significant increases in symptoms/problems with sitting, walking, reaching, in holding a telephone to talk, and in doing light straightening up/cleaning and washing/drying even a few clothes.

SUMMARY, IMPRESSIONS AND CONCLUSIONS

An individual's vocational potential, ability to work/employability status and ability to earn/earning capacity is largely determined by their age, education/functional educational abilities, training, work experience, job skills, transferability of job skills, general health, physical capacities, cognitive functioning, emotional stability, stamina/endurance, interpersonal relationships, motivation to work, attitudes of employers toward persons with a disability, nature of the labor force, and wage rates in a geographical area. The following is an analysis of Ms. Wilson's vocational potential, ability to work/employability status and ability to earn/earning capacity before and after these work-related injuries and her having to stop work completely.

Before she was injured in this accident, Ms. Wilson was an excellent employment prospect; and, in fact, had been in the same job with the same employer for almost twenty-one (21) years, and in other jobs for sixteen (16) years before that.

Based on Ms. Wilson's evaluation it is concluded that she is an individual who has sustained significant work-related injuries to her neck/cervical spine, right arm, right side of her body, lower back and right leg, with chronic pain problems and psychological overlay (depression and anxiety), on 5/09/06 while employed as a data entry clerk with James Simons Elementary School in Charleston, SC, Charleston County School District in Charleston, SC. At the time of her injuries two male students were fighting, knocking Ms. Wilson into a marble top counter in the school's administrative/reception office.

Her diagnoses included herniated disc C6-7, marked degenerative disc disease C6-7 with bulging disc, cervical spondylosis C6-7, mild to moderate osteoarthritis of the facet joints L4-5 and L5-S1 levels, and chronic neck and right upper extremity pain with lower back pain (with aggravation of pre-existing lumbar scoliosis with muscular and buttocks pain).

And, based on clinical findings, review of medical/orthopedic/surgical records, and the results of testing during this evaluation it is felt that Ms. Wilson is suffering some psychological overlay (adjustment disorder with depression and anxiety) because of these injuries, her ongoing chronic pain problems, and her inability to work.

After being injured, Ms. Wilson had to have surgery on her neck/cervical spine, anterior cervical diskectomy with osteophytectomy C6-7 level, anterior interbody fusion with tricortical iliac crest allograft, cervical plate fixation with DePuy Swift plating system/ interbody cervical fusion with plating and bone grafting C6-7 level on 3/28/07, performed by Dr. James K. Aymond, Orthopaedic Specialists of Charleston.

In addition, Ms. Wilson required medical pain management care, injection procedures in her neck/cervical spine, with Dr. J. Robert Alexander, Jr., Spine & Orthopaedic Specialists of South Carolina. Dr. Alexander also performed acupuncture in her right upper arm.

And, she has required, and continues to require medical psychological care with Dr. W. Pettigrew Clare, Sr., including follow-up office visits and prescribed psychotropic medications for anxiety and depression.

And, she continues to suffer ongoing problems and limitations including chronic pain problems with increase in pain with activity, depression, anxiety and work stamina or endurance limitations that will prevent her from being able to return to the kind of work she had performed in the past. This vocational opinion is consistent with Dr. Aymond's orthopedic records, and assigned work restrictions. That is, with the nature and degree of the medical/orthopedic/surgical/psychological impairments as compared with the physical/exertional demands of the work.

It is also concluded that Ms. Wilson has not been job ready or placeable since the day she was injured on 5/09/06, and that she remains unable to work because of these injuries and ongoing problems and limitations, and in need of continued medical pain management care, continued medical psychological care as she is currently receiving, and medical case management services to help coordinated her care/needs.

It is also my opinion that, without significant improvement in her overall condition or conditions (which is not likely considering the medical/orthopedic records), Ms. Wilson's prognosis for successful vocational rehabilitation to some kind of lighter, alternative work or job is quite poor; that is, most likely she will remain unable to work and vocationally disabled because of these injuries and ongoing problems and limitations. All vocational/occupational factors relating to Ms. Wilson (including her advanced age, poor dexterous abilities for performing sedentary and light jobs that require a fast pace, work experience and the fact she has been out of work completely for almost one and one half years) were considered in this opinion. In addition, all medical/orthopedic/surgical/ psychological factors (including her need for the continued medical pain management care, need for continued medical psychological care, chronic pain problems with need for prescribed medication, depression and anxiety with need for prescribed medication, work stamina or endurance limitations, permanently assigned work restrictions limiting her to nothing more than reduced/modified sedentary/light activity and inability to return to the kind of work she had performed in the past) were also analyzed in reaching this conclusion.

Additionally, while Ms. Wilson possesses certain educational abilities, her significant physical impairments and limitations including chronic pain with increase in pain with activity prohibit her from productively using them from a vocational standpoint. That is, her significant physical symptoms, which have been attributed to these injuries, prevent her from maintaining adequate concentration, pace and persistence, meeting normal/ expected levels of productivity/work output and maintaining a sufficient energy level (i.e., to regularly go to work), which are all necessary to sustaining employment, particularly at sedentary to light levels of work.

And, because of the length of time she has been disabled and the fact she will likely continue to have her current level of symptoms (with periodic exacerbations), it is unlikely her vocational prognosis will change. Consequently I do not believe a reasonably stable market exists for the types of services that Ms. Wilson is physically, psychologically, educationally or vocationally capable of performing/sustaining.

In addition, it should be noted that Ms. Wilson's labor market access/base, or the number of jobs she can be expected to successfully compete for, secure, perform and sustain, has also been significantly damaged and reduced because of these injuries and ongoing problems and limitations.

It is also concluded that Ms. Wilson's overall quality of life, or her ability to provide home maintenance services and to participate in personal, social, and family pursuits and activities (having had to give up the activities/involvements described/discussed above), has been damaged because of these injuries and ongoing problems and limitations.

Recommendations for Ms. Wilson include the continued medical pain management care, the continued medical psychological care, continued prescribed medications for pain and depression/anxiety, and the medical case management services.

As discussed with Ms. Wilson, please let me know if I can provide any additional information or be of further assistance from vocational or rehabilitation standpoints. Also, I would be willing to answer any questions relating to this difficult situation from a vocational rehabilitation standpoint.

William W. Stewart

Dr. William W. Stewart, CRC, CVE, LPC
Associate Professor of Rehabilitation Counseling
Certified Rehabilitation Counselor
Certified Vocational Evaluator
Licensed Professional Counselor

STATE OF SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
CASE NUMBER - 0608517

SARA Y. WILSON, CLAIMANT, VS. CHARLESTON COUNTY SCHOOL DISTRICT, EMPLOYER, CHARLESTON COUNTY SCHOOL DISTRICT, CARRIER, DEFENDANTS.	)	HEARING BEFORE COMMISSIONER WILLIAMS

COPY

WORKERS' COMPENSATION COMMISSION HEARING TAKEN BEFORE NADINE A. GARRETT, A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 10:37 AM ON JUNE 29, 2011, AT NORTH CHARLESTON CITY HALL, 2500 CITY HALL LANE, CHARLESTON, SOUTH CAROLINA.

NADINE A. GARRETT
COURT REPORTER
POST OFFICE BOX 1205
IRMO, SOUTH CAROLINA 29063
803-834-3410

THE COURT: Today's date is June 29, 2011. This is the Workers' Compensation Case of Ms. Sara Wilson versus Charleston County School District. They are self insured. WCC File No. 0608517. The date of accident, the original accident was May 9, 2006.

Attorney Tiffany Spann-Wilder for the Claimant. Attorney Leslie Whitten for the Employer and Carrier.

The hearing is set on the Forms 50 and 51. The average weekly wage is $502.87 with a corresponding comp rate of $235.26.

I have APA submissions from the parties and the deposition of Dr. Rosen and Dr. Aymond. Any objection to jurisdiction, venue or the APA submissions? Ms. Spann-Wilder?

MS. SPANN-WILDER: No, sir.

THE COURT: Ms. Whitten?

MS. WHITTEN: Commissioner, I do have an objection to jurisdiction under Regulation 67-602 in that there was no report attached to the Form 50 indicating a change of condition.

THE COURT: All right. That being stated, the Commission File is part of the record with the exception of any self-serving declarations or any unstipulated medical reports.

We have had a prehearing conference previously

and I know the issues in this case. However, I am going to let the parties state their position just so the record is clear. Ms. Spann-Wilder.

MS. SPANN-WILDER: Thank you, Commissioner. Commissioner, as to the - I will start with the jurisdictional objection. Regulation 67-602 requires just that the documents be filed within - documents were submitted at both times of the initial filing and the hearing request. It's our position that, if there was anything wrong with that submission, that the Commission certainly would have addressed it. And at that point, even in the initial filing, we were not at the door of our statute of limitations. And if that even had to be supplemented to the Commission, it was still a proper filing.

And those documents that were submitted, one was the initial appointment with Dr. Rosen on May 16, 2008 to support the change of condition for the psyche. The other was a pain management discharge from Dr. Geier for the injections, which the situation for the lumbar spine. I can tell you where those are in the APAs for Dr. Rosen. That document would be probably pages 24 and 25. And then Dr. Geier - and I've got the 50 here as well.

But it's just our position that the technicality

of it is just that a document be attached, that the Commission itself - the judicial department can't determine the strength of the document. That's for a hearing officer to do.

THE COURT: Okay.

MS. SPANN-WILDER: Commissioner, it is our position - first of all, the initial hearing gave Ms. Wilson ongoing care for her back and her neck. We have had some issues in that she has had some treatment and then it's been stopped right now. So, part of this too is the enforcement of that order. Lumbar spine injections have stopped. She received two or three and has been asking ever sine for them and can't get them because her health insurance won't pay for it because it's under comp. She was referred to Dr. Geier, the pain management specialist, from Dr. Aymond, who was the initial treating physician.

So, our issues today are her psyche, which our thing is that - her testimony will support that she has had some situational depression situations due to grief. She has never been in counseling for any of her anxiety, although her primary care physicians prescribed her medication. It was not until after this injury, after the initial hearing that her pain increased to where she could not get any resolution of

her issues and ended up in psychiatric care. That is where we come forth with filing the change of condition for the psyche.

You will see from her treatment notes, even her testimony to Ms. Whitten at that hearing that her neck was a whole lot better. Her records from Dr. Aymond support that her back issues were - she was feeling better. July of '07 is when she reached MMI and Dr. Aymond at that point - and it's the first time in the record, Commissioner, where it's even noted that injections would be considered a consideration. So, she went for months, from July until December of 2007 before she even presented again with any issues for her back that had to be addressed at that point in time. But if you look at Dr. Aymond's records, there is no mention of injections until July 2007 when she's rated for the neck and released. Subsequently in September of '07 she was rated for the back.

As to the psyche, in our prehearing Ms. Whitten stated that the psychiatric condition was there and that we were barred by Krell. However, it was not - it was just anxiety that we were addressing then. We were not addressing - when we asked for Ellison to be looked at on the whole at that hearing, we were not putting anything toward any pain issues that she had.

We were just saying here's a woman who has some situational anxiety and some other medical issues. Look at her as a whole. We were not putting it to the injury itself. It is not until after that she has experiencing pain at an enormous level, that she can't get a grasp of it.

And as to the psyche being endogenous, Dr. Rosen tells us in his deposition those items - those statements that make a condition endogenous are definitely clinical, not just situational, as she had dealt with all before. He testifies that May 16, 2008 when she appeared, it was more an adjustment disorder and a depressive disorder, so it wasn't endogenous then. However, Commissioner, if you look at Plaintiff's APA submissions, pages 81, 82, in that area where she visits with him, the first couple of visits, some things he notes, the things that make it endogenous, sleeping, appetite, mood, concentration, sociability, those things were normal at that point. It was still very situational. However, by July of 2008 and September of 2008 and definitely December of 2008, all still well within the one year change of condition, you see those things switch from normal to abnormal and fall into that endogenous pattern. So, if it's the Defenses' position that when she presented

on May 16, '08 that it wasn't endogenous as the doctor even stated, that's fine because by December, clearly by December '08 it was endogenous. And it is well within that filing period that we had in her change of condition.

THE COURT: Okay.

MS. SPANN-WILDER: And there were some other things that the Defense did plead that I want to address. There was an argument about the statute of limitations and Latches. Filing of the Form 50 tolls the statute of limitation. It does not require that the actual trial be had. Allen versus Benson Outdoor, which Ms. Whitten presented when we appeared before you earlier, addresses that. And it just says that the matter has to be filed within the one year of the last payment of compensation. And it's given a liberal construction as is the comp section is given that liberal construction. And it did not require an actual hearing.

There was another case that she was presented, the Richey case, which I think this is far off from there. Richey was an 11 year delay. We are nowhere near that in this matter. The file was destroyed at that point. There was no history around. The Commissioner wasn't around. There was nothing there.

And that is certainly not the case here.

Commissioner, it's our position that Ms. Wilson is not at MMI. Dr. Rosen said he cannot determine when she - he doesn't foresee her - an end of her treatment at this point. That's as to the psyche. The lumbar spine, she is still in need of injections. It's been over a year now since she's had an injection because the Carrier refuses to now pay for them after starting this session of them. Then she has issues still within the neck. Dr. Aymond's deposition addresses some of that. He could not pinpoint the neck problem that started to come in. He sent her to Dr. Ernst because the problem has gone into her arms. He is the hand specialist. He couldn't find it. They ordered an EMG.

And we know that there may be a technicality here, but by the time they got the EMG, which is on page - bear with my eyes, Commissioner. It is APA 5. The EMG was done May 19 and she saw Dr. Jervey as a part of this, trying to figure out what was going on with the neck. And it was diagnosed that she has denervation issues. I know that finding came - that the actual "this is what is wrong with her" came within a week of her year running. However, it's our position that as a result of that initial order

where she was entitled to care for her neck and her back, that it needs to be ordered that Dr. Jervey becomes the authorized treating physician for the ongoing problems with the neck. He has found that there has been a denervation as a result of the cervical fusion. Dr. Aymond says, "I am deferring to him in that regard because that's his area." Her treatment is at the point where everything that he has tried is not really helping and her next step is really to see a neurosurgeon.

THE COURT: All right. Ms. Whitten.

MS. WHITTEN: Thank you, Commissioner. First, just as to the jurisdiction issue, the statute of course is 42-17-90 and indicates that the Claim must be heard within a year. Regulation 67-602, which I wanted to read, says in Section C, "Any claim involving a change of condition the moving party must attach to the hearing request form a medical report indicating a change in the Claimant's condition." So, our argument as to jurisdiction is that neither of those reports actually indicated a change of condition. There was an injection. There was a report where she went to a psychiatrist saying that she had ongoing anxiety and depression. And the only change Dr. Rosen supports is in his deposition is that

her *** had stopped. That was the only change from prior to the hearing.

As to the Latches argument, under the Richey case the factors are the negligence of the other party, the party's opportunity to act sooner. And as a result, the asserting party suffered a material prejudice. The reason we think Latches applies here, obviously it hasn't been 11 years. I don't think that's a standard. But we didn't get any reports until May of this year indicating a change of condition. The change of condition had to happen between January of '08 and January of '09. There is no indication in those records that it happened in that time. The doctors do not say that it had happened, that there is a change that happened in that time. And it's prejudicial at this point to try to get the doctors to assume it happened within that year, two years later.

As far as the statute of limitations, again this is addressed in my - in the memorandum that I handed up. The Allen case says - all the Allen case says is that it's not - we are not going to punish the Claimant if the Commission cannot hear the matter within a year. But certainly the Commission has to request a hearing within a year. And my position would be that even though a Form 50 was filed, the

hearing was not requested within a year. And that is required under the Allen case and under the statute.

As far as the change of condition claim, there is no doctor whatsoever indicating that there is a change of condition to the neck. I don't think that that's been claimed. As far as the low back, we have Dr. Aymond, who in his deposition he pretty clearly says there has not been a change of condition. As far as Dr. Rosen, we have - as far as a psychiatrist, he is very clear in his deposition that her anxiety and depression from the work injury started at least a few months before the first hearing in this matter. There is no requirement under the statute or in any of the cases that it be endogenous depression. It just has to be psychological depression that would require treatment or medication or something like that. She was getting the treatment and medication for anxiety and depression related to the work injury prior to the first hearing in this matter. Under Krell, she had the opportunity to bring it at that time. She did not do it. It's too late to do that now. I believe that's it.

THE COURT: Swear Ms. Wilson in, please.

SARA WILSON,

having been first duly sworn, testified as follows:

THE COURT: Ms. Spann-Wilder.

MS. SPANN-WILDER: Thank you, Commissioner. Commissioner, I'm just going to just do a little bit of background.

THE COURT: Obviously you all don't have to take me all the way back. We can get to the issue at hand. But, yeah, certainly go ahead.

DIRECT EXAMINATION

BY MS. SPANN-WILDER:

Q Ms. Wilson, please state your full name and age for the record.

A Sara Young Wilson.

MS. SPANN-WILDER: Would you like her to direct to you?

THE COURT: No, she's fine.

BY MS. SPANN-WILDER:

Q Your marital status?

A Widow.

Q Do you have any children?

A One daughter, one grandson.

Q When did you first begin working for Charleston County?

A 1985-'86 school year.

Q Are you still employed there?

A No, I'm not.

Q When did that employment end?
A That employment ended August of 2006.
Q Would you just briefly describe for the Commissioner how you were injured?
A I was in - I had two offices. One was my office as a data tech and the other one was the main office where the secretary and principal was. I went over there as usual about 11:55 to collect some attendance cards and to go to lunch. There were two students in there and they were hitting back and forth. One was on the outside. One was on the inside. And as they moved to the inside, I saw something was happening so I tried to get out of the way. The next thing I knew, I heard my voice and I was sprawled on the counter. So, I was blindsided.
Q So, these students were fighting?
A Right. They were fighting back and forth. I couldn't get out of the way in time.
Q Okay. Ms. Wilson, in October of '07 you had a hearing on this claim and was awarded 45 percent to your spine, for your neck and your back; is that correct?
A That's correct.
Q And you ultimately received the money associated with that award, correct?
A Yes, I did.

Q And when did you receive that?
A In May of '08.
Q Okay. Before that hearing in 2007, when was the last time you had seen Dr. Aymond prior to that October hearing?
A I believe it was like July of '07.
Q At the time of your hearing, were you satisfied with what Dr. Aymond had done, your neck surgery? Were you feeling better?
A Technically I was. I was feeling better than I did before the surgery. I knew there was a difference.
Q You had some problems?
A Right. But there was a difference.
Q You were better than you had been initially with the injury; is that correct?
A Right.
Q When was the next time you saw Dr. Aymond after that July '07 visit?
A I believe - and I may have my dates wrong, but I believe it was in November of '07.
Q Okay. And what did you go see him about then?
A My neck and it could be - it may have been my neck because I saw him twice. I saw him in November and then I saw him in December also.
Q Okay.

A I saw him for my neck and my back.
Q And what was happening with your neck and your back at that time?
A My neck, I started to have some pain. It felt like little stickpins tingling in the neck. And I went - I called. And he told me, you know, if I had any problems, to call him. I called. They told me to come in. He did an x-ray. And it was related to the work injury. Then I went back in December because my back started to really get worse. It was to the point where I could not bear the pain anymore. And I asked him would he refer me to a doctor for the injection. And he did.
Q Prior to that December appointment and that referral for the injections, had the injections been something that Dr. Aymond had put out for you as something to do in your prior treatment?
A No. He told me that -

MS. WHITTEN: I would object to anything Dr. Aymond said.

THE COURT: Sustained.

BY MS. SPANN-WILDER:

Q Were the injections - just yes or no. Were the injections something that you had continuously had conversation with him about?

A No.
Q When was the first time you became aware of the injections as an option for you?
A In July.
Q In July of '07?
A Right.
Q When did you first see Dr. Geier?
A I believe it was January of '08.
Q Who paid for that visit?
A Workman's Comp.
Q How many other times had you seen Dr. Geier?
A I had two more injections.
Q So, that's a total of three?
A Right.
Q And who paid for them?
A Workmen's Comp.
Q Are you still seeing Dr. Geier?
A No.
Q Why not?
A Because Workmen's Comp would not authorize the treatment.
Q How long have you been - how long has it been since you have been trying to get in to Dr. Geier?
A Since 2010. Twice in 2010 and once in 2011.
Q Have you tried to use any other kind of coverages?

A Yes.
Q What's happened?
A They denied it.
Q Why is that?
A Because it's a Workmen's Comp issue.
Q Are you still experiencing pain at the levels that you believe require the injections?
A Yes, ma'am.
Q Now, in the interim of seeing Dr. Geier for your back, did you ever return to Dr. Aymond for any other - for the neck?
A Yes.
Q And when you went to Dr. Aymond, what was going on at that point with your neck?
A I started to have pain in my left arm. And it was radiating starting in the neck and coming down my arms, so I went to Dr. Aymond. And he, again, took x-rays and he referred me to Dr. Ernst.
Q What kind of doctor is Dr. Ernst?
A He deals - he's a hand doctor who deals with anything to do with the hands; carpal tunnel, and things like that.
Q Who paid for those visits with Dr. Aymond?
A Workmen's Comp.
Q And once you saw Dr. Ernst, was he able to figure out

what was wrong?

A Not really. He could tell me that it wasn't carpal tunnel. He referred me back to Dr. Aymond.

Q What happened -

MS. WHITTEN: Again, I would object to anything the doctor said.

BY MS. SPANN-WILDER:

Q Dr. Ernst referred you back to Dr. Aymond?

A Yes.

Q Okay. And to your understanding, did you have carpal tunnel?

A No, I didn't.

Q So, you went back to Dr. Aymond.

A Yes.

Q What happened from there?

A Dr. Aymond then referred me to Dr. Jervey.

Q What kind of doctor is Dr. Jervey?

A A neurologist.

Q Was there a difference in the problem in your neck than you had previously had? In asking that, I want to know from the time you left Dr. Aymond in July '07 and he released you up to this point now in 2008 what were the differences from how your neck felt from that time span?

A As the pain really like what I have now, it's a

constant pain. It does not go away. I wake up in the morning with it and I go to bed at night with it.

Q Was it like that in October '07 at your hearing?

A No, it wasn't.

Q Was it just isolated to your neck?

A No. When I went to Dr. Aymond, no, it was down my arms.

Q Okay. And when you went to see Dr. Jervey, who paid for that?

A The initial visit Workman's Comp paid for it, for the nerve test.

Q And what is your understanding from that nerve test of your condition?

A That it was caused, and this is through my research -

MS. WHITTEN: Commissioner, I object to the Claimant giving a medical opinion.

THE COURT: She can tell me her understanding of it. What's your understanding?

BY MS. SPANN-WILDER:

Q What is your understanding of your EMG results, your nerve test results?

A That it's coming from my neck.

Q Was there a formal name for the condition that you were given?

A Denervation.

Q Okay. And what have been the treatment options that you have taken on to deal with the denervation?
A It started with pain medicine, the patch that I wear. The most recent is - there was a time it was discussed about another type of medication. I couldn't tolerate it, so I never - that one was never - the prescription was never given to me because I couldn't tolerate it.
Q You had taken samples?
A No. Another doctor tried to give it to me and I had a bad reaction to it, so I couldn't take that. The most recent was a cream. And it's a numbing cream. And you put it on and it just deadens your arm. I could use that for 30 days. That's where I am right now until I go back to the doctor in July.
Q Were there any injections or anything like that in the neck?
A With the neck, not from Dr. Jervey.
Q Okay. But did you have neck injections since your hearing as well?
A No. I haven't had any neck injections. I had a cervical injection.
Q That's the neck.
A Okay. Yeah.
Q Cervical spine.
A I had cervical injections.

Q Who performed that?
A Dr. Geier.
Q Who was that ordered by? Dr. Jervey or Dr. Aymond?
A Dr. Jervey.
Q So, you've had a cervical injection trying to deal with this denervation?
A Right.
Q What are your options now, your medical options for the denervation?
A When I get back to Dr. Jervey, I have to ask him what the next step is. There's a possibility that I will see a specialist, a neurosurgeon. And I have to make a decision as to whether I can take a chance of having any type of surgery on my neck to find out if something is pressing on the nerve.
Q So, an exploratory?
A Like an exploratory surgery. And I have to consider the fact that sometimes these things turn into paralysis.
Q Now, Ms. Wilson, let's change gears from your physical problems. How did you come to see Dr. Samuel Rosen?
A Dr. Oliverio referred me.
Q And who is Dr. Oliverio?
A My primary care doctor.
Q What kind of physician is Dr. Rosen?

A A psychiatrist.
Q Prior to seeing Dr. Rosen, had you ever seen a psychiatrist?
A No.
Q Why did you feel you needed to see Dr. Rosen?
A This is hard. I wake up in the morning and I can't even do anything. I'm in constant pain. I don't want to move. I don't want to get up. I have to walk out of my house, I go to a neighbor to get her to zip up my dress. I can't do things that I used to do. I can't go out with my friends because I'm so afraid that I'm going to ruin the times with them. I was always so active. Now I just feel like I'm not any use to anybody. I just feel so helpless and that's not me. That's not the type of life I live. So, I had to get somebody. I needed some help.
Q Now, Ms. Wilson, from your medical records that the Commissioner has, there are notes from Dr. Clare, who was your primary care before Dr. Oliverio, and Dr. Oliverio showing that you were on I believe a one-milligram dosage of Lorazepam and Diazepam. They have never been at the same time, but those have been the two drugs. What were you taking them for and when did it start?
A Anxiety. And it started after the death of my

husband.

Q And so, you have taken it for anxiety. Have you ever sat with even a psychologist, any type of counselor that worked in conjunction with these meds?

A No.

Q Have you ever had any kind of hospitalization or anything related to psychological or psychiatric problems?

A Not psychiatric. Anxiety.

Q And tell us a little bit about that.

A After my husband's death, I went back to work. And I just had an anxiety attack. And I was taken from the school to Dr. Clare's office. And from there, he put me in the hospital for two days for close observation. He said it was an anxiety attack.

Q What year was that?

A In 2003.

Q What hospital?

A St. Francis.

Q And while you were there, were you in a psychiatric unit or anything like that?

A No.

Q Okay. Was that the beginning of taking the anxiety medicine?

A I was on Lorazepam. I believe he started me on it a

little bit before that because my husband died in January, so it was like right about the same time.

Q During his illness?

A Yeah. During that time.

Q Okay. What did you use the Lorazepam for?

A At night when I was ready to go to sleep. And sometimes I would have to take one in the morning if I felt a little bit anxious when I got up. I had to get used to being in the house alone. Sometimes I would wake up and I just feel a little anxious and I would take one. But most of the time it was at night.

Q At your past hearing, and this is page 25 of the hearing transcript, line 21 through 23, you testified that you had some increase of anxiety meds before your injury, but you were being weaned off them. Is that accurate?

A Yes.

Q So, is it your testimony that while you were taking those medications, you were decreasing them prior to the October 2007?

A Yes, I was.

Q Now, are you still on medications for anxiety?

A Yes, I am.

Q Who is prescribing them now?

A Dr. Rosen prescribes one and Dr. Oliverio prescribes

another one. Well, Dr. Rosen and Dr. Jervey prescribes one. That's the Cymbalta. And Dr. Oliverio prescribes the Valium.

Q Valium?

A Well, it's Diazepam.

Q Okay.

A The generic.

Q Okay. What happened that put you at seeing Dr. Rosen? What was different from the anxiety you experienced with your husband's death and coping with that along the way?

A I was in so much pain and I couldn't figure out what do I do next? It just - like I said, I woke up in the morning with pain. I was in pain all day. I would cry. I didn't know what to do with myself. I walk to the door, sit in the recliner and go up to the bed. I just felt like I didn't know what was going on. I spoke to Dr. Oliverio about it. And he told me he thought it was about time that I talked to somebody.

Q Can you tell us what your lowest point was from your first hearing up to actually seeing Dr. Rosen?

A We go back to when I - like I said, when I would wake up in the morning and I can't - I'm in pain and I can't do what I normally would do. I didn't have a job to go to. I didn't have people around me. I was

by myself. I'm a widow. I live by myself. I'm not a telephone person. And even if I was, I couldn't talk on the phone because I can't hold the phone for a long time. I felt very hopeless. I felt very helpless. And I felt very useless. And when Dr. Oliverio suggested it, I felt that I just needed some help. I needed to talk to somebody to try to find out exactly if something was wrong with me as far as the way I was feeling, whether it was normal for me to feel this way because the pain was just so bad.

I had just - my life - on May 9 when I walked into work that morning, I wasn't even going to work that summer. I was looking forward to - I said, "I'm not working this summer. I'm going to just have a nice time during the summer." I never knew that at 12:00 that day that my life would have changed. And it changed drastically. And it was something - I needed somebody to help me to adjust. And as of now I still haven't adjusted.

Q Ms. Wilson, after seeing Dr. Rosen, what kind of diagnosis did you come to have?

A Depression, frustration, anxiety.

Q Have any of those changed since you started seeing him?

A No.

Q Who has paid for your visits to Dr. Rosen?
A My insurance.
Q Now, there is a gap in your treatment with Dr. Rosen. Why was that?
A My insurance - I had to do some paperwork in order for him to continue. I had an appointment in October. I was sick, I had to cancel it. And then I got some paperwork in the mail. And I had to do the paperwork. And they approved it. And by the time that I was able to get an appointment with Dr. Rosen, I had developed pneumonia. That was the delay in me getting to see him.
Q Are you still seeing him?
A Yes.
Q Is it helping?
A Sometimes I think so.
Q Now Dr. Rosen noted in your first appointment about financial situations. Were you there because of your finances? What led you to see him? What was the issue with the finances?
A My finances didn't have anything to do with me going to Dr. Rosen. I went to Dr. Rosen to get some help with my mental and my physical state.
Q But he noted that. What was it that you told him about your finances?

A We talked. I told him I was used to working. I had a check every two weeks. Now I had to rely on early retirement, early Social Security, which was a decrease, and a small annuity.

Q So, it was the transition of your financial -

A Going from being able to have extra money to do things to once a month from every two weeks. But my finances didn't have anything to do with me going to Dr. Rosen. We were just talking. And that was one of the things that was asked of me.

Q Okay. So, it was an adjustment of how your finances were having to be handled?

A Right.

Q When you were there, were you distraught about having lost a home or anything like that?

A No.

Q Okay.

A I'm still in my savings.

Q Okay. Ms. Wilson, quality of life issues, how long can you stand without having issues?

A Less than an hour.

Q In your last hearing you testified that you often walked the one mile I think between your home and to school and you could do it in about 15 minutes. Are you still doing that now? Are you still able to walk

that mile?
A No.
Q Why not?
A Because of the pain in my back and my left leg more than my right leg.
Q What's going on with the left leg?
A It cramps up on me. It buckles. It gets cold. It gets pain. I have pain in it.
Q Is that associated when the back -
A Yes.
Q - issues are there?
A Yes.
Q Are there any activities that you could do after your surgery that Dr. Rosen performed?
A Dr. Aymond?
Q I'm sorry, Dr. Aymond performed and that you could do them up the time of having that first hearing that you cannot do now?
A Yes.
Q What are those kind of things?
A I can't put out my garbage. I can't go out in the yard and pick up a piece of paper if a piece of paper is out there. It has to stay there until somebody gets it. I can't do - I was able to do some housework. Now it's even more limited. I have to be

careful.

Q When you say limited, what kind of things are you not able to do and how do they get done since you live alone?

A I have a girlfriend that comes in to help me like make the bed and vacuum. I have an adopted daughter who comes in and does things for me. When I wash clothes, I have to make sure - I can't wash sheets and stuff like that. Somebody has to do that. I can wash small items.

Q Why can't you wash the sheets?

A Because I have to pull them out of the washing - pull things out of the washing machine and that hurts. That hurts the neck as well as now my arm. There - like I said, I can't even zip up my clothes when I'm getting dressed.

Q You can't zip in the front?

A The back.

Q Okay. If I want to like boil some eggs, I have to be very, very careful because I tend to - sometimes when I hold on to something, I get spasms. And whatever is in my hand I will have to drop it. So, I have to be very careful with that. Sweeping is out of the question. I can't do that at all.

Q What keeps you from sweeping?

A The back and forth of the broom. Cleaning the bathroom. I can clean the basin, but I can't do the tub. All of those things that take on the daily things to take care of them, most of them I can't do now.

Q Ms. Wilson, do you feel that there is more that can be done medically to help you feel better than you are feeling currently?

A I hope so.

Q What about mentally? Do you feel like there's more treatment that would be beneficial to you?

A I would like to continue seeing Dr. Wilson.

Q Now, if the Commissioner's decision is contrary to yours in that there's a finding that you are at the maximum capacity and just periodic treatments would be the only things to help you, how would you rate your neck and your back? Your previous rating was 45 percent. Where do you feel you are right now with those situations?

A I think about 75 percent.

Q Can you separate them? That's 30 percent more than where your rating is at this time. How would you attribute to the neck and to the back?

A Probably half and half.

Q At your prior hearing you rated your neck as being

more problematic than your back. Where would you put that now?

A I can't.

Q You couldn't prioritize them?

A I can't.

Q Ms. Wilson, what do you understand to be the condition of your back?

A I have had scoliosis since birth. I was diagnosed at a young age and told I had it since birth. I just found out recently through a deposition that I had some arthritis, because I didn't know anything about that. I didn't go to the doctor for my back, so I didn't know -

Q Before this injury you didn't see a doctor for your back regularly?

A No, I didn't.

Q Psychiatrically, considering that you were on your medicines before this injury occurred, if I just said that maybe you were at 95 percent psychiatrically prior to this injury, now with the problems that you have and the treatment with Dr. Rosen, where would you put yourself from a psychiatric standing in terms of your wholeness or an impairment to that?

A The 95 percent was my whole body?

Q I'm just saying if you started out at 95 percent,

because taking into consideration that you did take medicines for anxiety prior to your injury, where from 95 percent would you go?

A About 80.

Q Now, that's insinuating a 15 percent kind of loss of use because of that. What would you base that on with the psyche?

A Just the way I'm feeling, no motivation, I just want to sleep all day, frustrated. I just can't enjoy life. I just want to be able to enjoy life again. Instead of me getting better, it seems like I'm getting worse.

MS. SPANN-WILDER: Thank you, Ms. Wilson. Please answer any questions Ms. Whitten has.

THE COURT: Ms. Whitten.

MS. WHITTEN: Thank you, sir.

CROSS EXAMINATION

BY MS. WHITTEN:

Q Just to be clear Ms. Wilson, you were offered injections to your low back before we went to the hearing in October 2007; is that right?

A Been offered? No, not offered.

MS. WHITTEN: Commissioner, I'll just refer you to APA 1 page 5.

///

BY MS. WHITTEN:

Q In fact, when we went to the hearing, I asked you if your back was bad enough for the injections and you said yes, but you were just afraid to have them. Do you remember that?

A Yes.

Q But as far as your neck, the range of motion in your neck, if you can remember, in 2007 was the same as it was at the end of 2008; is that right? As far as you could move your neck around, it was the same at the end?

A Yeah. From side to side.

Q Okay. And the restrictions that you had from your doctor at the end of 2007 for your neck were the same as the end of 2008; is that correct?

A Yeah. Because my body -

Q Okay. And the neck pain that you had after your surgery never actually went away, right? It's not like it went away and then came back. You continue to have pain in your neck?

A Yes.

Q And your neck and back both did get a lot better in 2010; is that right?

A In 2010?

Q Yes, last year.

A No, they did not.

MS. WHITTEN: Commissioner, APA 5 page 71.

BY MS. WHITTEN:

Q And then you talked a bit about going to see Dr. Rosen in May 2008. And that was after your temporary total disability checks had stopped, the checks from the school district; is that correct?

A Yeah. That stopped in 2007.

Q And you told Dr. Rosen that you were particularly upset about that and you were concerned about the financial issues that that raised; is that right?

A We talked about my financials, yes.

Q And you told him that you were upset about your checks stopping?

A I told him - I may have said I did not get anymore Workman's Comp checks.

Q Okay.

A But that wasn't the reason I was there.

MS. WHITTEN: All right. Commissioner, that's APA 6, Page 77.

BY MS. WHITTEN:

Q Now, I think you already testified you were taking medications for anxiety and depression at the time of the hearing in October of 2007?

A Yes.

Q And it had been about four years since your husband passed away by that point?
A Yes.
Q And do you remember seeing William Stewart? Do you remember interviewing with him before the hearing?
A Yes.
Q Did you tell him that you had little pleasure in the things you used to enjoy, a loss of energy, a change in your appetite, things like that?
A I saw him in 2007.
Q Yes. Did you tell him all of that?
A I may have.
Q Did you tell him that you were unsteady and nervous?
A Yes. All of that goes by anxiety.
Q Okay. So, you told him in September 2007 that you had anxiety?
A Yes.
Q Okay.
A He wanted to talk to me about from the time I was born.
Q Okay. But at the time you saw him, you were having those issues?
A Yes.

MS. WHITTEN: Okay. Commissioner, I'm just referring to the old APAs, page 149. and that's all I

have.

THE COURT: All right. Any redirect?

MS. SPANN-WILDER: Nothing else.

THE COURT: Any witnesses for the Employer and Carrier?

MS. WHITTEN: No, sir.

THE COURT: That being the case, that'll conclude this hearing.

(THE HEARING CONCLUDED AT 11:30 AM.)

From:	Nicholson, J. C. Law Clerk (Katherine O. Hendricks)
To:	Whitten, Leslie; "Blake Hewitt"
Subject:	RE: Wilson v. Charleston County School District
Date:	Tuesday, July 08, 2014 10:37:34 AM

Thank you, both. Please e-mail me your proposed orders in Microsoft Word format when they are ready. Thank you!

Kind regards,

Kate

Kate Hendricks

Law Clerk to The Honorable J.C. Nicholson, Jr.

From: Whitten, Leslie [mailto:lwhitten@ycrlaw.com]
Sent: Tuesday, July 08, 2014 10:12 AM
To: 'Blake Hewitt'
Cc: Nicholson, J. C. Law Clerk (Katherine O. Hendricks)
Subject: RE: Wilson v. Charleston County School District

Hey Blake,

Oh good! I only saw the transcripts, orders, and a couple of WCC filings but not the briefs/apas. However, if that was part of what you sent him and I missed it, that's great.

Thanks,

Leslie

From: Blake Hewitt [mailto:bhewitt@bntdlaw.com]
Sent: Tuesday, July 08, 2014 10:08 AM
To: Whitten, Leslie
Cc: Nicholson, J. C. Law Clerk (Katherine O. Hendricks)
Subject: Re: Wilson v. Charleston County School District

Leslie:

I prepared a bound "record" for him with those documents. You should have received a copy. Please let me know if you did not.

I hope you had a relaxing holiday weekend.

Blake

Sent from my iPhone

On Jul 8, 2014, at 9:55 AM, "Whitten, Leslie" <lwhitten@ycrlaw.com> wrote:

> Hello Ms. Hendricks,
>
> Should I mail my proposed order when it is ready or email it to you? Also, does Judge Nicholson have the Commission's file? I just want to make sure he has the pre-hearing briefs and APA submissions from both hearings.
>
> Thanks!
>
> Leslie Whitten
>
> **From:** Whitten, Leslie
> **Sent:** Thursday, June 12, 2014 9:17 AM
> **To:** 'Nicholson, J. C. Law Clerk (Katherine O. Hendricks)'
> **Cc:** 'Blake Hewitt (bhewitt@BNTDlaw.com)'
> **Subject:** RE: Wilson v. Charleston County School District
>
> I will do that. Thanks.
>
> **From:** Nicholson, J. C. Law Clerk (Katherine O. Hendricks) [mailto:JNicholsonLC@sccourts.org]
> **Sent:** Wednesday, June 11, 2014 5:02 PM

To: Whitten, Leslie
Cc: 'Blake Hewitt (bhewitt@BNTDlaw.com)'
Subject: RE: Wilson v. Charleston County School District

Dear Ms. Whitten and Mr. Hewitt:

Judge Nicholson would like for you to both submit proposed orders reflecting rulings in your favor so that the proposals may assist in his review of this appeal. Please do so within thirty days. Thank you.

Kind regards,

Kate

Kate Hendricks

Law Clerk to The Honorable J.C. Nicholson, Jr.

From: Whitten, Leslie [mailto:lwhitten@ycrlaw.com]
Sent: Monday, April 28, 2014 11:30 AM
To: Nicholson, J. C. Law Clerk (Katherine O. Hendricks)
Cc: 'Blake Hewitt (bhewitt@BNTDlaw.com)'
Subject: RE: Wilson v. Charleston County School District

Hello again,

I just went to the court website and noticed that the claimant's appellant brief and reply brief are scanned into the system, but my Respondent's Brief is not. I mailed that on March 7 and am emailing that to you now to make sure you have received it. If I need to do anything else, please let me know.

Thanks!

Leslie Whitten

From: Whitten, Leslie
Sent: Friday, March 14, 2014 1:44 PM
To: 'JNicholsonLC@sccourts.org'
Cc: Blake Hewitt (bhewitt@BNTDlaw.com)
Subject: Wilson v. Charleston County School District

Hello Caroline,

It has just been pointed out to me that there is a typographical error in my Respondent's Brief in this matter, which I mailed to your office on March 7. On the last paragraph of the first page, I wrote that the date of the claimant's injury was May 6, 2009, but it was actually on May 9, 2006. Please note this for me to Judge Nicholson and apologize for me for any inconvenience or confusion.

Thanks!

Leslie M. Whitten

Partner

Attorney at Law

Young Clement Rivers, LLP

Phone: (843) 724-6691

Fax: (843) 579-1329

<image001.jpg>

Young Clement Rivers, LLP
http://www.ycrlaw.com
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South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0608517
Carrier File # 07-06-000554
Carrier Code #
Employer FEIN

Sara Y. Wilson [redacted] SSN
Claimant's Name
[redacted], Charleston, SC [redacted]
Address City State Zip
0 0
Home Phone Work Phone

Charleston County School District
Employer's Name
75 Calhoun Street, Charleston, SC 29401
Address City State Zip
Charleston County School District
Insurance Carrier

Leslie M. Whitten P.O. Box 993, Charleston, SC 29402 (843) 724-6642
Preparer's Name Address 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 5/9/2006 2. AWW: $ 502.87 Comp. Rate: $ 335.26

3. Type of injury and body part(s) Neck

4. Facts in controversy: Whether or not the claimant has reached maximum medical improvement; whether or not the employer/carrier may stop payment of compensation; whether or not the employer/carrier is entitled to a credit for overpayment of compensation; extent of disability.

5. Legal issues involved: See Facts in Controversy.

6. Unusual problems: None at this time.

7. Witnesses (designate if expert)* William Dixon, and another representative of Charleston County School District; David Price (vocational assessment and updated vocational assessment submitted in lieu of testimony).

8. Exhibits: Claimant's deposition to be submitted at the hearing; Dr. Aymond's deposition to be submitted at the hearing; records from claimant's personnel file; payroll records for claimant

9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance)

Dr. Alexander	11/16/2006	(2 pages)
Dr. Aymond	7/20/07	(1 page)
David Price	2/19/07 - 8/30/07	(10 pages)

10. Name, address, and specialty, if any, of the treating physician: Dr. Alexander; Dr. Aymond

11. Impairment rating(s); body part(s); physician and date of opinion: 8% to the whole person relative to the cervical spine by Dr. Alexander on November 16, 2006; 5% to the whole person relative to the lumbar spine by Dr. Aymond in his deposition on 9/11/07; 23% impairment to the cervical spine on 7/20/07

SIGNATURE Leslie M. Whitten
Leslie M. Whitten

DATE OF HEARING: 10/2/2007 TIME OF HEARING: 12:45 p.m.

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.

WCC FORM # 58 REV. DATE 3/96 58 PRE-HEARING BRIEF

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	)	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
SARA Y. WILSON, Claimant, vs. CHARLESTON COUNTY SCHOOL DISTRICT, Employer/Self-Insurer.	)	WCC FILE NO. 0608517 NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF DEFENDANTS

To: South Carolina Workers' Compensation Commission
Tiffany R. Spann-Wilder, Esquire

YOU ARE HEREBY NOTIFIED that the Defendants, pursuant to the provisions of the South Carolina Workers' Compensation Act and S.C. Code Ann. §1-23-330, (1985), herewith submits the following reports/physician or other evidence on behalf of the Defendants, to wit:

Name Of Report(s)/Physician or Other Evidence	Date of Report(s)	Number Of Pages
Dr. Alexander	11/16/2006	(2 pages)
Dr. Aymond	7/20/07	(1 page)
David Price	2/19/07 - 8/30/07	(10 pages)

Exhibits:

Records from claimant's personnel file
Payroll records for claimant
Claimant's deposition to be submitted at the hearing*
Dr. Aymond's deposition to be submitted at the hearing*

YOU ARE FURTHER HEREBY NOTIFIED that you have the right of 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 purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be submitted at the Hearing before the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Defendant.

YOU ARE FURTHER HEREBY NOTIFIED that the following witnesses may be called on behalf of the Defendants. William Dixon, and another representative of Charleston County School District; David Price (vocational assessment and updated vocational assessment submitted in lieu of testimony).

Leslie M. Whitten
Attorney for Employer/Carrier

September 17, 2007

STATE OF SOUTH CAROLINA
BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NUMBER 0608517

Sara Y. Wilson,

Employee,

-versus-

Charleston County School District,
Employer/Self-Insured.

VERIFICATION

Pursuant to Section 42-1-700 (C) and Section 42-1-705 (C)

I verify the contents of this FORM 58 are accurate and true to the best of my knowledge.

Leslie M. Whitten

Leslie M. Whitten
Attorney for the Employer/Carrier

September 17, 2007
Date

Sara Y. Wilson v. Charleston County School District
WCC No. 0608517
APA SUBMISSIONS

NAME OF REPORT(S)/PHYSICIAN OR OTHER EVIDENCE	DATE OF REPORT(S)	PAGE NO.
APA		
APA#1-Dr. Alexander	11/16/2006	(Pgs. 1-2)
APA#2-Dr. Aymond	7/20/07	(Pg. 3)
APA#3-David Price	2/19/07 - 8/30/07	(Pgs.4-13)
Exhibits:		
Exhibit#A-Records from claimant's personnel file		(Pgs. 14-19)
Exhibit#B-Payroll records for claimant		(Pgs. 20-34)

Claimant's deposition to be submitted at the hearing
Dr. Aymond's deposition to be submitted at the hearing

SPINE & ORTHOPAEDIC SPECIALISTS of South Carolina PA

J. Robert Alexander, Jr. M.D.
Chris P. Tountas, M.D.

1311 Chuck Dawley Blvd, #102
Mt. Pleasant, SC 29464

700 Medical Park Drive
Hartsville, SC 29550

843-856-9669 — 888-856-9669 — Fax 843-856-9161

WILSON, SARA
DOB [redacted]/43
CHART # 2136
11/16/06

HPI: Ms. Wilson is seen today in follow-up from 10/25/06. She had surgical second opinion with Dr. Stovall who advised her about potential risks and benefits of operative measures. States that it is an option that he feels would likely help with her right upper extremity symptoms, but may not help with her cervical axial discomfort. Patient states she prefers to hold off on operative intervention at this time.

Initial history and physical findings reviewed and she reports no new complaints.

PHYSICAL EXAM: Tenderness right cervical paraspinal region.

ASSESSMENT: Cervical and intermittent right upper extremity pain/paresthesias with right paracentral disc protrusion C6-7 on MRI. Unremarkable EMG.

PLAN:

1. Patient has had two operative evaluations with Dr. Dennis and Dr. Stovall. She has decided against surgical measures at this time. Subsequently determined to be at MMI given she has undergone exhaustive nonoperative conservative measures. Will utilize AMA guides to determine impairment rating.
2. Continue diclofenac and Ultram on a p.r.n. basis. Also continue TENS and home traction.
3. Continue home exercise program.
4. Recommend permanent restrictions of sedentary work status. Of note, patient is retired, however.
5. Individual will likely require periodic interventional measures, including injections, p.o. medications, and P.T. in the future depending on level of symptomatology. Operative measures also remain an option. Patient understands she can contact our office on a p.r.n. basis any major changes in current status.

J. Robert Alexander, Jr., M.D.

JRA/ls

cc: Worker's Comp.
R. Blake Dennis, M.D.

RECEIVED
NOV 30 2006
BY:

SPINE & ORTHOPAEDIC SPECIALISTS of South Carolina PA

J. Robert Alexander, Jr., M
Chris P. Tountas, M

1311 Chuck Dawley Blvd., S
Mt. Pleasant, SC 29

700 Medical Park D
Hartsville, SC 29

843-856-9669 -- 888-856-9669 -- Fax 843-856-9161

WILSON, SARA
DOB [redacted]/43
CHART # 2136
11/17/06

Ms. Wilson was determined to be at maximum medical improvement on office visit 11/16/06. Utilizing AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, she is determined to fall in DRE cervical category II given cervical and radicular symptoms with paracentral disc protrusion on MRI. Unremarkable neurologic and electrodiagnostic examination. Given non-verifiable radicular complaints, she is subsequently determined to have an eight percent impairment rating of the whole person.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.

RECEIVED
NOV 30 2006
BY

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON C
CHART#: W89612WC
SSN [redacted] DOB: [redacted]/1943 AGE: 63 y

07/20/2007 JAMES K AYMOND MD

FOLLOW UP

Ms. Wilson is four months status post cervical fusion at the C6-7 level. Overall she continues to do very well. She is not having any further neck discomfort. She continues to have some degree of lower back discomfort secondary to what was found to be mild to moderate osteoarthritis of the facet joints at L4-5 and L5-S1 level.

Range of motion of the cervical spine is 90% of normal. Motor and sensory exam are normal.

Radiographs of the cervical spine reveal complete consolidation of the arthrodesis, C6-7 level.

RECOMMENDATIONS: At this time we will recommend that Ms. Wilson continue with activities of daily living. I would have her remain on a lifting restriction of 20 lbs. or less and she should avoid repetitive overhead activities. She is considered at maximum medical improvement with respect to her cervical spine and I would rate her impairment to be 23% impairment of the whole person as it relates to her cervical disc altered motion segment integrity. I will plan to have her notify us if she desires to proceed with facet injections performed in her lumbar spine.

JKA/ls 07/23/07
Schaffer Company WC (75500)
Charleston County School (EC011443)

JUL 2 3 2007

BY.....

Page 1 of 1

SARA Y. WILSON - PAGE #3

David R. Price, M.Ed. CRC
222 King Rail Lane
Huger, SC 29450

VOCS

Phone & Fax: 843-336-4902
E-mail: PriceAdvice@msn.com
Mobile: 843-810-6582

February 19, 2007

VOCATIONAL ASSESSMENT OF SARA WILSON

Introduction:

Sara Wilson is a sixty three year old data entry clerk formerly employed at James Simons Elementary School by the Charleston County School District. She has been an employee since 1985. She was earning approximately $27K per year. On May 9, 2006 she injured her neck and back when two fighting students fell into her. She was struck from behind and knocked into an office counter. She was diagnosed with a herniated cervical disc and underwent a course of conservative treatment that included medications, physical therapy, TENS unit, and cervical epidural steroid injection. Ms. Wilson had two surgical opinions and was offered aggressive treatment in the form of anterior cervical disc fusion. She declined and was placed at maximum improvement. Her permanent work restrictions are sedentary. She has 8% permanent impairment of the whole person. Ms. Wilson subsequently retired from her job citing issues of pain and inability to give 100% effort to her job. She is referred for vocational assessment.

On February 19, 2006 medical records of Sara Wilson were examined. This included files from: James K. Aymond, MD, R. Blake Dennis, MD, J. Robert Alexander, Jr., MD. Donald O. Stovall, MD, Pettigrew Clare, Sr., MD, Tricounty Radiology Associates, Roper Radiologists, Progressive Physical Therapy, Doctor's Care, Private Therapy Services, Roper St. Francis Healthcare, Modern Medical Inc., and the January 23, 2007 deposition of Sara Y. Wilson. The conclusions and recommendations contained in this report were formulated from a review of this material and represent my professional opinion as a certified vocational rehabilitation counselor.

Medical Treatment:

Ms. Wilson initially sought treatment from her family physician, Pettigrew Clare, Sr., MD. She was referred by her worker's compensation insurance carrier to Doctor's Care where x-rays and MRI scan indicated referral for orthopedic evaluation. She saw Blake Dennis, MD of Palmetto Orthopedics on June 6, 2006. Dr. Dennis diagnosed C6-7 spondylosis. He had another MRI scan done and on July 18, 2006. His interpretation is stated in his note of that date:

"She has a degenerative disc at C6-7 with some mild right foraminal stenosis. There is no fracture or cord change. The report shows some marked left-sided degenerative facet changes at C3-4 and C4-5 as well as C5-6 and a degenerative disc at C6-7."

"It is my opinion, to a reasonable degree of medical certainty that the patient would benefit from an anterior cervical discectomy and fusion, C6-7 level, for her residual and persistent neck pain as well as right upper extremity dysesthesias."

Impairment and work restrictions were not addressed by Dr. Aymond.

Ms. Wilson attempted to return to work on a part-time basis. She had some difficulty doing all of her duties and was dissatisfied that she could not give 100% to her job. She subsequently retired from the workforce.

Work Restrictions:

Blake Dennis, MD, 7/18/06- *"We will make an appointment for her to see Dr. Alexander. I think it is reasonable to wait until she sees her before returning her to work."*

J. Robert Alexander, MD, 11/16/06- *"Recommend permanent restrictions of sedentary work status."*

Sedentary work, as defined by the U.S. Department of Labor limits maximum lifts to 10 lbs on an occasional basis. Sedentary work may also require frequent standing, walking, and/or sitting.

Medications:

Nexium and Librax for irritable bowel syndrome
Premarin for estrogen therapy
Lanoxin for arrhythmias
Zoloft for depression
Toprocol and Micardis for hypertension
Ultram for pain

Symptoms:

Ms. Wilson complains of daily pain in her right arm, upper back, lower back, and leg. She describes her neck pain as constant and states that it radiates into the right shoulder. She states that pain is aggravated by prolonged sitting and standing. Ms. Wilson states that she needs to change positions at 30-45 minute intervals. She states that she has occasional headaches and pain with range of motion extremes. Sleep patterns are reported as basically sound. Ms. Wilson has been on anti-depressive medications since October of 2005.

Activities of Daily Living:

Ms. Wilson states that she is independent with personal hygiene and dressing but with some difficulty and slowness. On good days she may spend time in a reclining chair

Diagnosis:

1. Cervical spondylosis
2. Neck pain

Dr. Dennis gave Ms. Wilson a surgical option for fusion at C6-7 but could not guarantee that it would remove all of her neck pain. She declined the procedure and he released her to return to work with a five pound lifting restriction and no work above eye level. She was given a referral to Robert Alexander, MD for pain management and follow up.

Dr. Alexander's initial consultation was on July 27, 2006. He did electrodiagnostic studies that showed no evidence of median or ulnar nerve entrapment, no evidence of peripheral neuropathy, and no evidence of cervical radiculopathy. His treatment plan included therapy, medication management, TENS and a series of cervical epidural steroid injections. These provided temporary relief but symptoms soon returned. Ms. Wilson was referred to Donald O. Stoval, MD, spine surgeon, on November 13, 2006. He stated in his note of that date:

"As far as conservative treatment she appears to have reached MMI. Surgical options would include C6-7 ACDF and plating."

Ms. Wilson returned to Dr. Alexander on November 16, 2006 and was placed at maximum recovery and restricted to sedentary work status. She was advised to continue using the TENS unit and keep up her home exercise program. Dr. Alexander documented the need for on-going treatment that would possibly include future surgical intervention for cervical fusion. On November 17, Ms. Wilson was assigned a rating of permanent impairment.

"Given non-verifiable radicular complaints, she is subsequently determined to have an eight percent impairment rating of the whole person."

For evaluation of low back pain Ms. Wilson saw James K. Aymond, MD, spine surgeon, on January 16, 2007. He stated:

"Films of the thoracolumbar spine from May 20, 2006 are reviewed. These reveal a right thoracolumbar scoliosis with compensatory lumbar scoliosis."

Working off the diagnosis: *"Aggravation of pre-existing lumbar scoliosis with muscular and buttock pain"* Dr. Aymond recommended MRI scanning. Records beyond the initial evaluation were not available. Final diagnosis and treatment status of the lumbar spine is unknown to me at this time.

Dr. Aymond's evaluation included the cervical spine. He concurred with the diagnosis of disc herniation at C6-7. He stated:

reading or listening to the radio. She talks on the phone with friends for brief periods. She enjoys walks, movies, and dancing but states that she is no longer doing these things. She may occasionally go out for a meal but mostly she has them brought to her. Ms. Wilson attends church and is a volunteer worker there. She has got back on her participation since injury. Occasionally she has visitors over. She tries to do prescribed exercises on a daily basis but has difficulty with cervical range of motion.

Social:

Ms. Wilson lives alone in Charleston, SC. She is a widow and has one adult daughter and one grandson who live nearby. The daughter is in the US air force. Ms. Wilson's weight is approximately 110 lbs. She is retired from the Charleston County School District and receives $272.00 per month. She receives $575.00 from social security and a small annuity from her deceased husband.

Education:

Ms. Wilson graduated from Burke High School in 1961. She attended Palmer Business College and took courses in typing and bookkeeping. She attended the College of Charleston and took computer courses. She does not have a formal degree. She has never been in the military.

Work History:

Ms. Wilson has been employed by the Charleston County School District since 1985. She started as a substitute teacher and ended as a data entry specialists. She was earning $27,000 per year when she retired. Prior to this she worked for Sears Department Store as a customer service representative and cashier. She worked in gift wrapping and the credit department as well.

Job Description:

Ms. Wilson states that her work responsibilities included keeping data on all students and teachers. She was responsible for attendance records. She reported to work at 7 am and worked two hours in the main office answering the phones, registering students, and helping the principal. At 10 am she went to her office where she did reports, checked data for accuracy, made corrections and entered it into the computer. She had secretarial responsibilities and took care of the bulletin board. She monitored classrooms, worked as a proctor, and served on committees. She was a ten month employee. Her last day at work was May 9, 2006.

Her work is consistent with the US Department of Labor's Description for:

203.582-034 Data Entry Clerk (clerical) – *"Operates keyboard or other data entry device to enter data into computer or onto magnetic tape or disk for subsequent entry."* *(See page 173 Dictionary of Occupational Titles, 4th Ed., Vol. I).*

The occupation is listed as sedentary work.

Conclusions and Recommendations:

Sara Wilson is a 63 year old data entry technician for Charleston County School District. She was injured on May 9, 2006 when she was struck in the back and knocked into a marble counter by two fighting students. She had been employed by the district for twenty one years. This represents the entirety of her past relevant work.

Ms. Wilson has a cervical disc herniation at C6-7. She is at maximum recovery following completion of conservative spine management that included medications, physical therapy, and cervical epidural steroid injections. Ms. Wilson declined surgery for anterior cervical discectomy and fusion. She is rated with 8% whole man impairment and restricted to sedentary work. Ms. Wilson currently presents with on-going complaints of pain and physical limitations and states that she is not capable of gainful employment. She retired from work following her accident. Her stated reason was that she could not give 100% effort to her job.

Ms. Wilson's occupation is listed by the US Department of Labor as sedentary work. Her work restrictions are sedentary. Ms. Wilson is not medically prohibited from returning to work at her occupation. She is not prohibited from future work as a data entry technician. There are no specific medical restrictions on the upper extremities or restrictions on sitting, standing, or walking. The 11/16/06 work release of J. Robert Alexander, MD has no limitations on hours worked per day or number of days per week. It appears to be a full duty sedentary release. It is my belief that if Dr. Alexander had intended for his release to be less than fulltime he would have specifically stated so as he did in his medical notes on four previous occasions. This is not to discount Ms. Wilson's complaints. She has objective findings on diagnostic imaging to support her report. It is very probable that Ms. Wilson will have permanent discomfort whenever she is involved in physical activity, prolonged sitting or standing. Certainly, at age sixty three if she chooses to remain retired I would not question her wisdom. However, I see no objective reasons within the terms of her physicians release to prohibit her from returning to her job with the school district or with any other employer as a data entry clerk. If she chooses to seek employment outside the school district she will experience a loss of access to the labor force based on her classification as an older worker. It is also probable that she would not start out with a new employer at the same rate of pay she had reached with the district.

The medical file documents the need for on-going future treatment that may include surgery for cervical discectomy and fusion. Should this occur I would certainly want to reevaluate my position after Ms. Wilson's recovery and assignment of permanent work restrictions. There is also the issue of low back pain that is currently being diagnosed. At

present this is an open ended issue and could also impact Ms. Wilson's employability. However, by the current medical record, at the present time I see no contraindication that she is not qualified as a full time data entry technician.

David R. Price, M. Ed., CRC

Certified Vocational Rehabilitation Counselor

David R. Price, M.Ed. CRC
222 King Rail Lane
Huger, SC 29450

Phone & Fax: 843-336-4902
E-mail: PriceAdvice@msn.com
Mobile: 843-810-6592

August 30, 2007

ADDENDUM TO THE VOCATIONAL ASSESSMENT OF SARA WILSON

Introduction:

Sara Wilson is a sixty four year old data entry clerk. She is retired from this position with the Charleston County School District and has retired through the social security system. She also receives disability benefits through the South Carolina Worker's Compensation system and the SC state disability program.

Ms. Wilson injured her neck and back in May of 2006 when two fighting students knocked her into a marble counter. On February 19, 2007 I reviewed her medical records and gave an opinion on her employability in my vocational assessment report of that date. She had reached maximum recovery and been returned to sedentary physical demand by her physician. I found this release compatible with the physical demands of her job and stated that I saw no objective reasons that would prevent her from returning to work as a data entry clerk. Since that time her condition worsened and she returned to her physician, James K. Aymond, MD for surgery. On March 28, 2007 she had an anterior cervical discectomy and fusion. She reached maximum recovery on July 20, 2007. Dr. Aymond assigned her 23% permanent impairment of the whole person for her neck injury and surgery. She was released to light duty. On August 30, 2007 I had the opportunity to interview Ms. Adams and talk with her about the results of her surgery.

Ms. Adams reports that she obtained good improvement of her neck and upper extremity pain. She only rarely has dysesthesias. This usually occurs if she spends too much time on her computer keyboard. Good strength has returned to her arms. Where she formerly occasionally dropped things she is now reporting resolution of that problem. She is sleeping better by using a rolled towel beneath her neck and a foam wedge between her knees. Her level of physical activity is improved and she has taken over housework that previously was being done by someone else. She does state that she has pain operating a vacuum cleaner and avoids this task. Ms. Adams tells me that she will have occasional neck pain. Sometimes it is the result of overexertion and at other times it appears for no apparent reason. When this occurs she takes Tylenol, uses heat and ice, and may apply TENS therapy. Most of the time this is effective. On rare occasions when it is not, she will take pain medication and lie down.

Ms. Adams continues to report low back pain. She has a history of congenital scoliosis. MRI scanning reveals no disc herniation or canal stenosis. She is found to have mild to moderate osteoarthritis of the facet joints at L4-5 and L5-S1. She manages this with the same protocol that is effective for her neck. Dr. Aymond has given her the option to have

lumbar facet joint injections but so far she has not needed them. The latest medical records available to me make no mention of permanent impairment or physical restrictions relative to the lumbar condition.

Activities of Daily Living:

Ms. Wilson was widowed in 2003. She now lives alone. She usually gets up around 6-6:30 am. She has a cereal bar for breakfast and may talk to her daughter or grandchild on the telephone. Afterwards she takes a daily walk for therapy and does prescribed therapeutic exercises. Upon return she spends quiet time reading her Bible and saying prayers. She cooks meals and independently tends to her home. She has a maid come in once a week to do the heavy cleaning. Ms. Wilson does not have a driver's license. She lives in downtown Charleston and calls a taxi or a friend when she needs to go shopping or run an errand. She is proficient with a computer and does a lot of her shopping on-line. Ms. Wilson likes to read and will do so several hours per day sitting in a chair. She is active in her church. She attends regularly, leads a bible study class, and goes to meetings and prayer groups. She also volunteers her time to church activities.

Medical Restrictions:

James K. Aymond, MD, 07/20/2007- *"I would have her remain on a lifting restriction of 20 lbs. or less and she should avoid repetitive overhead activities. She is considered at maximum medical improvement with respect to her cervical spine and I would rate her impairment to be 23% impairment of the whole person as it relates to her cervical disc altered motion segment integrity."*

These restrictions are consistent with the U.S. Department of Labor's definition of "light" physical demand.

Medications:

Mepergan Fortis- Taken about twice a month for breakthrough pain.
Tylenol 100 mgs- Taken three times daily for pain control.
Lorazepam- Taken once daily for anxiety.
Toprocol and Micardis- Taken daily for hypertension
Promarin- Taken daily for estrogen therapy
Nexium and Liberax- Taken daily for irritable bowel syndrome.
Zocor 40 mgs- Taken daily for elevated cholesterol.

Symptoms:

Ms. Wilson reports occasional pain in the back of her neck. At its worse she rates it 6-7/10 on the visual analog pain scale. When it reaches this level she medicates with Mepergam and lies down. This occurs about twice a month. She no longer has radiation

into the upper extremities. She has pain in her low back that radiates into the right leg. This pain is reported to reach level 8/10 about once every ten days. Activities such as bending, kneeling, getting up and down, or prolonged walking lead to pain increases. Ms. Wilson states that she needs to change from sitting to standing about every 20-30 minutes. She states that the right leg will occasionally give way. She now uses a cane for extended ambulation.

Observations:

Ms. Wilson is a petite lady of about 110 lbs who was most pleasant to interview. She answered interview questions in a clear and concise manner. No speech or cognitive impairments were noted. Her memory appeared intact as she was a very good historian. Ms. Wilson sat comfortably for thirty five minutes and then stood as she continued the interview. At about the same point she was observed to massage the back of her neck. She did not verbally complain. When asked she rated her exit pain at level 6/10. I did not suspect any effort on her part to exaggerate her symptoms. Her presentation was accepted as genuine. When asked if she had any plans to return to work she stated: *"I'm happy with my retirement."*

Conclusions and Recommendations:

Sara Wilson is six months status post anterior cervical discectomy and fusion at C6-7. By her account she got a good result and is much improved. In particular her upper extremity pain has been completely resolved. She continues to have some residual neck pain that is largely controlled with exercise, heat and ice, or TENS therapy. Very rarely she will have a bad day and need to take pain medication and lie down. She continues to have low back pain. She does exercises for this and on June 8, 2007 Dr. Aymond's notes state that she was having improvement. She has been offered lumbar facet joint injections but so far she has declined. Overall, Ms. Wilson states that she has a much better quality of life since having surgery. She has less pain, has increased strength, and is more active. Dr. Aymond has given permanent restrictions of 20 lb lifts and no repetitive overhead use. This actually represents an upgrade in her physical capacity. Before surgery she was limited to sedentary physical demand which restricted lifting to 10 lbs. Her present classification provides her more physical freedom and capability.

Ms. Wilson is a pleasant lady who has taken a very realistic approach to her physical situation. She has accepted the fact that she will likely always have some discomfort. She exercises, remains active and keeps her weight under control. She is happy with her retirement and states that she has no intention of returning to work. As I told her, she worked many years to earn retirement and certainly she is entitled to make the decision to remain retired. Vocationally speaking, her former occupation of data entry clerk is classified as sedentary work. Ms. Wilson is capable of light physical demand, which is a more physically demanding category. Dr. Aymond has not limited her is sitting, standing, walking, or the number of hours she can be active per day. There is no conflict with the terms of her medical release or any contraindication to returning to work as a data entry clerk. As far as I am concerned returning to work is a valid option for her. I

would equally support her decision to work or remain retired. Both options are available to her and I wish her well however she chooses.

Submitted by:

David R. Price M. Ed., CRC.

Form 6283
Revised 04/04/2002
Print or type in black ink

EMPLOYER'S DISABILITY EMPLOYMENT STATUS REPORT

To Be Completed by Applicant's Payroll/Benefits Officer
State Budget and Control Board, Employee Benefits Division
South Carolina Retirement Systems
Attention: Customer Services Annuity Claims
PO Box 11960, Columbia, SC 29211-1960

☑ SCRS ☐ PORS ☐ GARS

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.

Employee Name: Sara Y. Wilson
Social Security Number: [redacted]
Employer: Charleston County School District
Employer Code: 810.01
Position Title: Student Data Clerk

1. Is the position title shown above correct?
◉ Yes ○ No (please explain)

2. Annual salary on date of disability:
$ 26,107.44

3a. Is the employee currently working?
◉ No (last day physically worked): 5-9-06 MM-DD-YYYY (skip to Question 4a)
○ Yes (proceed to Question 3b)

3b. Is the employee performing all regular duties?
○ Yes (skip to Question 8a)
○ No (proceed to Question 3c)

3c. In what capacity is the employee currently working?
○ Light duty* ○ Diminished capacity* ○ Leave without pay (not terminated) (attach copy of Personnel Policy)
○ Reduced hours
○ Other (please explain)

*Attach letter explaining current duties in relation to normal work functions.

3d. Date member was placed in status shown at left: MM-DD-YYYY

4a. Is this employee terminated?
○ No (skip to Question 5)
◉ Yes (date of termination): 9-11-06 MM-DD-YYYY (proceed to Question 4b)

4b. Last day compensation was earned (including pay continuation, using annual and sick leave):
9-11-06 MM-DD-YYYY

4c. Amount of lump-sum payments for unused leave
Annual leave $
Sick leave $

4d. Number of days of unused leave: (complete and proceed to Question 8a)
Annual leave ∅
Sick leave 9.37 days

5. Employee's current payroll status (check one and indicate appropriate date):
○ On annual leave (date leave began): MM-DD-YYYY
○ On leave without pay (date leave began): MM-DD-YYYY
○ On sick leave (date leave began): MM-DD-YYYY
○ Applied for leave under sick leave bank, (date leave begins): MM-DD-YYYY
◉ Other (please explain): Retirement 9-11-06

8a. Was this employee injured on the job?
○ No ◉ Yes (date of injury) MM-DD-YYYY

8b. Is employee on leave without pay (not terminated) pending settlement of a Workers' Compensation claim?
◉ No ○ Claim settled (date): MM-DD-YYYY
○ Yes

I hereby certify that to the best of my knowledge, the information above correctly reflects the records of the employing entity.

Prepared by Annette M. Heyward Title HR Technician
Signature Annette M. Heyward Date 10-2-06 Telephone 843-937-6366

Return completed form to the SC Retirement Systems (address above).
Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800

Form 6253
Revised 02/03/2004
Print or type in black ink

EMPLOYER'S DISABILITY EMPLOYMENT STATUS REPORT

To Be Completed by Applicant's Payroll/Benefits Officer
State Budget and Control Board
South Carolina Retirement Systems
Attention: Customer Service Annuity Claims
PO Box 11960, Columbia, SC 29211-1960

☑ SCRS ☐ PORS ☐ GARS

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above at your earliest convenience. Upon receipt of this completed form, the employee's application will be processed.

Employee Name: Sara Y. Wilson | Social Security Number: [redacted]

Employer: Charleston County School District | Employer Code: 8[illegible]01

Position Title: Student Data Clerk

1. Is the position title shown above correct?
☑ Yes ☐ No (please explain)

2. Annual salary on date of disability: $ [illegible]

3a. Is the employee currently working?
☐ No (last day physically worked): _____ MM-DD-YYYY (skip to Question 4a)
☑ Yes (proceed to Question 3b)

3b. Is the employee performing all regular duties?
☑ Yes (skip to Question 6a)
☐ No (proceed to Question 3c)

3c. In what capacity is the employee currently working? ☐ Leave without pay (not terminated) (attach copy of Personnel Policy)
☐ Light duty* ☐ Diminished capacity*
☐ Reduced hours
☐ Other (please explain): _____

*Attach letter explaining current duties in relation to normal work functions.

3d. Date member was placed in status shown at left: _____ MM-DD-YYYY

4a. Is the employee terminated?
☐ No (skip to Question 5)
☐ Yes (date of termination): _____ MM-DD-YYYY (proceed to Question 4b)

4b. Last day compensation was earned (including pay continuation, using annual and sick leave): _____ MM-DD-YYYY

4c. Amount of lump-sum payments for unused leave
Annual leave $ _____
Sick leave $ _____

4d. Number of days of unused leave: (complete and proceed to Question 6a)
Annual leave _____
Sick leave _____

6. Employee's current payroll status (check one and indicate appropriate date):
☐ On annual leave (date leave began): _____
☐ On sick leave (date leave began): _____
☐ Other (please explain): _____
☐ On leave without pay (date leave began): _____
☐ Applied for leave under sick leave bank (date leave begins): _____

6a. Was this employee injured on the job?
☑ No ☐ Yes (date of injury): _____ MM-DD-YYYY

6b. Is employee on leave without pay (not terminated) pending settlement of a Workers' Compensation claim?
☑ No ☐ Claim settled (date): _____
☐ Yes MM-DD-YYYY

I hereby certify that to the best of my knowledge, the information above correctly reflects the records of the employing entity.

Prepared by: Annette M. Heyward Title: HR Technician

Signature: Annette M. Heyward Date: 9-27-06 Telephone: 843-937-6360

Return completed form to the SC Retirement Systems (address above).

Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6600

SARA Y. WILSON Prince - PAGE #18

CHARLESTON COUNTY SCHOOL DISTRICT

DIVISION OF PERSONNEL SERVICES
The Center Building, Hutson and Meeting Streets
Charleston, South Carolina 29403
803/724-7707

Dr. Rodney E. LeBoeuf
Superintendent

Dr. Barbara D. Dilligard
Deputy Superintendent

Application For Classified Non-Administrative Position

POSITION(S) DESIRED

Check position for which application is made

Bus Driver ___ Lunchroom ___ School Nurse ___ Teacher Assistant ___ Substitute Teacher ___

Clerical (specify position) Clerk Typist

Data Processing (specify position) _____

Maintenance (specify skill area(s)) _____

Other (Please specify) _____

PERSONAL DATA

Name Wilson (Last) Sara (First) Young (Middle)

Address [redacted]

City Charleston State SC Zip [redacted]

Telephone 724-7763 (Work) [redacted] (Home) Social Security Number [redacted]

Please list relative(s) employed with the Charleston County School District and his/her/their employment assignment(s). n/a

RECEIVED
JUL 26 1994
DEPARTMENT OF EMPLOYMENT

COMPLETE ONLY IF APPLYING FOR OFFICE WORKER POSITION

Check skills in which you are proficient.

Computor (specify types) NCR, Apple, MacIntosh, & IBM

Key Punch Machine ___ Calculator ✓ Memory Typewriter ✓

Transcribing Machine ___ Word Processing ✓

Other office machines (specify) Copier & fax machine

EDUCATION/TRAINING	List schools attended including high school, business school, or other.				
	INSTITUTION AND LOCATION	FROM TO	COURSE OF STUDY	NO. OF YRS. COMPLETED	DIPLOMA OR DEGREE
1	Burke High School Chas. SC	'57-'61	Business	4 yrs.	Diploma & Business Cert.
2	Palmer College	'63-'64	Busines	1 yr.	Certificate
3	College of Charleston	'90-'91	Intro to Computers	1 semester	
4					
5					
6					
7					

OTHER RELEVANT DATA: *(Include employment in non-education fields, special training, special experiences, military experience, etc.)*

College of Charleston
Dos, Lotus 1-2-3, Word Processing & D-Base.

Training Alliance
OSIRIS I, II — Intro to Dos 5.0
Q's A I, II — Word Perfect 6.0 I, II

I have been doing the daily attendance for the last two school terms when our clerk or secretary was absent.

} Copies where sent to Mr. Prislan to go in my records in Personnel Office Certificates

GENERAL INFORMATION:

1. *Have your ever been convicted of a felony or a misdemeanor involving moral turpitude regardless of the sentence received? If yes, please explain on a separate sheet of paper and attach to this form.*
   ✓ *No* ___ *Yes, please see attachment.*

2. *Have you ever been asked to resign or been discharged from any position in education or related to the type of position for which your are applying?* ✓ *No* ___ *Yes, please see attachment.*

3. *Have you ever been employed by CCSD? If yes, please provide dates of employment, positions, and any other names under which you worked.* ___ *No* ✓ *Yes*
   1985 - Present

EMPLOYMENT *This section must be completed in addition to submitting a resume'. Please give an accurate and complete record of your full and part-time employment. Start with your current or last assignment. Use additional paper, if necessary.*

1

School/District/CompanyName: James Simons Elementary - Dist. 20
Address: 741 King St.
Name and Title of Supervisor: Brenda Williams, Prin.
Reason for Leaving: Career Advancement

Telephone (724) - 7763
Employed (State Month and Year)
From: Aug. '92 To: Present
State Your Job Title and Describe Your Work: Media Clerk- Processing books, Assisting Media Spec. w/students, Distributes & receives equip., Shelve books, late notices, etc.

2

School/District/Company Name:
Address: Same as above
Name and Title of Supervisor: Nathaniel Washington, Principal
Reason for Leaving: Permanent Position & Benefits

Telephone (803) - 724-7763
Employed (State Month and Year)
From: Aug. '92 To: 1985 From: 1985 To: 1992
State Your Job Title and Describe Your Work: Substitute Teacher- Several Long Term Assignments. Working with students in teachers absence. K-1 (Nov. '86-June '87) Music (Sept.-Dec. 1987?) Media Clerk (Twice for 6 weeks, & Art (Oct. '90-June '

3

School/District/Company Name: Sears, Roebuck & Co.
Address: Calhoun & ST. Phillip Streets.
Name and Title of Supervisor: Mary Martin, Head Supervisor
Reason for Leaving: Resigned for Health Reasons

Telephone (?) -
Employed (State Month and Year)
From: April 1973 To: June 1981
State Your Job Title and Describe Your Work: Training new employees, Gift Wrapping, & Serving Customers (Credit, Customer service, & Cashier)

4

School/District/Company Name:
Address:
Name and Title of Supervisor:
Reason for Leaving:

Telephone ( ) -
Employed (State Month and Year)
From: To:
State Your Job Title and Describe Your Work:

We may contact the employers listed above unless you indicate those you do not want us to contact.
I give my permission for a CCSD representative to receive confidential references regarding my work performance.
V Yes ____ No

DO NOT CONTACT
Employer No. (s) ____
Reason(s): ____

REFERENCES	Please include the last supervisor with whom you worked.		
	PERSON/POSITION (To be contacted)	ADDRESS	PHONE
1	Mr. Nathaniel Washington Retired Principal James Simons	[redacted] Charleston, SC [redacted]	[redacted]
2	Brenda William, Priv. James Simons Elem.	[redacted] Charleston, SC [redacted]	[redacted]
3	Angie M. Evans, V. Principal James Simons	[redacted] Charleston SC [redacted]	[redacted]
4	Deborah Washington V. Prin. Oakland Elem.	[redacted] Charleston, SC [redacted]	[redacted]

I give my permission for a Charleston County School District (CCSD) representative to receive confidential references regarding my work performance as a CCSD employee and/or with other employers. I understand that by responding "yes", I waive my right to review these references. Such references will be held in strict confidence and will be used by CCSD for employment decision making only.

CHECK ONE PLEASE: ✓ Yes _____ No

A State Law Enforcement (SLED) background reference check will be conducted on all applicants. Additional reference checks may be necessary for selected positions. If this is required, a Charleston County School District representative will inform you of this requirement.

Additional Record Check Required: _____ Yes _____ No

If yes, please indicate type:

____ Credit Record Check

____ Other, Please specify _____

I hereby certify that the above information is true, accurate and complete to the best of my knowledge and belief. Any misrepresentation or willful omission of fact shall be sufficient cause for disqualification of this application or termination of employment. Further, I understand that this application and records become the property of the District, which reserves the right to accept or reject it. I further agree to observe all rules, regulations, and policies of the District. I hereby authorize the District to conduct work history, personal reference and criminal record inquiries to determine my acceptability for employment.

SIGNED Sara Y. Wilson DATE 7/19/94

THIS APPLICATION IS NOT COMPLETE WITHOUT A SIGNATURE.

The Charleston County School District is an Equal Opportunity Employer and does not discriminate in employment on the basis of race, color, sex, religion, national origin, marital status, age, or handicapping conditions.

FOR PERSONNEL USE ONLY

E____INE____R1____R2____R3____NTE____AC____SCC____OSC____BY____

REF TO: _____

South Carolina Workers' Compensation Commission
P.O. Box 1715 ▪ 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0608517
Carrier File #
Carrier Code #
Employer FEIN

Sara Y. Wilson [redacted] SSN
Claimant's Name

[redacted] SC [redacted]
Address City State Zip

[redacted] (843)
Home Phone # Work Phone #

Charleston County School District
Employer's Name
75 Calhoun Street Charleston, SC 29401
Address City State Zip

Charleston County School District c/o The Schaffer Companies Limited
Insurance Carrier

Tiffany Spann-Wilder, Esquire, Attorney for Claimant (843) 266-7792
Preparer's Name Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

[X] Injury by Accident [ ] Occupational Disease [ ] Both Injury by Accident & Disease [ ] Other

1. Date of accident: 05/09/06 2. AWW: $ 502.87(disputed) Comp. Rate: $335.00 (disputed)

3. Type of injury and body part(s): right arm, right shoulder, neck, back, right leg/hip, left leg & headaches

4. Facts in controversy: See Attached Addendum.

5. Legal issues involved: (1)Determination of the Claimant's need for medical treatment including but not limited to back, neck, both arms and both legs §42-15-60 & Davis v. Bruccoli, Clark, Layman, Inc. and Companion Property & Casualty Co. 514 SE 2nd 593; (2) Compensable Accident §42-1-160 for all body parts pled; (3) Entitlement to past, present and ongoing medical treatment, §42-15-60; (4) Entitlement to compensation under the SC Workers' Compensation Act- §42-9-10; (5) Determination of the appropriate AWW/CR under §42-[illegible]; (6) TTD Disability Benefits from June 7, 2006 to August 7, 2006; (7) Entitlement to ongoing temporary compensation; (8) Reimbursement to Claimant and subrogation to insurance carrier; (9) If at Maximum Medical Improvement (MMI), a finding of permanent total disability under §42-9-10 or with alternative under §42-9-20; (10) Lifetime Medical treatment and prescriptions for all body parts pled per Dr. Alexander's notes of; and (11) Lump sum payment & UTICA Mohawk Language.

6. Unusual problems: Not been provided with Claimant's most recent performance evaluation per subpoena. Reserve the right to supplement.

7. Witnesses (designate if expert)*: The Claimant and all other witnesses listed by the Defendants.

8. Exhibits: Medical Records & Personnel Records.

9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance)
APA (3) Roper Hospital-(Hospital)- medical records -5/9/06 -(8 pages);
APA (4) W Pettigrew Clare, Sr.-(Internal Medicine) -5/12/06 and 8/12/06- (4 pages);
APA (5) Doctors Care West Ashley - medical records- 5/20/06 to 5/31/06- (5 pages);
APA (6) Tri-County Radiology Associates- - 5/25/06- (2 pages);
APA (7) Private Therapy Services- (Physical Therapy)- 6/13/06 to 8/15/06 (23 pages);
APA (8) Dr. R. Blake Dennis-(Palmetto Orthopaedics of Charleston)- 6/6/06 to 7/18/06 (8 pages);
APA (9) Dr. J. Robert Alexander(Spine,& Orthopaedic Specialists of SC)- medical records- 7/27/06 to 11/17/06 (24 pages);
APA (10) Dr. James K. Aymond-(Orthopaedic Specialist of Charleston)- 1/16/07 (8 pages);
APA (11) Dr. Beverly M. Genez-(Charleston Neuroscience Institute)- 1/16/07 (2 pages);
APA (12) Deposition of Sara Wilson- 1/23/07 (56 pages);
APA (13) Deposition of William Dixon-(Corporate Designee- 1/23/07 (25 pages);
EXH (A) Charleston City Police Department-(Incident Report)- 5-9-06 (2 pages);
EXH (B) Personnel Records - Charleston County School District- (20 pages);
EXH (C) SC Retirement System- 9/28/06 to 9/29/06 (3 pages); and
EXH (D) MISC Documents- 12/20/06 to 1/11/07 (3 page).

10. Name, address, and specialty, if any, of the treating physician: Dr. James Aymond (Orthopaedist) -(Orthopaedic Specialists of Charleston), 2093 Henry Tecklenburg Drive, Charleston, SC 29414; Dr. J. Robert Alexander -(Spine & Orthopaedic Specialists of SC), 2145 Henry Tecklenburg Drive, Ste. 220, Charleston, SC 29414; Dr. Don O. Stovall (Lowcountry Orthopaedics & Sports Medicine), 2880 Tricom Street, N. Charleston, SC 29406, Dr. R. Blake Dennis (Palmetto Orthopedics of Charleston), 615 Wesley Drive, Suite 100, Charleston, SC 29407.

11. Impairment rating(s); body part(s); physician and date of opinion: Claimant is not at MMI and is in need of surgery for the neck and treatment for back, both arms and both legs. *11/16/06 Dr. Alexander "subsequently determined to be at MMI given she has undergone exhaustive non-operative conservative measures."*

Signature: Tiffany R. Spann-Wilder

DATE OF HEARING: February 20, 2007 -- North Charleston, S.C. TIME OF HEARING: 3:30 P.M.
On behalf of [X] Claimant [ ] Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212.
*Commissioners reserve the right to admit expert witnesses at hearings.

WCC Form 58 - Pre-Hearing Brief
SARA WILSON v. CHARLESTON COUNTY SCHOOL DISTRICT
WCC File No. 0608517

The Claimant is sixty-three (63) years old, widowed and has a high school diploma. She has been employed with Charleston County School Districts since 1986. She has worked in various capacities such as Substitute Teacher, Clerk Typist and lastly as a Data Technician concentrating on Attendance matters but essentially assisting the Principal for other duties assigned whether that be school secretary, preparing bulletin boards, running errands throughout the school, classroom monitor or monitor to children who are not able to reside in the mainstream classes and have "special needs". Her position was at James Simons Elementary School.

On May 9, 2006 the Claimant who stands 4'11" and 115 pounds was assaulted when 2 male students (who were overaged for Elementary School) engaged in fight and their fight pushed them into the Claimant. Her body hit the Secretary's desk along her right side and she landed with her body laid half across the marble countertop. She was escorted by the School Nurse to Roper Hospital and has had consistent complaints that have been ignored by the carrier. They have focused solely on her cervical spine and nothing else. Dr. Dennis stated that he did not believe the surgery would provide any relief for Claimant's neck and put her in pain management with Dr. Alexander. The 2nd opinion by Dr. Stovall says too that he does not think her neck will improve by surgery only her right leg and arm symptoms but made no definitive statement about her neck. Claimant sought another opinion with Dr. Aymond to address all symptoms, he was only able to address the cervical and lumbar spine. His opinion to a medical certainty is that the surgery will help the Claimant. She has been looking for a physician who would speak candidly and Drs. Dennis and Stovall have not fit and have spoken half-heartedly about the procedure at best. Dr. Dennis even says he doesn't think it would meet *her* level of expectation. Dr. Alexander had the Claimant at a permanent part-time sedentary position. She tried working under these standards for 2-3 days and Charleston County returned her to TTD status. If the Claimant is found to be at MMI then she is totally disabled or in the alternative partially disabled based on the last restrictions of Dr. Alexander for her work capacity.

She is currently retired under the SC Retirement system and pursuing disability retirement.

Claimant is seeking to have the Hearing Commissioner find:

(1) Determination of the Claimant's need for medical treatment including but not limited to back, neck, both arms and both legs §42-15-60 & Dodge v. Bruccoli, Clark, Layman, Inc. and Companion Property & Casualty Co. 514 SE 2nd 593;

(2) Compensable Accident, §42-1-160 for all body parts pled;

(3) Entitlement to past, present and ongoing medical treatment, §42-15-60;

(4) Entitlement to compensation under the SC Workers' Compensation Act- §42-9-10;

(5) Determination of the appropriate AWW/CR under §42-1-40;

(6) TTD Disability Benefits from June 7, 2006 to August 7, 2006;

(7) Entitlement to ongoing temporary compensation;

(8) Reimbursement to Claimant and subrogation to insurance carrier;

(9) If at Maximum Medical Improvement (MMI), a finding of permanent total disability under §42-9-10 or in alternative under §42-9-20;

(10) Lifetime Medical treatment and prescriptions for all body parts pled per Dr. Alexander's notes of 11/16/06; and

(11) Lump sum payment & UTICA Mohawk Language.

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON SARA WILSON, Claimant, vs. CHARLESTON COUNTY SCHOOL DISTRICT, Employer, and THE SCHAFFER COMPANIES, LTD, Carrier, Defendants.	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION WCC FILE NO.: 0608517 NOTICE OF WITNESSES AND WRITTEN MEDICAL REPORTS TO BE INTRODUCED AS DIRECT EVIDENCE ON BEHALF OF CLAIMANT

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION and LESLIE WHITTEN, ESQUIRE, ATTORNEY FOR THE DEFENDANTS

YOU ARE HEREBY NOTIFIED that the Claimant, pursuant to the provision of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended) herewith submits the following medical

APA (3) Roper Hospital-(Hospital)- medical records -5/9/06 -(8 pages);
APA (4) W Pettigrew Clare, Sr. (Internal Medicine) -5/12/06 and 8/12/06- (4 pages);
APA (5) Doctors Care West Ashley - medical records- 5/20/06 to 8/31/06- (5 pages);
APA (6) Tri-County Radiology Associates-(Specialist in Outpatient Imaging)- 5/25/06- (2 pages);
APA (7) Private Therapy Services- (Physical Therapy)- 6/13/06 to 8/15/06 (23 pages);
APA (8) Dr. R. Blake Dennis-(Palmetto Orthopaedics of Charleston- 6/6/06 to 7/18/06 (8 pages);
APA (9) Dr. Alexander- medical records- 7/27/06 to 11/17/06 (24 pages);
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EXH (B) Personnel Records - Charleston County School District- (20 pages);
EXH (C) SC Retirement System- 9/28/06 to 9/29/06 (3 pages); and
EXH (D) MISC Documents- 12/20/06 to 1/11/07 (3 page).

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 depositions of any of the physicians, whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Employee/Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant: The Claimant and all other witnesses listed by the Defendants.

The Spann-Wilder Law Firm, L.L.C.
2131 Dorchester Road
P.O. Box 70488
N. Charleston, SC 29415
(843) 266-7792

This 12th day of February, 2007.
North Charleston, South Carolina

Tiffany R. Spann-Wilder, Esquire
Attorney for the Claimant

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 0608617

SARA WILSON, Employee/Claimant
vs.
CHARLESTON COUNTY SCHOOL DISTRICT, Employer; and
THE SCHAFFER COMPANIES LTD, Carrier

APA SUBMISSIONS

HEARING ON FEBRUARY 20, 2007 - 3:30 p.m - Commissioner Funderburk

PHYSICIAN	PRACTICE	DATES OF SERVICE	PAGE NUMBERS
3. Roper Hospital		5/9/06	Pages 6-13
4. W. Pettigrew Clare, Sr.	Internal Medicine	5/12/06 and 9/12/06	Pages 14-17
5. Doctors Care West Ashley		5/20/06-5/31/06	Page 18-22
6. Tri-County Radiology Assoc.		5/25/06	Pages 23-24
7. Private Therapy Services	Physical Therapy	6/13/06 to 8/15/06	Pages 25-47
8. Dr. R. Blake Denn's	Palmetto Orthopaedics of Charleston	6/16/06 to 7/18/06	Pages 48-55
9. Dr. J. Robert Alexander	Spine & Orthopaedic Specialist of SC	7/27/06 to 11/17/06	Pages 56-79
10. Dr. James K. Aymond	Orthopaedic Specialist of Charleston	1/16/07	Pages 80-87
11. Chas. Neuroscience Inst.	Diagnostic Imaging	1/16/07	Pages 88-89
12. Dep. of Sara Wilson		1/23/07	Pages 56
13. Dep. William Dixon	Corporate Designee	1/23/07	Pages 25

EXHIBIT	ORGANIZATION	DATES OF SERVICE	PAGE NUMBERS
A. Charleston City Police Dept.	Incident Report	5/9/06	Pages 90-91
B. Personnel Records	Charleston County School District		Pages 92-112
C. SC Retirement System		9/28/06- 9/29/06	Pages 113-115
D. MISC Documents		12/20/06 - 1/11/07	Pages 116-118

ROPER ST FRANCIS HEALTHCARE

ADMISSION RECORD

D/C

MED. REC. #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM NO.	PAT TYPE	F.C.	BU/ACCT #
000309896	05/09/06 1238	16		MED	ERA	-	ERA	B	05129-00916

PATIENT

LOCATION(S)	REL	PAT. CLA	PUB/VAL	LNG	SEX	RACE	MS	DATE OF BIRTH	AGE
ERA	MET		/N	E	F	B	W	[redacted]43	62

PATIENT NAME AND ADDRESS	SOC-SEC-NO	PATIENT EMPLOYER	TELEPHONE NO.
WILSON,SARA Y [redacted] CHARLESTON, SC [redacted]	[redacted] PH TELEPHONE NO. [redacted]	CHAS CTNY SCH DIST 75 CALHOUN ST CHARLESTON, SC 29401	(843)805-671[redacted]

GUARANTOR / **EMPLOYERS**

GUARANTOR NAME AND ADDRESS	SOC-SEC-NO.	GUARANTOR EMPLOYER	TELEPHONE NO.
WILSON,SARA Y [redacted] CHARLESTON, SC [redacted]	[redacted] TELEPHONE NO. [redacted] RELATION SELF	CHAS CTNY SCH DIST 75 CALHOUN ST CHARLESTON, SC 29401	(843)805-671[redacted]

INSURANCE

INSURANCE 1	INSURANCE 2
BCBS STATE HEALTH PLAN PO BOX 100605 COLUMBIA, SC 29260-0605 CHARLESTON C [redacted]2100 [redacted]6756 WILSON,SARA;Y	

MISC.

IN CASE OF EMERGENCY NOTIFY	SPOUSE
ROBINSON,CHARLES OTHER HM: [redacted] WK: [redacted]	NOT,GIVEN OTHER HM: WK:

ADM DX/PRESENTING COMPLAINT	ARRIVAL MODE	ADM TYP/SOURCE
INJURY TO ANTERIOR CHEST WALL 05/09/06	WHEEL CH	1 / 1

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
MCADAMS-MD,DOUGLAS	MCADAMS-MD,DOUGLAS	CLARE SR-MD,W PETT	CLARE SR-MD,W PETTIGRE

ALERTS	PREVIOUS ADM DATE	OPT OUT	DR	FND	MKT	PHN	PRIMARY	ALT.		BY
NO NONE	02/14/06	OPT OUT	No		A	MSG	Yes			AC

FOR EMERGENCY DEPARTMENT USE ONLY

ALLERGIES	TEMP#	RESP#	PULSE#	BP#	TIME	SIGNATURE
						RS

PRINCIPAL DIAGNOSIS:

	DRG
OTHER DIAGNOSISIES:	CODE(S) 78.
	786.
PRINCIPAL OPERATION/PROCEDURE:	1.4.
	3.17
OTHER OPERATION(S)/PROCEDURE(S):	

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED PHYSICIAN SIGNATURE: _____ DATE: _____

6

Roper Hospital, 316 Calhoun Street, Charleston, SC 29401 | Roper St. Francis Hospital, 2095 Henry Tecklenburg Drive, Charleston, SC 29414 | Roper Rehabilitation Hospital, 316 Calhoun Street, Charleston, SC 29401 | Roper Berkley Day Hospital, 730 Stony Landing Road, Moncks Corner, SC 29461

CHART COPY

Roper Hospital
316 Calhoun Street
Charleston, SC 29401

Final

Emergency Department Chart

Patient Name: WILSON, SARA Y.	Account Number: 0612900916
Medical Rec. Number: 000609696	Birthdate: [redacted]/1943
Visit Date: 05/09/2006 12:29	Primary MD: W CLARE SR-MD MD

Vital Signs/Data

Time	Temperature	Pulse	Respiration	Blood Pressure	Pulse Oximetry	Pain
12:30	97.9 F Oral	76 /min	16 /min	163/86 mm hg.	100%	9/10
16:05						4/10

Allergies

AMOXICILLIN (05/09/2006 13:26)
CIPROFLOXACIN (13:26)
CODEINE (13:26)
PENICILLIN AND ANALOGUES Severe - causes Unknown (13:26)
PROPOXYPHENE (13:26)
QUINOLONES Severe - causes Unknown (13:26)
PENICILLINS (SSM 12:30)
CODEINE (SSM 12:30)
Aspirin (SSM 12:30)
Darvocet-N 100 (SSM 12:30)

Chief Complaint

Injury to anterior chest wall. (SSM 05/09/2006 12:30)

Pre-Hospital Treatment

Patient arrived by private transportation. (SSM) 05/09/2006 12:30

Triage

4-Non-urgent (SSM 05/09/2006 12:30)
Influenza was given -no . (SSM 12:30)
Pneumonia Vaccine was given -no . (SSM 12:30)
Tetanus within last 10 years. (SSM 12:30)
No language barrier. (SSM 12:30)
Due to the increase in domestic violence, we ask all patients: Are you being hurt, hit, or frightened by anyone at home or in your life? (SSM 16:05)
Domestic violence survey NEGATIVE risk for this elderly patient. (SSM 16:05)
Onset of symptoms was 30 minutes ago. (SSM 12:30)
History comes from patient. (SSM 12:30)
Patient has no history of tobacco use. (SSM 12:30)
Patient denies use of alcohol. (SSM 12:30)
Patient denies illicit drug use. (SSM 12:30)
Patient indicates no infectious disease risk factors. (SSM 12:30)
Patient is triaged to the Main ER WR. (SSM 12:30)

Height/Weight

Hgt: 59 Inch (SSM 05/09/2006 12:30)
Wgt: 53.2 kg (SSM 12:30)

Roper Hospital
316 Calhoun Street
Charleston, SC 29401

Final

Emergency Department Chart

Patient Name: WILSON, SARA Y.	Account Number: 0812900916
Medical Rec. Number: 000609096	Birthdate: [redacted]/1943
Visit Date: 05/09/2006 12:29	Primary MD: W CLARE SR-MD MD

Current Medications

LIBRAX 1 tablet Oral Every pm [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (02/10/2006 17:28)
Zoloft 50 mg Oral Every am [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Premarin 0.9 mg Oral Every am [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Micardis 40 mg Oral Every am [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Lanoxin 250 mcg Oral Every pm [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Vitamin E 1 tablet Oral Every am [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Toprol XL 50 mg Oral Every am [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Nexium 40 mg Oral Every am [Confirmed by SHELLEY SOLOMON RN on 02/14/2006 09:04:00.] (17:28)
Patient takes medications. (SSM 05/09/2006 12:30)
Ultram 1 tablet Oral Every 4 hrs as needed [Confirmed by SUSAN S MOMEIER RN on 05/09/2006 16:07:00.] (SSM 16:07)

Nursing Assessment

GENERAL
NEGLECT/ABUSE: Survey shows NEGATIVE risk for this patient. (SSM) 05/09/2006 12:30

Nursing Continuation Notes - Refer to Order

Dr McAdams in to see pt (VSG 05/09/2006 14:41)

Treating Provider Summary

Pushed against counter by fighting students at school. c/o pain Rt anterior ribs. Also, c/o pain Rt prox thigh and shoulder. No SOB, abdominal pain, n/v. (DSM) 05/09/2006 14:34

Clinician History of Present Illness

States she was pushed against a counter while 2 children were fighting at school. (SSM) 05/09/2006 12:32 Exam started at 14:27. Presenting problem started minutes ago. History comes from patient. Have reviewed and agree with RN note. Able to get a good history. Patient's injury occurred while she was pushed against counter by fighting students. Complains of rib/chest wall pain affecting the right hemithorax. This is described as mild. No penetrating wounds. Adequate circulatory status with no significant respiratory complaints at this time. No pleuritic component, trouble breathing or hemoptysis. Denies abdominal pain. The skin over the right shoulder is intact. No active bleeding or abrasions. Patient complains of pain over the right shoulder. Sustained contusion type of injury to right shoulder. right hip hurts. No history of ecchymosis over the right hip. Normal ambulation and weight bearing. Problem occurred at school. (DSM) 05/09/2006 14:27

Review of Systems

Problem specific ROS otherwise negative. (DSM) 05/09/2006 14:27

Family History

No relevant family history related to current problem. (DSM) 05/09/2006 14:27

Physical Exam

GENERAL:
Vital signs reviewed. Alert The patient appears to be comfortable. (DSM) 05/09/2006 14:27

ENT:
Pharynx normal. The neck is supple, with no evidence of meningismus. (DSM) 05/09/2006 14:27

B

Emergency Department Chart

Patient Name: WILSON, SARA Y.	Account Number: 0612900916
Medical Rec. Number: 000609896	Birthdate: [redacted]1943
Visit Date: 05/09/2006 12:29	Primary MD: W CLARE SR-MD MD

Physical Exam

EYE EXAM:
Pupils are reactive to light. Normal extraocular movements without diplopia or entrapment. (DSM) 05/09/2006 14:27

PULMONARY:
The area over the right chest to lower costal margin is minimally tender to palpation. No chest wounds or lacerations noted. Currently in no acute respiratory distress. Normal, non labored respirations. The breath sounds are normal, with good equal air movement. (DSM) 05/09/2006 14:27

CIRCULATORY:
Regular rate and rhythm. No murmur. No rub. (DSM) 05/09/2006 14:27

ABDOMEN:
The abdomen is soft and nontender to palpation. No organomegaly. (DSM) 05/09/2006 14:27

NEUROLOGIC:
Alert, oriented to person, place, and time. No motor deficit. (DSM) 05/09/2006 14:27

MUSCULOSKELETAL:
The patient has mild to moderate pain with movement affecting the right hip and iliac crest. Moderately tender to palpation over the right hip and iliac crest. Findings are localized over the anterior aspect of the hip. The patient has mild to moderate joint pain with movement of the right shoulder. Moderately tender to palpation over the right shoulder. No evidence of soft tissue swelling over the right shoulder The rest of the shoulder exam is normal. No contractures or significant decrease in ROM. The distal neuro vascular exam is intact. Strength is appropriate for patient's build. No extremity edema. (DSM) 05/09/2006 14:27

SKIN:
Skin color is normal. Warm. Dry to touch. (DSM) 05/09/2006 14:27

PSYCHIATRIC:
Mood and affect normal. (DSM) 05/09/2006 14:27

Consultations

Pushed against counter by fighting students at school. c/o pain Rt anterior ribs. Also, c/o pain Rt prox thigh and shoulder. No SOB, abdominal pain, n/v. (DSM) 05/09/2006 14:34

Primary Diagnosis

Contusion shoulder (DSM 05/09/2006 15:56)
Local rib/chest wall pain (DSM 15:56)
contusions chest wall, Rt shoulder and Rt hip (DSM 15:56)

Drug Orders

Acetaminophen 1000 mg PO Single dose now
Entered (VSG 05/09/2006 13:27) In Progress (VSG 13:31) Completed (VSG 13:31) MD Sign (DSM 15:59) Notes: Just gave analgesic and antipyretic medication. (VSG 13:31)

Roper Hospital
316 Calhoun Street
Charleston, SC 29401

Final

Emergency Department Chart

Patient Name: WILSON, SARA Y.	Account Number: 0612900918
Medical Rec. Number: 000609896	Birthdate: [redacted]1943
Visit Date: 05/09/2006 12:29	Primary MD: W CLARE SR-MD MD

Non-Drug Orders

Dip urine
Entered (VSG 05/09/2006 13:27) Secretary Entered (EJ3 13:28) In Progress (VSG 13:46) MD Sign (DSM 16:59)
Rib series on the right
Entered (VSG 05/09/2006 13:30) Secretary Entered (EJ3 13:31) In Progress (VSG 13:46) Completed (VSG 13:46) MD Sign (DSM 15:59) Indications: Blunt chest injury Comments: Possible bruised broken ribs
Portable CXR - AP
Entered (VSG 05/09/2006 13:30) Secretary Entered (EJ3 13:31) In Progress (VSG 13:46) Completed (VSG 13:46) MD Sign (DSM 15:59) Indications: Blunt chest injury Comments: Possible bruised broken ribs
X-ray of right Femur
Entered (DSM 05/09/2006 14:44) Secretary Entered (EJ3 14:48) In Progress (SSM 15:02) Completed (SSM 15:02) MD Sign (DSM 14:44) Indications: Hip injury. Thigh injury

Results

Rib series - films were reviewed by me. (DSM 05/09/2006 15:55)
X-ray 2 view of chest - films were reviewed by me. (DSM 15:55)
No acute abnormalities seen on chest X-ray. (DSM 15:55)
Lung fields are clear. No loss of volume (DSM 15:55)
Normal cardiac shadow (DSM 15:55)
Negative for pneumothorax. (DSM 15:55)
X ray of right Femur - films were reviewed by me. (DSM 15:55)
No radiographic evidence of acute fracture. (DSM 15:55)

Disposition

Arrange for a follow up appointment with W CLARE SR-MD, MD in 3-5 days or immediately if your symptoms get worse. Patient discharged from department. Condition at discharge - stable. I have reviewed the chart of SARA Y WILSON and it is ready for final disposition - DOUGLAS S MCADAMS-MD MD. (DSM) 05/09/2006 15:56 Discharged home. Patient left by self. Verbalizes understanding of after-care instructions. Verbalizes understanding of need for follow-up and how to access follow-up care. Verbalizes understanding of signs and symptoms to return to ED. A discharge pain score was documented: Pain 4/10 at 16:05. A disposition has been done for SARA Y WILSON. The dispositioning nurse is SUSAN S MOMEIER RN (electronic signature). Patient removed from Tracking Board by SUSAN S MOMEIER RN. (SSM) 05/09/2006 16:05

Discharge Prescriptions

Ultram 1 capsule PO Q 4H PRN (15) (DSM 05/09/2006 15:56)

10

ROPER HOSPITAL IMAGING SERVICES

Name: WILSON,SARA Y
Exam Date: 05/09/06 1339
Ord. Phy.: DANIEL-MD,STEPHEN L

MR#: A000609896
DOB: [redacted]/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)724-2010
Phy. Fax #: (843)720-8345

DANIEL-MD,STEPHEN L
** 316 CALHOUN STREET
ER DEPT
CHARLESTON SC 29401

Acct_Nbr : A0612900916
Pat_Type : ERA

Chk-in #	Order	Exam	
1486059	0001	30144	XR CHEST 1 VIEW PA/AP
			Ord Diag: ;INJURY
1486060	0001	30410	XR RIBS UNILATERAL 2 VIEWS*R
			Ord Diag: ;INJURY

AP PORTABLE SUPINE CHEST AT 1349 HOURS: 05/09/06

INDICATION: Injury chest or chest contusion.

There is no pneumothorax. The soft tissues and bony thorax are unremarkable. There are no cardiac or pulmonary abnormalities.

IMPRESSION:

Normal AP supine chest radiograph.

UNILATERAL RIGHT RIB SERIES: 05/09/06

No fracture is demonstrated. AP and bilateral shallow oblique views were obtained. On these films, there is evidence of a mild thoracolumbar dextroscoliosis. No rib fractures are demonstrated. There are no osseous abnormalities. There is no pneumothorax, pleural effusion, or pulmonary infiltrate.

IMPRESSION:

ROPER HOSPITAL IMAGING SERVICES

Name: WILSON,SARA Y
Exam Date: 05/09/06 1339
Ord. Phy.: DANIEL-MD,STEPHEN L

MR#: A000609896
DOB: [redacted]/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)724-2010
Phy. Fax #: (843)720-8345

DANIEL-MD,STEPHEN L
** 316 CALHOUN STREET
ER DEPT
CHARLESTON SC 29401

Acct_Nbr : A0612900916
Pat_Type : ERA

[illegible]-Exam Code Summary
1486059-30144,1486060-30410

Normal right rib series.

sak

Transcriptionist- SHARON A KEENE
Reading Radiologist- PAMELA COYLE-MD
Releasing Radiologist- PAMELA COYLE-MD
Released Date Time- 05/10/06 1313

FINAL DUPLICATE

12

ROPER HOSPITAL IMAGING SERVICES

Name: WILSON,SARA Y
Exam Date: 05/09/06 1449
Ord. Phy.: MCADAMS-MD,DOUGLAS

MR#: A000609896
DOB: [redacted]/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)724-2010
Phy. Fax #: (843)720-8345

MCADAMS-MD,DOUGLAS
** 316 CALHOUN STREET
ER DEPT
CHARLESTON SC 29401

Acct Nbr : A0612900916
Pat Type : ERA

Chk-in #	Order	Exam	
1486161	0002	30180	XR FEMUR 2 VIEWS*R

Ord Diag:.;INJURY

RIGHT FEMUR: 5/9/06

AP, lateral and oblique views of the right femur were obtained. There is no evidence of fracture or dislocation. No acute bony or soft tissue abnormality is seen.

IMPRESSION:

Negative right femur.

sam

Transcriptionist- SHERRY E MULLINGS
Reading Radiologist- MICHAEL N BAGG-MD
Releasing Radiologist- MICHAEL N BAGG-MD
Released Date Time- 05/10/06 1255

W Pettigrew Clare
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARA Y — Encounter — 05-12-2006

Patient: WILSON, SARA Y Sex: F Physician: W Pettigrew Clare
Birth Date: [redacted]1943 Referring:
Birth Place: SSN: [redacted]
Patient_ID: 3616 Chart No.:

Description: routine Type: Office or Outpatient; Established
Seen By: W Pettigrew Clare Date: 05-12-2006
Signed By: Signed: Not Signed
Billing Note:

Medications	Started	Stopped	Sig	Sub
lanoxin 0.25mg	11-01-2005		1 PO QD	Y
librax	11-01-2005		1 PO QD	Y
Lorazepam 1mg	11-01-2005		1 po q TID prn	Y
meclizine 25mg	11-17-2005	05-12-2006	1 po QID prn	Y
micardis 40 mg	11-01-2005		1 PO QD	Y
nexium 40mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
nexium 40mg	05-12-2006		1 PO QDay	Y
premarin .9mg	05-12-2006		1 PO QDay	Y
premarin .9mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	05-12-2006		1 PO QDay	Y
vitamin e 400 iu	11-17-2005		1 PO QD	Y

Completed Labs	Ordered	Completed	Facility
Urinalysis	05-18-2006	05-18-2006	

Test Name	Data Value	Abnormal Flags	Lo Norm	Hi Norm	Units	Te Sta
leukocytes,urine	neg					
nitrite,urine	neg					
urobilinogen,urine	neg					
protein,urine	neg					
ph,urine	8		5.	8.5		
blood,urine	trace					
specific gravity	1.010		1.	1.03		
ketone,urine	neg					
bilirubin,urine	neg					
glucose,urine	neg					

CPT/HCPCS	Description	ICD	ICD Description
99213	office visit, established	959.8	INJURY MLT SITE/SITE NEC

Physician: W Pettigrew Clare . Note: 05-18-2006
Note Description: Progress Note /18/06

wt 114 bp 142/68 p 72 temp 97.0
urinalysis trace blood

The patient presents for painful injuries .

14

W Pettigrew Clare
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARAY Encounter 05-12-2006

HPI:She comes in stating that when she was at work in a room two students were fighting and came into the room with one of them being shoved into her knocking her down. Her shoulder and rib cage hit the corner of the desk on her way down,injuring her ribcage shoulder and leg. She went to the emergency room where X Rays of her ribs , femur, and chest the did not reveal any bony fractures. She was given an analgesics. she has continued to have considerable pain in her shoulder and reads. The pains are sufficiently bad that they interfere with her normal activities.

ROS
Respiratory: denies cough, dyspnea.
Cardiovascular: denies chest pains, palpitations, dyspnea
GI: denies abdominal pain, heartburn,nausia and vomiting or bowel problems
GENT/Genitourinary: denies urgency dysuria incontinence, nocturia
BJE/Musculoskeletal: As in present illness she is having neck pain , shoulder pain, pains in her right rib cage, and pains in her femur,

General Exam: she appears uncomfortable
Neck/Thyroid: She is tender in the posterior neck and shoulder muscles. There is.no limitation of motion although motion causes the pain to be worse .

Respiratory Effort- Lungs sound clear. She has marked tenderness in the right rib cage.

Heart findings: Her heart is a regular without significant murmur .

Gastrointestinal: There are no enlarged organs or masses . She does have some mild diffuse tenderness

Problems: Multiple trauma secondary to a fall. initiated by being hit by two students

Plan:
She is to continue analgesics .

She is to avoid any
activity and call me if no improvement

15

Printed by VersaForm 3.125 For W. Pettigrew Clare Sr., MD On 05/12/2006

Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843.723 5705

WILSON, SARAY — Encounter — 08-17-2006

CPT	CPT Description	ICD	ICD Description
36415	BLOOD DRAWING FEE	401.1	BENIGN HYPERTENSION
99213	office visit, established	722.4	CERVICAL DISC DEGEN
99213	office visit, established	401.1	BENIGN HYPERTENSION
36415	BLOOD DRAWING FEE	272.0	PURE HYPERCHOLESTEROLEM

Physician: W Pettigrew Clare Sr., MD Note: 08-17-2006
Note Description: Progress Note

urinalysis +2 protein, moderate blood

«chief complaint»

HPI:

ROS
Constitutional: denies anorexia, chills, fatigue, fevers, malaise, sweats, weight loss
Respiratory: denies cough, dyspnea.
Cardiovascular: denies chest pains, palpitations, dyspnea
GI: denies abdominal pain, heartburn,nausia and vomiting or bowel problems
GENT/Genitourinary: denies urgency dysuria incontinence, nocturia
BJE/Musculoskeletal: denies arthritis, back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness

«Multi-System Exam»

«E&M Problems»

«Plan_»

Physician: W Pettigrew Clare Sr., MD Note: 08-17-2006
Note Description: Progress Note

wt 115 bp 132/70 p 72 temp 95.0
blood sugar 116
urinalysis +2 protein, moderate blood

The patient presents for Follow up

HPI:She comes in with several problem. she continues to have neck and shoulder pain she other wise has been doing about the same. n. She additionally has been having urinary symptoms with frequency. She has been taken her medications as prescribed. She has been a concern because of some night sweats.

ROS
Respiratory: denies cough, dyspnea.
Cardiovascular: denies chest pains, palpitations, dyspnea
GI: denies abdominal pain, heartburn,nausia and vomiting or bowel problems
GENT/Genitourinary:As in present illness
BJE/Musculoskeletal: only as in present illness

Problems:
Urinary tract infection
degenerative disk disease

Plan:

16

Printed by VersaForm 3.128 For W. Pettigrew Clare Sr., MD On 09/12/2008

Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARAH — Encounter — 09/12/2006

She is given an antibiotic
she will continue her other medications
She will retuin in two months

17

Doctor Care DOCTORS CARE WEST P
1601 SAM RITTENBURG BLVD
CHARLESTON SC 29407
(843) 556-5585

PAT # Encounter#: 48486
PAT # 526410.0

DATE: 05/20/06 NAME: SARA WILSON 212 p

TIME: Sat May 20 13:42 SEX: F AGE: 62 BIRTHDATE: [redacted]/43

HOME ADDRESS: [redacted] CHARLESTON SC [redacted] Rm 2 HOME PHONE #: [redacted]

EMPLOYER: JAMES SIMONS ELEMENTARY BUSINESS PHONE #: (843) 805-6715

RESPONSIBLE PARTY: Sara y Wilson SS #: [redacted]

TIME BACK: 2-3 PRIMARY INS: [redacted] COMPANY

History (- or +, or details) [1/3, 2/3]

Personal Hx	Family Hx		Social Hx
DM	DM	Cancer:	alcohol
HTN	HTN	Colon	tobacco
CV	MI<50	Breast	drugs
Chol	CVA	Ovarian	reg exer.
Surg	Chol	Prostate	occup.

Prev chart rev., no sig chg ____ Above Hx reviewed DL

Preventive (year of last)

		Women	Men
Tetanus	2004	LMP	PSA
Cholesterol	04	Pap	Rectal
Colonoscopy	05	Mamm	
Flu Shot	—	BMD DEXA	
Pneumovax	—		

Circle recommendations

Allergies: "cillins" cortisone sulfa

Medications: Ultram, Toprol XR, Micardis 8 mg, Nexium HCT, Lipitor, Imitrex 25 mg, Atrovent

Vouchered into counter 6/9/06

WGT	BP	Pulse	Resp	Temp
115	116/60	64	12	97.9

Chief Complaint: Pain ER DOI: 5/19/06 Dr Chase

- ☐ general
- ☐ endo
- ☐ eent
- ☐ imm/allergy
- ☐ eyes
- ☐ muscle/skel
- ☐ cv
- ☐ hene/lymph
- ☐ rsp
- ☐ neuro
- ☐ gi
- ☐ m. status
- ☐ gu
- ☐ skin/breasts

HPI (4 items at least): pt slipped into counter in admin office by 2 students fighting - shoulder, back, but pt states she cannot remember exactly what happened during injury. pt evaled @ Roper ER - stressed xrays - was given pt & sent home on Ultram - pt taking 1 mild relief. pt then saw her PCP - eval'd for hematoma - had pulled up into pt WNL

PE: WNL Y42 Y08 P WNL HEENT WNL

Physical: (see reverse) Omit if N/A
(√ if nrml., O if abnrml & give details)

- ☐ general
- ☐ abd
- ☐ eent
- ☐ back Midline TTP along C.T. spine pain
- ☐ neck Supple
- ☐ ext
- ☐ nodes Head
- ☐ gu
- ☐ lungs
- ☐ neuro Gen'l decline, pulses, ROM, sensation intact
- ☐ cv
- ☐ skin/breasts

Tests/Labs in-house: CBC, Strep, Mono, U/A, H pylori, FBS, u preg, Home, microalbumin, HbA1c, KOH, wet prep, EKG, X-ray

Tests/labs sent out: 1598 Strep - 5/5 DTR

Injections/treatment: today c/o neck pain, upper back pain, midline TTP, limited ROM, pain with movement

PSR Notes: 99203 J3010

72100 NO
72070 ✓ (35)

ASSESSMENT/DIAGNOSIS/ES: Neck/Back Pain; Multiple Contusion

- ☐ Patient Care Instructions Discussed:
- ☐ Lifestyle Modification

Date to Return:
If worse or if not better: 1 wk
for follow up: prn

Go to ER if:

Off work/school Restrictions:

Referrals, tests, treatments: Ibuprofen 800 mg TID pt advised - Flexeril 10 mg TID prn

Prescriptions/OTC meds (SEP discussed): Rx PT (hold until pt RTW) RTC RTW - Espine D/C Ultram

Note: If outside tests are ordered, we will call with results, positive or negative. If you haven't heard from us in 5 – 7 days after the test, please call for results.

Staff: JM Jeanne Cash PA MD, DO, PA, FNP

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

Patient or Authorized Person's Signature: Sara y Wilson Date: 5/20/06

4. Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier, or other professionals involved in my care or rehabilitation, regarding my medical records and the treatment I have received or will receive.

Patient or Authorized Person's Signature: _____ Date: _____

18

RETURN T_ WORK FORM

CHARLESTON AREA

☐ BEAUFORT
1610 S. Ribaut Road
Port Royal, S.C. 29935
770-0676

☐ MT. PLEASANT
631 Johnnie Dodds Blvd
Mt. Pleasant, S.C. 29464
881-0816

☐ BLUFFTON
84 Bluffton Rd.
Bluffton, S.C. 29910
757-0676

☐ CHARLESTON WEST
3424 Shelby Ray Court
Charleston, S.C. 29414
402-6834

☐ SUMMERVILLE
10160 Dorchester Road
Summerville, S.C. 29485
871-7900

☐ _____

☐ NORTHWOODS
8091 Rivers Avenue
North Charleston, S.C. 29406
572-7000

☐ WEST ASHLEY
1851 Sam Rittenberg Blvd.
Charleston, S.C. 29407
556-5595

☐ _____

NAME: Sara Y. Wilson

DATE: 5/20/06

ARRIVAL TIME: 12:55

DISCHARGE TIME: ~~12:55 pm~~ 1:25

COMPANY NAME: James Simons Elementary/CCSD#20

WORK STATUS: (Check appropriate boxes)

☐ 1. May perform Full Duty work as of _____ without accommodations.

☐ 2. Off Duty due to work-related condition.
Estimated return to work date modified duty: _____.
Estimated return to work date full duty: _____.
Return for re-evaluation at this office on _____ Time: _____

☒ 3. May work with the following accommodations as of: 5/20/06.
- ☒ No lifting more than ~~_____~~ lbs.
- ☒ No operation of hazardous or fast-moving machinery; no driving.
- ☒ Ground level work only, no ladder or heights.
- ☒ No repeated bending, stooping, squatting, pushing, jerking, twisting or bouncing.
- ☒ No continuous standing and/or sitting.
- ☒ Minimum walking, climbing (includes stairs).
- ☐ Limited use of _____.
- ☒ No overhead lifting.
- ☐ No high repetitive hand activities for extended periods of time.
- ☐ No use of _____.

☐ 4. Has reached Maximum Medical Improvement (MMI).

☒ 5. Return for re-evaluation at this office on PRN Time: _____

COMMENTS: _____

PATIENT DISCHARGE INSTRUCTIONS: ☒ Diagnosis: Neck Pain, Muscle Strain, Whiplash Contusion

Medications: ☐ as directed ☒ as needed

Wound Care or Injury Care:
- ☐ keep dry & clean
- ☐ do not remove dressing
- ☐ Home exercise instructions given
- ☐ elevate extremity
- ☐ apply ice every _____
- ☐ Follow instruction sheet given
- ☐ warm soaks
- ☐ apply heat every _____
- ☐ Bed rest for _____
- ☐ wear elastic support/immobilizer/keep taped

REFERRAL: (If a referral is made to Therapy, or another Physician, please complete this section)

To: NKC Ospine Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my Employer.

EMPLOYEE SIGNATURE: Sara Y Wilson Date: 5/20/06

PHYSICIAN SIGNATURE: Deanna Corn PA Date: 5/20/06

Docto Care DOCTORS CARE WEST C
1e .. SAM RITTENBURG BLVD .RT Encounter#: 49019
CHARLESTON SC 29407 PAT # 526410.0
DATE: 05/31/06 (843) 556-5585
NAME: SARA WILSON

TIME: Wed May 31 12:51 SEX F AGE: 62 BIRTHDATE: [redacted]43

HOME ADDRESS [redacted] CHARLESTON SC [redacted] HOME PHONE # [redacted]

EMPLOYER: JAMES SIMONS ELEMENTARY BUSINESS PHONE #(843) 805-6715

RESPONSIBLE PARTY: Sara Y Wilson SS # [redacted]

TIME BACK: PRIMARY INS/KC/SCHAFFER COMPANY

History (- or +, or details) [1/3, 2/3]

Personal Hx	Family Hx		Social Hx
DM	DM	Cancer:	alcohol
HTN	HTN	Colon	tobacco
CV	MI<50	Breast	drugs
Chol	CVA	Ovarian	reg exer.
Surg	Chol	Prostate	occup.

Prev chart rev., no s/g chg ____ Above Hx reviewed ____

Preventive (year of last)

Tetanus UTD	Women		Men
Cholesterol 06	UA		RSA
Colonoscopy 05	Pap	05	Rectal
Flu Shot	Mamm	[illegible]	
Pneumovax	BMD DEXA		

Ckd/a recommendations

Allergies: Cortisone, Sulfa,

Medications: Lubrex Toprol Lanoxin Macardis Atavan Nexium Klonopin

WGT	BP	Pulse	Resp	Temp
15	140/60	68	12	98.4

Chief Complaint: Mal Back/neck/Side Pain

- O general
- O ent
- O eyes
- O cv
- O rsp
- O gi
- O gu
- O endo
- O imm/allergy
- O muscle/skel
- O hem/lymph
- O neuro
- O m. status
- O skin/breasts

HPI (4 items at least):

PE:

Physical: (see reverse) Omit if NA
(√ if nml., O if abnml & give details)

- O general
- O heent
- O neck
- O nodes
- O lungs
- O cv
- O abd
- O back
- O ext
- O gu
- O neuro
- O skin/breasts

WMC Pd 25 OV

PSR Notes
99214-120
99070, BUN-15.07

Tests/Labs in-house

CBC	H pylori	microalbumin	
Strep	FBS	HbA1c	EKG
Mono	u preg	KOH	x-ray
U/A	Hema	wet prep	

Tests/labs sent out

IV/Injections/treatment

ASSESSMENT/DIAGNOSIS/ES:

- ☐ Patient Care Instructions Discussed:
- ☐ Lifestyle Modification

Referrals, tests, treatments

Prescriptions/OTC meds (SEP discussed)

IBUPROFEN 600 MG 60 TABLETS LOT # 61039 EXP: 01-08 NDC 68382-020-21 RX# 8504834

Date to Return:
If worse or if not better: ____
for followup: ____

Go to ER if:

Off work/school
Restrictions:

Note: If outside tests are ordered, we will call with results, positive or negative. If you haven't heard from us in 5 – 7 days after the test, please call for results.

Staff: ____ MD, DO, PA, FNP

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.

Patient or Authorized Person's Signature: Sara Y Wilson Date: ____

4. Workers Compensation patients: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier, or other professionals involved in my care or rehabilitation, regarding my medical records and the treatment I have received or will receive.

Patient or Authorized Person's Signature: ____ Date: ____

20

RETURN TO WORK FORM

CHARLESTON AREA

☐ BEAUFORT
1510 S. Ribaut Road
Port Royal, S.C. 29935
770-0678

☐ MT. PLEASANT
631 Johnnie Dodds Blvd
Mt. Pleasant, S.C. 29464
881-0815

☐ BLUFFTON
84 Bluffton Rd.
Bluffton, S.C. 29910
757-0676

☐ CHARLESTON WEST
3424 Shelby Ray Court
Charleston, S.C. 29414
402-6634

☐ SUMMERVILLE
10180 Dorchester Road
Summerville, S.C. 29485
871-7600

☐ _____

☐ NORTH WOODS
8091 Rivers Avenue
North Charleston, S.C. 29406
572-7000

☐ WEST ASHLEY
1851 Sam Rittenberg Blvd.
Charleston, S.C. 29407
556-5595

☐ _____

NAME: Sara Y. Wilson

DATE: 5/31/06

ARRIVAL TIME: 12:25

DISCHARGE TIME: _____

COMPANY NAME: Charleston County School #20 / James Simons Elem.

WORK STATUS: (Check appropriate boxes)

☐ 1. May perform Full Duty work as of _____ without accommodations.

☐ 2. Off Duty due to work-related condition.
Estimated return to work date modified duty: _____.
Estimated return to work date full duty: _____.
Return for re-evaluation at this office on _____ Time: _____

☒ 3. May work with the following accommodations as of: _____.
☒ No lifting more than 15 lbs.
☐ No operation of hazardous or fast-moving machinery; no driving.
☒ Ground level work only, no ladder or heights.
☒ No repeated bending, stooping, squatting, pushing, jerking, twisting or bouncing.
☐ No continuous standing and/or sitting.
☐ Minimum walking, climbing (includes stairs).
☐ Limited use of _____.
☐ No overhead lifting.
☒ No high repetitive hand activities for extended periods of time.
☐ No use of _____.

☐ 4. Has reached Maximum Medical Improvement (MMI).

☐ 5. Return for re-evaluation at this office on _____ Time: _____

COMMENTS: will f/u with Dr Rob Alexander

PATIENT DISCHARGE INSTRUCTIONS: ☑ Diagnosis: cervical disc

Medications: ☑ as directed ☐ as needed

Wound Care or Injury Care:

☐ keep dry & clean	☐ do not remove dressing	☐ Home exercise instructions given
☐ elevate extremity	☐ apply ice every _____	☐ Follow instruction sheet given
☐ warm soaks	☐ apply heat every _____	☐ Bed rest for _____
☐ wear elastic support/immobilizer/keep taped		

REFERRAL: (If a referral is made to Therapy, or another Physician, please complete this section)

To: _____ Date: _____ Time: _____

For: _____

Address: _____

I understand the above instructions and what to do for my follow-up care. I have received a copy of these instructions for myself and for my Employer.

EMPLOYEE SIGNATURE: Sara Y. Wilson Date: 5/31/06

PHYSICIAN SIGNATURE: _____ Date: 5/31/06

Form 1004-891

211

Doctor's Care Medical Centers

6/1 (3)

RADIOLOGY FORM

Typed Report Required: ( ) Yes ( ) No ☐ Request B Reading

X-Ray No. 04-1598 Patient Name Sara Wilson M (F)

Office DCWA SS DOB Age 62

Date 5/20/06 Requesting Physician Garcia

Operator's Signature Reyes

HISTORY: Shoved into counter 5/19/06

LMP Hysterectomy

LOCATION OF PREVIOUS FILMS

( ) ABDOMEN, 1V, 74000	( ) FINGER, 3V, 73140	(X) LS-SPINE, 3V, 72100	( ) SINUSES, 2V, 70210
( ) ABDOMEN, 3V, 74022	( ) FOOT, 2V, 73620	( ) MANDIBLE, 3V, 70100	( ) SINUSES, 3V, 70220
( ) ANKLE, 3V, 73610	( ) FOOT, 3V, 73630	( ) NASAL, 3V, 70160	( ) SKULL, 2V, 70250
(X) C-SPINE, 3V, 72040	( ) FOOT-FB, 2V, 73620	( ) NECK-ST, 2V, 70360	( ) SKULL, 4V, 70260
( ) C-SPINE, 5V, 72050	( ) FOREARM, 2V, 73090	( ) OSCALCIS, 2V, 73650	(X) T-SPINE, 2V, 72070
( ) CHEST, 1V, 71010	( ) HAND, 3V, 73130	( ) PELVIS, 1V, 72170	( ) THUMB, 3V, 73140
( ) CHEST, 2V, 71020	( ) HAND, 2V, 73120	( ) RIBS, 4V, 71101	( ) TIB & FIB, 2V, 73590
( ) CLAV, 2V, 73000	( ) HIP, 2V, 73510	( ) RIBS-BILAT, 4-5V, 71111	( ) TOES, 3V, 73660
( ) COCCYX, 2V, 72220	( ) HUMERUS, 2V, 73060	( ) SACRUM, 2V, 72220	( ) WRIST, 2V, 73100
( ) ELBOW, 2V, 73070	( ) KNEE, 2V, 73560	( ) SCAPULA, 2V, 73010	( ) WRIST W/NAV, 3-5V, 73110
( ) ELBOW, 4V, 73080	( ) KNEE & SUN, 3+1, 73564	( ) SHOULDER AC, 2V, 73050	( ) ADD VIEW, 1V, 70001
( ) FEMUR, 2V, 73550	( ) KNEE & TUN, 3+1, 73564	( ) SHOULDER 2V, 73030	

Other _____ # Views _____ Code _____

INITIAL IMPRESSION: Fracture, mild degenerative disease

Cspine - Vertebral, C4-7 degenerative disease

Right Or Left Extremity	( ) R ( ) L
Lead Shielding Used	( ) Y (X) N
Is Patient Pregnant?	( ) Y (X) N
Circle # Films Taken	1 2 3 4 (5)

8

RADIOLOGIST'S INTERPRETATION

( ) Normal Examination.

(X) I agree with the initial impression stated above.

( ) I disagree with the initial impression, see comments:

( ) DJD - Degenerative Joint Disease

( ) STS - Soft Tissue Swelling

( ) CPD - Chronic Pulmonary Disease

( ) Osteopenia - Decrease In Bone Density

( ) Patient Referred To:

( ) Patient Notified

( ) Report Called to Center

( ) Report Reviewed By Physician

MAY 24 2006 22

Radiologist

FORM # 1014-5/95

Tricounty
RADIOLOGY ASSOCIATES
Specialists in Outpatient Imaging

5/30/06 pt will be in on 5/31 to go over X-RAY

Darron Morris, MD
1861 Sam Rittenberg Blvd
Charleston, SC 29407

PATIENT: Wilson, Sara
Phone #: [redacted]
ID Number: 443981
Birthdate: [redacted]1943

EXAM: MRI OF THE CERVICAL SPINE

EXAM DATE: 5/25/2006

CLINICAL HISTORY: Pain and limited range of motion.

TECHNIQUE: Sagittal T1-weighted, sagittal T2-weighted, sagittal STIR, axial gradient echo, and axial proton density images were obtained through the cervical spine.

FINDINGS: Evaluation of vertebral body alignment is within normal limits. Evaluation of bone marrow reveals marked spondylosis at the C6-C7 level. No other focal areas of bone marrow signal abnormality. I do not see evidence of abnormal spinal cord signal. Evaluation of the portion of posterior fossa visualized appears unremarkable.

The C2-C3 level appears normal.

C3-C4: Marked left-sided degenerative facet joint disease results in moderate left neural foraminal stenosis.

C4-C5: Mild left posterior disc osteophytic changes. Marked left-sided degenerative facet joint hypertrophy. Moderate left neural foraminal stenosis.

C5-C6: Mild left-sided degenerative facet changes. There appears to be mild left neural foraminal narrowing.

C6-C7: Mild diffuse disc osteophytic bulge. Superimposed broad-based right paracentral to foraminal disc protrusion. No significant central canal stenosis. Moderately severe right neural foraminal stenosis.

C7-T1: Unremarkable.

IMPRESSION:
1. Marked degenerative disc disease at C6-C7 with mild disc osteophytic bulge. Superimposed broad-based right paracentral to foraminal disc protrusion. Only mild overall central canal stenosis, but moderately severe right neural foraminal stenosis.

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Ashley Crossing East Cooper North Charleston West Ashley

23

Tricounty
RADIOLOGY ASSOCIATES
Specialists In Outpatient Imaging

Wilson, Sara ID#: 443981

2. Marked left-sided degenerative facet changes at C3-C4 and C4-C5 resulting in moderate left neural foraminal stenosis at these levels.

3. Mild left-sided degenerative facet change with mild left neural foraminal narrowing at C5-C6.

Kevin Snyder, MD / lsb
Dictated on 05/25/06

Job # 30015361
This document has been electronically reviewed and signed.
Kevin E. Snyder, M.D.

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Ashley Crossing East Cooper North Charleston West Ashley

24

MAY-30-2006 TUE 11:54 AM FAX NO. P. 02/02

PTS Private Therapy Services
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Charleston SC 29407
Phone 843-766-2121 Fax 843-766-8644
www.askmypt.com

Physical Therapy Assessment

Patient Name: Sara Wilson DOB:

Physician: Dr. Dunn's Diagnosis: Neck Pain

Date of Onset: 5-9-06 Date of Surgery: Next MD Appt:

Occupation: Data Technition

Subjective complaints/functional limitations
Dif sleeping - pain ē all ROM(cervical) -

FAXED

PMH Allergies Bowel/Bladder/HTN
Pain Rating (0-10) Today 8 Over last 7 days: Best 7 Worst 10 Pain limiting function (Yes) No

Prior Function Level: Pain Free

Patient's/Family Goal(s) Restore PLOF

Objective
(+) pain to palpation T/o c-spine ā shld girdle musculature
(+) pain ē all Cervical mvts
(+) pain ē shld elev (B) (L) > (R)
- Demo Cervical ROM WNL (all mvts painful)

Today's Treatment:
Stretching X ROM X Strengthening Gait Training Transfer Training Education X

Comments:

Todays Treatments: Eval, Pt Ed, PROM, AROM, STM/DTM, Cervical stretch

Assessment (clinical impression) Pt presents ē significant m guarding yielding pain ē cervical and UE mvts anticipate pt will benefit from therapy

Learning Barriers: No / Yes Exercise skill performance: Good/Fair/Poor
HEP and self care comparison Good/Fair/Poor

HEP Shrugs, Scap Retraction

REHABILITATION GOAL(S)
1. Skill – Will be able to perform prescribed rehabilitation exercises with good technique
2. Comprehension – Will be able to verbally recite HEP, follow up care, and knee precautions
3. STG ↓ pain to ≤ 6 @ all times
4. STG
5. LTG Restore PLOF
6.

RECOMMENDED FRENQUENCY 2-3 times a week for 3-4 week(s)

Clinician's Signature:
M Bothwell PT Date 6-13-06

I agree with the above stated Plan of Care:

Physician's Signature

25

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Treatment Note/ Billing Sheet

Date 6-13-06 Name: Susan Wilson
First Last

Office Visit

Evaluation/Insurance	97001	(1)
Reassessment	97002	

Modalities

Traction	97122	
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	

Procedures, 15 minutes

Therapeutic Exercise	97110	(1)
Functional Activities	97530	
Manual Therapy	97140	(1)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: Neck/shld/LBP/arm/leg pain
p being crunched by students
that were sighting

O: Eval
Pt Ed
HEP

A/P: See Eval

Physical Therapist: MDuckhall PT

26

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Treatment Note/ Billing Sheet

Date 6-15-06 Name: Sara Wilson
First Last

Office Visit		
Evaluation/Insurance	97001	
Reassessment	97002	
Modalities		
Traction	97122	
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	(1)
Procedures, 15 minutes		
Therapeutic Exercise	97110	(1)
Functional Activities	97530	
Manual Therapy	97140	(3)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: C/o pain neck/back

O: (B) cervical m. stretch
PA mobs cervical
STM/DTM Cervical
PA mobs T Spine
E-stim T-Spine x 15'
Review HEP
-add sitting trunk rotation

A: Cont muscle guarding

P: Cont c POC
Begin to ↑ TE

Physical Therapist: M Rodhall PT

21

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Treatment Note/ Billing Sheet

Date 6-27-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032____

Procedures, 15 minutes

Thorapeutic Exercise	97110 (1)
Functional Activities	97530____
Manual Therapy	97140 (3)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: "I actually feel like I am getting worse" - Pt only seen for 3 visits c almost 2wks btwn last 2 sessions

O: (B) cervical stretch
c/T/L PAmobs (Most pain c Typine)
STM/DTM c/T/L extensors
Subocipital release

A/P: See Reassess

Physical Therapist: MDodd PT

28

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PT Reassessment

Patient Name: Sara Wilson DOB:

Physician: Dr. Dennis Diagnosis: Cervical Spondylosis

Date of Onset: 5-9-06 Date of Surgery: Next MD Appt: 6-29-06

Occupation: Data Technition

Subjective complaints/functional limitations: "It feels like I am getting worse." "I am not able to do my household chores"

Patient Goal(s): Restore Pain Free PLOF

Pain rating today (0-10) Today 8 Over last 7 days: Best 7 Worst 10

Pain limiting function? Yes X No

Objective Pt seen for treatment sessions Cancellations No Shows

Treatment:

AAM/PROM	(Mobilization)
(Strengthening)	Education
(Stretching/Flexibility)	Edema Reduction
(Home Exercise Program)	Traction

Modalities: E-stim

Other:

HEP: Shrugs - Scap Retraction - Prone Press - cervical AROM all planes

Problems/Comments:

1. Pt only seen for 3 sessions 2° pt schedule and illness
2. Pt cont ↑ significant reports of activity limiting pain
3. Pt does report ↓ pain ↓ HA ↑ each PT session
4.
5. * Pt may benefit from a TENS unit *

DISCHARGED

Assessment: Rehab Progress: Excellent Very Good (Good) Fair Poor - secondary to only 3 visits

Exercise Skill Performance: Good Fair Poor

HEP Comprehension: (Good) Fair Poor

REHABILITATION GOALS: Met Not Met (Partially Met)

Plan/Recommendations:

Cont ↑ PT to ↓ pain

RECOMMENDED FRENQUENCY 3 times a week for 3-4 week(s)

Clinician's Signature: M Goodall PT Date 6-27-06

I agree with the above plan of care:

Physician's Signature

29

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Treatment Note/ Billing Sheet

Date 6-29-06 Name: Sara (First) Wilson (Last)

Office Visit		
Evaluation/Insurance	97001	
Reassessment	97002	
Modalities		
Traction	97122	
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	(1)
Procedures, 15 minutes		
Therapeutic Exercise	97110	(2)
Functional Activities	97530	
Manual Therapy	97140	(2)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: "I have not had a HA since I saw you last"

O: Lat Pull 1#
Std Rows 15#
Tricep Press 15#
Shrugs 5#
Reverse Curl/Press 4# Dowel
(B) cervical in stretch
STM/DTM (B) UT + cervical
E-stim x 15'

A: Muscle spasm especially in (L) UT/LS

P: Cont c POC

Physical Therapist: M Gadwell PT

30

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Treatment Note/ Billing Sheet

Date 7-3-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110 (1)
Functional Activities	97530____
Manual Therapy	97140 (2)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: "It doesn't hurt as much when you press on it"

O: STM/DTM
(5) acrutech/ m. stretch
E-stim
Review HEP

A: Slowly ↓ pain

P: Cont ± POC
TE in Gym

Physical Therapist: [signature] PT

31

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Treatment Note/ Billing Sheet

Date 7-5-06 Name: Sara (First) Wilson (Last)

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110 (2)
Functional Activities	97530____
Manual Therapy	97140 (2)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: Just not feeling well today

O: Pulleys pain in ⓑ shld
Lat Pulls 1plt pain ⓑ shld
Chest press ⓟplt
std Rows
Tricep Press
Shrugs
Reverse Curl/Press
LTR on Swiss
std Rows 4/R hip

A: Progressing ē TE

P: Cont ē POC

Physical Therapist: MBradwell PT

32

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Treatment Note/ Billing Sheet

Date 7-6-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110 (3)
Functional Activities	97530____
Manual Therapy	97140 (1)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: "It was surprised... I didn't hurt as much p my last sess. on"

O: Lat Pull 1½ plt
Chest Press ø plt
Std Rows
Lat Raise
LTR on Swiss
Tricep press
Shrugs
Curls
Shld press
(B) cervical m stretch
STM/DTM
E-stim

A: ↓ pain ↑ Sx'l mob

P: Cont x poc

Physical Therapist: M Goodhall PT

33

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Treatment Note/ Billing Sheet

Date 7-10-06 Name: Sara (First) Wilson (Last)

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032__(1)__

Procedures, 15 minutes

Therapeutic Exercise	97110____
Functional Activities	97530____
Manual Therapy	97140(3)__
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other_____	_____

SOAP Note

S: On Friday was reaching behind her and a jolt of electricity shot from her shld up/down and has been in pain since

O: STM/DTM
(B) cervical m stretch
Scap mobs Sub occ release
E-stim

A: Poss impingement of dorsal scapular nerve

P: Cont c POC c attempt to release pressure on nerve

Physical Therapist: M Goodall PT

34

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Treatment Note/ Billing Sheet

Date 7-12-06 Name: Sara (First) Wilson (Last)

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032____

Procedures, 15 minutes

Therapeutic Exercise	97110 (1)
Functional Activities	97530____
Manual Therapy	97140 (3)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: C/o (B) Shld./Upper back pain

O: STM/PTM (B) UT/LS/Rhom
Scap mobs
Scap Release 3 (B)
Review HEP

A: Possible dorsal scapular nerves impingement (B)

P: Cont. a POC

Noticeable ↓ in pain a scapular release

Physical Therapist: MDalhall PT

35

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Treatment Note/ Billing Sheet

Date 7-13-06 Name: Sara (First) Wilson (Last)

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032____

Procedures, 15 minutes

Therapeutic Exercise	97110 (1)
Functional Activities	97530____
Manual Therapy	97140 (3)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: "My (R) shld feels much better but my (L) one still hurts"

O: STM/DTM (B) UT/LS/Rhom.
(B) scapular mobs
(B) scapular release

A: ↓ muscle guarding on (R)
Cont muscle guarding on (L)

P: Cont ↑ POC

(See Reassess)

Physical Therapist: M Cardwell PT

226 36

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Faxed

PT Reassessment

Patient Name: Sara Wilson DOB:

Physician: Dr. Dennis Diagnosis: Cervical Spondylosis

Date of Onset: 5-9-06 Date of Surgery: Next MD Appt:

Occupation: Data Technician

Subjective complaints/functional limitations
Was getting noticeably better until pt reached behind her and felt a shock go up through her back to her neck (7-7-06)

Patient Goal(s)
Be able to return to work pain free

Pain rating today (0-10) Today 5-6 Over last 7 days: Best 4 Worst 8
Pain limiting function? Yes X No

Objective Pt seen for treatment sessions Cancellations No Shows

Treatment:

A/AA/PROM	(Mobilization)
(Strengthening)	Education
(Stretching/Flexibility)	Edema Reduction
Home Exercise Program	Traction
(Modalities)	
(Other) Manual	

HEP

Problems/Comments:

1. * Pt has noticeable muscle guarding around both scapulae
2. - I have been able to release pressure on dorsal scapular
3. nerve on the (R) but the (L) is very guarded
4. * Pt cont to have some LBP - anticipate pt will progress
5. & cont PT.

Assessment: Rehab Progress: Excellent Very (Good) Good Fair Poor - secondary to

Exercise Skill Performance: (Good) Fair Poor

HEP Comprehension: (Good) Fair Poor

REHABILITATION GOALS: Met Not Met (Partially Met)

Plan/Recommendations:
Cont & PT to mobilize (R) scapulae - stretch and strengthen cervical - thoracic - lumbar musculature

RECOMMENDED FREQUENCY times a week for week(s)

Clinician's Signature: MBethell PT Date 7-13-06

I agree with the above plan of care:

Physician's Signature

PTS
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Charleston SC 29407
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Treatment Note/ Billing Sheet

Date 7-18-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001
Reassessment	97002

Modalities

Traction	97122
Ultrasound, 15 mins	97035
Iontophoresis, 15 mins	97033
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110 (1)
Functional Activities	97530
Manual Therapy	97140 (1)
Neuromuscular Re-ed	97112
Gait Training	97116
Dressing Change	16025
Massage	97124
Self-Care Training	97535
Other	

SOAP Note

S: Bulging disc per MD per MRI @ C5-6 C6-7 -

O: Review HEP
STM/DTM
E-stim

A: Cont muscle guarding

P: Cont to progress back to TE

Physical Therapist: M Godbold PT

228

38

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Treatment Note/ Billing Sheet

Date 7-19-06 Name: Sara (First) Wilson (Last)

Office Visit		
Evaluation/Insurance	97001	
Reassessment	97002	
Modalities		
Traction	97122	
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	(1)
Procedures, 15 minutes		
Therapeutic Exercise	97110	
Functional Activities	97530	
Manual Therapy	97140	(2)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: "It feels worse today than yesterday"

O: STM/DTM c emphasis around
(L) shld blade
Scap mobs (L)
Scap release (L)
E-stim/IF x 15'

A: Muscle guarding from pinched nerve in C-Spine

P: Cont c POC

Physical Therapist: M Ford Hall PT

30

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Treatment Note/ Billing Sheet

Date 7-20-06 Name: Sara Wilson
First Last

Office Visit		
Evaluation/Insurance	97001	
Reassessment	97002	
Modalities		
Traction	97122	(1)
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	
Procedures, 15 minutes		
Therapeutic Exercise	97110	(1)
Functional Activities	97530	
Manual Therapy	97140	(2)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: Pain as severe as yesterday in (L) shld/neck

O: Traction (cervical)
Manual cervical stretch
UT/LS stretch
STM/DTM (L) UT/LS
Axial Extension
Self stretching

A: ↑ muscle spasm/guarding

P: Cont. c POC

Physical Therapist: MTardhall PT

40

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Treatment Note/ Billing Sheet

Date 7-25-06 Name: Sara (First) Wilson (Last)

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110 (2)
Functional Activities	97530____
Manual Therapy	97140 (1)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: Not feeling too bad today

O: TM x 5'
Bike x 5'
Lat Pull
Chest Press
Std Rows
Curl/Press 6#
STM/PTM
E-stim

Physical Therapist: M David Hall PT

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Treatment Note/ Billing Sheet

Date 7-26-06 Name: Sara (First) Wilson (Last)

Office Visit		
Evaluation/Insurance	97001	
Reassessment	97002	
Modalities		
Traction	97122	
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	(1)
Procedures, 15 minutes		
Therapeutic Exercise	97110	
Functional Activities	97530	
Manual Therapy	97140	(3)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: A little sore today

O: STM/DTM
-(B) UT/LS/Rhom
Scap mobs
E-stim

A: Muscle soreness & some spasms

P: cont c poc
-TE if tolerable

Physical Therapist: M Bedwell PT

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Treatment Note/ Billing Sheet

Date 8-1-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110____
Functional Activities	97530____
Manual Therapy	97140 (3)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: "The pain seems to be coming back" - Reports ~ 4/10 pain

O: STM/DTM (B) UT/LS/Rhom
- muscle spasm noted on (R) Rhom
Light PAIVMs C/T spine
(B) UT eccentric mm stretch

E-stim Upper thoracic region

A: Cont muscle guarding

P: Return to TE
begin c. light resistance

Physical Therapist: MDuBell PT

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Treatment Note/ Billing Sheet

Date 8-2-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001
Reassessment	97002

Modalities

Traction	97122
Ultrasound, 15 mins	97035
Iontophoresis, 15 mins	97033
Electrical Stim, 15 mins	97032 (1)

Procedures, 15 minutes

Therapeutic Exercise	97110 (1)
Functional Activities	97530
Manual Therapy	97140 (2')
Neuromuscular Re-ed	97112
Gait Training	97116
Dressing Change	16025
Massage	97124
Self-Care Training	97535
Other	

SOAP Note

S; Pain is coming back

O; Discussed TE
- Pros/Cons c/t injury

STM/DTM
Sub Occ Release
@UT/LS stretch

E-Stim x 15'

A; ↓ muscle spasm + pain temporary

P; Cont c POC

Physical Therapist: M Bradshaw PT

44

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Treatment Note/ Billing Sheet

Date 8-9-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032____

Procedures, 15 minutes

Therapeutic Exercise	97110____
Functional Activities	97530____
Manual Therapy	97140 (3)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other____	____

SOAP Note

S: ↓ pain btwn shld. - cont pain @ ~ C_5-C_7

O: STM/DTM (B) UT/LS/Rhom (B) cervical m stretch
Light PA mobs
STM/DTM cervical
(+) muscle spasm (B) Rhomboids

A: ↓ pain

P: Cont c POC
return to TE in gym
-light for m. recruitment

Physical Therapist: MOodhall PT

45

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Treatment Note/ Billing Sheet

Date 8-10-06 Name: Sara Wilson
First Last

Office Visit

Evaluation/Insurance	97001	
Reassessment	97002	

Modalities

Traction	97122	
Ultrasound, 15 mins	97035	
Iontophoresis, 15 mins	97033	
Electrical Stim, 15 mins	97032	(1)

Procedures, 15 minutes

Therapeutic Exercise	97110	(2)
Functional Activities	97530	
Manual Therapy	97140	(1)
Neuromuscular Re-ed	97112	
Gait Training	97116	
Dressing Change	16025	
Massage	97124	
Self-Care Training	97535	
Other		

SOAP Note

S: c/o pain in neck/shld

O: STM
Lat Pull 1plt
Std Row 8#
Shrugs 3#
Curls 3#
Lat Raise 1#
Shld Press Wood Dowel in cable rack
E-stim

A: starting to get a little stiff

P: Cont to progress & TE

Physical Therapist: MD Hall PT

46

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Treatment Note/Billing Sheet

Date 8-15-06 Name: Shea Wilson (First / Last)

Office Visit

Evaluation/Insurance	97001____
Reassessment	97002____

Modalities

Traction	97122____
Ultrasound, 15 mins	97035____
Iontophoresis, 15 mins	97033____
Electrical Stim, 15 mins	97032____

Procedures, 15 minutes

Therapeutic Exercise	97110 (2)
Functional Activities	97530____
Manual Therapy	97140 (2)
Neuromuscular Re-ed	97112____
Gait Training	97116____
Dressing Change	16025____
Massage	97124____
Self-Care Training	97535____
Other_____	_____

SOAP Note

S: "I was sick all weekend"

O: Bike
Shrugs 3-5#
Lat Raise 1#
Shld Rows 10#
Bicep curls 3#
Tricep press 10#
Lat Pull 1plt
STM/DTM
(B) cervical sx stretch

Discussed sleeping on back ε towel roll under neck

A: Cont to experience mm guarding and pain in (B) UT

P: Cont ε POC

Physical Therapist: MOdell PT

PALMETTO ORTHOPAEDICS OF CHARLESTON, P.A.

WADDELL H. GILMORE III, M.D. • R. MARSHALL HAY, M.D. • JAMES R. DEMARCO, M.D. • R. BLAKE DENNIS, M.D.

MEDICAL HISTORY

PATIENT NAME Sara Y. Wilson DOB [redacted]/43

REFERRING PHYSICIAN Doctors Care FAMILY PHYSICIAN W. Pettigrew Clare, Sr.

REASON FOR SEEING THE DOCTOR TODAY Body Injury

IS THIS AN INJURY OR ILLNESS? AUTO/MOTORCYCLE ACCIDENT WORK RELATED OTHER ACCIDENT NO ACCIDENT

DATE OF INJURY OR ONSET

PLEASE EXPLAIN INJURY OR ILLNESS AND HOW IT HAPPENED

SIGNATURE DATE

CHRONIC ILLNESS OR HOSPITALIZATIONS (w/dates)

PREVIOUS SURGERIES (w/dates) C Section - 1970/Partial Hysterectomy - 1983/Ovarian Cyst - 1990/Removal of Gallbladder - 2000/Laparotomy - 1/2006

LIST ALLERGIES TO ANY MEDICATIONS Codeine/Darvocet/Percocet/Demerol/Muscle relaxers

LIST NAME/DOSE OF MEDICATION YOU TAKE DAILY Topa 50mg 1 per day, Maxide 50mg 1 per day, Premarin .09 1 per day, Neurontin 400mg 1 tid a day, Advil (Celecoxib) 1 per day, Zoloft 25mg every other day, Vitamin C 1 per day, Lipitor 1 per day

DAILY ASPIRIN YES NO

REVIEW OF SYSTEMS:

HAVE YOU EVER HAD ANY PROBLEMS WITH OR BEEN TREATED FOR:

NERVES?	YES (NO)		CANCER?	YES (NO)	
HEART?	(YES) NO		HEART ATTACK?	YES (NO)	
BLOOD PRESSURE?	YES (NO)		STOMACH ULCERS?	(YES) NO	Irritable bowel
COLON TROUBLE?	YES (NO)		DIABETES?	YES (NO)	
KIDNEY STONES?	YES (NO)		BLADDER TROUBLE?	YES (NO)	
BACK TROUBLE?	YES NO		URINARY TROUBLE?	(YES) NO	

DO YOU SMOKE? Y (N) HOW MUCH? DO YOU DRINK ALCOHOL? Y (N) HOW MUCH?

REVIEWED BY (TREATING PHYSICIAN) (Signature) (Date) 6/6/06

PHYSICIAN NOTES: (To be filled out by physician)

48

117936

WILSON, SARA

06/06/06

CHIEF COMPLAINT: Body injury.

PRESENT ILLNESS: Ms. Wilson is a 62-year-old female who works for Charleston County Schools. She was an "innocent bystander" when apparently 2 students who were fighting bumped into her. She was shoved into a marble counter and was pinned against it on her right side. She is mainly having pain across her upper back and neck and occasionally will get some pain into her right arm. She also has some pain into the right side. She has seen her primary care physician, Dr. Clare, and he has checked her. She did have some blood in the urine. He did an ultrasound of the kidneys, which apparently did not show any abnormality. Her Worker's Comp carrier referred her to Doctor's Care, where she had x-rays of her neck and back. Those were not brought in for review. MRI scan of the cervical spine was done and she has been referred in by her Worker's Comp carrier for a second opinion. She states she does not have pain all of the time but she states the pain is worsening from the time of the accident. She will occasionally get some leg pain and pain into her thigh.

PAST MEDICAL HISTORY: Updated and reviewed and includes problems with her nerves and heart, hypertension, stomach ulcers, and chronic bladder and urinary trouble.

ALLERGIES: She is allergic to cortisone, sulfa, Demerol, and muscle relaxants.

PHYSICAL EXAMINATION: Exam is done with a female chaperone and shows an alert, cooperative female. She appears much younger than her stated age. She does not have significant cervical spasm or tenderness. She has good cervical mobility. She has excellent mobility of both shoulders with negative impingement and apprehension. She has normal strength in the upper and lower extremities. Biceps, triceps, brachioradialis, knee, and ankle reflexes are symmetrical. She has a downgoing Babinski and no clonus. Hoffmann is negative. She has a negative Tinel's at the wrist and elbow and a negative Phalen's.

IMAGING: X-rays of the cervical spine reveal degenerative disc narrowing at C6-7. She has minimal degenerative spondylolisthesis at 5-6, 4-5, and 3-4. Disc space heights are otherwise normal. MRI scan of the cervical spine is an open-sided study. Images are not great. She has a degenerative disc at C6-7 with some mild right foraminal stenosis. There is no fracture or cord change. The report does show some marked left-sided degenerative facet changes at C3-4 and C4-5 as well as C5-6 and a degenerative disc at C6-7. That would fit with her x-ray findings of degenerative disc at 6-7 and some spondylolisthesis at multiple levels. There is no evidence of fracture or acute abnormality.

DIAGNOSIS:

1. Cervical spondylosis.
2. Neck pain.

RECOMMENDATION: We will refer her to physical therapy for cervical strengthening. I don't see any problem that is going to get better by staying at home. I think she can return to work with some restrictions of no lifting over 5 pounds in the right hand and no work above eye level. She was under the impression that only her Worker's Compensation carrier could determine when she was ready to return to work, but I explained to her that as a Worker's Compensation treating physician, I think it is an obligation I have to recommend return to work. I will see her in 3 weeks. If she is not significantly improved, we may have to send her for pain management.

R. Blake Dennis, M.D. /af
CC: W. Pettigrew Clare, M.D.
Doctor's Care

50

117936

WILSON, SARA

06/29/06

CHIEF COMPLAINT: Follow up, neck pain.

PRESENT ILLNESS: The patient is a 62-year-old female who is having neck pain that she relates to an injury sustained on May 9 when she was struck during an altercation between 2 students. We have been treating her nonoperatively with physical therapy. She reports today that she is not doing any better. She states her hands are hurting and puffy and every time the physical therapist does anything to her neck, he touches very tender areas about her neck and upper back. She is not describing any true radicular symptoms or true myelopathy symptoms. She relates that she was not having any of these problems prior to this injury. I am in receipt of a note from physical therapy. In item #3 in their comments, "the patient does report decreased pain and decreased headache post each physical therapy session." They have discussed a TENS unit.

PHYSICAL EXAMINATION: She is an alert, cooperative female in no acute distress.

IMAGING: I have obtained flexion/extension x-rays of the cervical spine and these show C6-7 degenerative disc changes consistent with cervical spondylosis. She does have very minimal spondylolistheses at 5-6, 4-5, and 3-4. These reduce on extension and have about 1 mm spondylolisthesis on flexion. Disc space heights are normal.

DIAGNOSIS: C6-7 spondylosis.

RECOMMENDATION: I cannot explain her symptoms of worsening pain given the abnormality seen on plain film x-rays and open-sided MRI. I could not advise her regarding other treatment options. I would recommend a good quality hospital-based cervical MRI at Roper Hospital. I will check her back at that time. In regards to her work capability, it is the same as when I saw her on June 6.

R. Blake Dennis, M.D. /af
CC: W. Pettigrew Clare, M.D.

51

NNIS,RICHARD BLAKE:Far. ield Diag. Ctr. - JGR:84376_4868

ROPER HOSPITAL IMAGING SERVICES

Name: WILSON,SARA Y
Exam Date: 07/06/06 1413
Ord. Phy.: DENNIS,RICHARD BLAKE

MR#: A000609896
DOB: [redacted]/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)884-0302
Phy. Fax #: (843)849-9308

DENNIS,RICHARD BLAKE
913 BOWMAN ROAD
SUITE 2-B
MT.PLEASANT SC 29464

Acct_Nbr : A0618700298
Pat_Type : DMA

Chk-in #	Order	Exam	
1522984	0001	36152	FMR SPINE CERVICAL W/O CONTRAST

Ord Diag: SPONDYLOLITHESIS

MRI OF THE CERVICAL SPINE: 7/6/06

The patient has neck and back pain.

Sagittal T1, T2, and STIR images were followed by oblique axial T2 and gradient echo pulse sequences.

Midline sagittal images demonstrate the craniocervical junction to be unremarkable. There is moderate narrowing of the C6-7 intervertebral disc space with some slight vertebral body edema. The cervical cord is normal in signal.

The C2-3 disc space is unremarkable.

At C3-4 there is a minimal left posterior disc osteophyte with slight left-sided foraminal stenosis.

At C4-5 there is trivial posterior disc bulging and mild bilateral foraminal stenosis.

At C5-6 there is no evidence of disc herniation or significant bulging. Minimal left uncovertebral osteophyte formation is present.

At C6-7 there is moderate loss of height of the intervertebral disc space with right paracentral and posterolateral disc protrusion extending to and very slightly deforming the right anterior margin of the cervical cord without intrinsic signal changes. There is

FINAL DUPLICATE Page 1

ROPER HOSPITAL IMAGING SERVICES

Name: WILSON,SARA Y
Exam Date: 07/06/06 1413
Ord. Phy.: DENNIS,RICHARD BLAKE

MR#: A000609896
DOB: [redacted]/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)884-0302
Phy. Fax #: (843)849-9308

DENNIS,RICHARD BLAKE
913 BOWMAN ROAD
SUITE 2-B
MT.PLEASANT SC 29464

Acct Nbr : A0618700298
Pat_Type : DMA

Checkin-Exam Code Summary
1522984-36152

minimal bilateral foraminal stenosis. No free disc fragments are identified. There is also an anterior disc herniation at C6-7.

At C7-T1 there is no evidence of disc herniation or significant bulging with the canal and foramina well maintained.

IMPRESSION:

1) C6-7 right posterolateral and central disc protrusion very slightly deforming the right anterior margin of the cervical cord without evidence of cord edema or significant foraminal stenosis.

2) Minimal degenerative changes at other levels without evidence of disc herniation or significant bulging. The cervical cord is normal in signal.

yay

Transcriptionist- YVONNE YANCEY
Reading Radiologist- WESLEY D HENRY-MD
Releasing Radiologist- WESLEY D HENRY-MD
Released Date Time- 07/07/06 1118

ROPER HOSPITAL IMAGING SERVICES

Name: WILSON,SARA Y
Exam Date: 07/06/06 1413
Ord. Phy.: DENNIS,RICHARD BLAKE

MR#: A000609896
DOB: [redacted]/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)884-0302
Phy. Fax #: (843)849-9308

DENNIS,RICHARD BLAKE
913 BOWMAN ROAD
SUITE 2-B
MT.PLEASANT SC 29464

Acct_Nbr : A0618700298
Pat_Type : DMA

Checkin-Exam Code Summary
1522984-36152

Releasing Radiologist- WESLEY D HENRY-MD
Released Date Time- 07/07/06 1118

316 Calhoun Street, Charleston S.C. 29401 * (843) 724-2150

54

117936

WILSON, SARA

07/18/06

CHIEF COMPLAINT: Follow up, MRI scan.

PRESENT ILLNESS: Ms. Wilson is not improved since last seen. She is predominantly having axial pain in the lower neck and upper scapular and trapezius area. She does occasionally have some arm pain. She will occasionally get some right leg pain. She reports overall no lasting improvement since the date of her injury, May 9. She reports that she is not able to go back to work on the date that I specified, as she has too much pain when she sits.

IMAGING: I have reviewed her MRI scan at length. This does show some mild degenerative spondylolistheses and facet changes throughout the cervical spine but does show a central right-sided small disc herniation at C6-7.

DIAGNOSIS:

1. Neck pain.
2. Cervical spondylosis.
3. Cervical disc herniation.

RECOMMENDATION: I have reviewed the findings with Ms. Wilson and her friend, who is with her today. I discussed a surgical procedure for cervical discectomy and fusion at C6-7. I explained the procedure as well as possible outcomes, risk, and complications including paralysis, infection, bone-graft-related problems, vocal cord problems related to recurrent laryngeal nerve problems, and continued pain. I explained that cervical spine surgery for radicular pain is predictable with 90% success but very unpredictable for the type of symptoms that she manifests, such as more axial symptoms. She does not want to proceed with any surgery and I think that is reasonable. I do not think a surgical procedure would meet her level of expectation. I do not have other suggestions for her except referral to someone who specializes in nonsurgical pain management. We will make an appointment for her to see Dr. Alexander. I think it is reasonable to wait until he sees her before returning her to work. I'm not sure that continued therapy is going to make any long-term difference.
R. Blake Dennis, M.D. /af
CC: W. Pettigrew Clare, M.D.

The following questions are designed to provide your physician with a thorough understanding of your medical history. Please answer every question as completely as you can.

1. Name Sara Y. Wilson Age 62 Height 4'11" Weight 114

2. Please circle the number below to indicate the level of pain you are having. Use the following scale as a rough guide:

   0 = No pain
   3 = Take Tylenol or Advil for pain
   6 = See your doctor for prescription
   10 = Worst pain you could ever have

   0 1 2 3 4 5 6 (7) 8 9 (10)

3. What position or activity makes your injury or pain worse? Sitting for a long period of time or walking

4. What position or activity reduces your pain? lying down or physical therapy (temporary)

5. Have you had any of the following tests or treatments concerning your current symptoms? If so, please list date, location and result, if known.

		Yes	No	Date/Location/Result
a.	X-ray	☑	☐	Doctors Care
b.	Myelogram	☐	☑	
c.	CAT Scan	☐	☑	
d.	MRI Scan	☑	☐	Tri County? / Kaper Radiologist
e.	Bone Scan	☑	☐	ST. Francis or Kaper
f.	EMG or Nerve Conduction Study	☐	☑	
g.	Physical Therapy	☑	☐	Private Therapy 3 times a wk
h.	Chiropractor	☐	☑	
i.	TENS Unit	☑	☐	Private Therapy 3 times a week
j.	Back Brace	☐	☑	
k.	Trigger Point Injection	☐	☑	
l.	Epidural Steroid Injection	☐	☑	
m.	Facet Joint Injection	☐	☑	
n.	Discogram	☐	☑	
o.	Neck or Back Surgery	☐	☑	

6. List any drug allergies or sensitivities you have: Demerol, cortisone, all sulfas, sulfites, Darvocet, muscle relaxers

7. List prescription medications you are currently taking. Include dosage and how many times per day you take it: Toprol 50mg 1 a day, Micardis 50mg. 1 per day, Premarin .09 1 per day, Reflux 40mg 1 twice a day, Atwan (xanax) 1 per day, Zoloft 25mg 1 per day, Estrace Lanoxin 1 per day, Albuterol 1 per day. for: O

56

8. Have you ever been diagnosed with any of the following?

	Yes	No		Yes	No
Hepatitis	☐	☑	Kidney Disease	☐	☑
AIDS / HIV	☐	☑	Cancer	☐	☑
Arthritis	☑	☐	Heart Disease	☐	☑
Diabetes	☐	☑	~~Osteoporosis~~ Osteopedia	☑	☐
Ulcers	☐	☑	Thyroid Problems	☐	☑
Unexplained Weight Loss	☐	☑	Migraines	☐	☑
Night Sweats / Fever	☑	☐	Lung Problems	☐	☑
Seizures	☐	☑	Bleeding Disorders	☐	☑

If you answered "Yes" to any of the above, please describe: Dr. Dennis recently said my MRI showed some Arthritis, Osteopedia in the left hip - Most recent Bone Scan was normal 2004

8a. Have you ever had weakness/numbness in your legs or arms? If yes, please explain.
Yes, occasionally since I have been injured

8b. Have you ever had any changes in bowel/bladder functions? If yes, please explain.
Yes, I have irritable Bowel Syndrome

8c. List any additional medical problems or surgeries you have had: C-section 1970 / Hysterectomy 1983 and 1990 / Gall Bladder removal 2000 / Lumpectomy 2006 / HTN

9. Are you: ☐ Married ☐ Single ☐ Divorced ☑ Widow/Widower ?

10. What is your current job or occupation? Data Technician

10a. How long have you been working at this position? 12 yrs

11. Have you missed any work because of your injury? ☑ Yes / ☐ No / ☐ N/A
If so, please list dates: I have not worked since 5/9/06, I am a 10 month layoff

11a. Is your injury work-related? ☑ Yes / ☐ No / ☐ N/A
If yes, please list date of accident: May 9, 2006

12. Do you smoke? If yes, how much and for how long?
No

12a. Do you drink? If yes, how much and for how long?
NO

57

13. Do you have any blood relatives who have had the following illnesses? Please check those that apply.

Illness	Yes	No	Relationship to Patient
Cancer	☐	☑	
Seizures	☐	☑	
Osteoporosis	☐	☑	
Thyroid Problems	☐	☑	
Heart Disease	☑	☐	Brother
Nerves/Depression	☑	☐	Brother
Diabetes	☑	☐	Brother
Migraine Headaches	☐	☑	

In the space provided below, please list any other family illnesses your doctor should be aware of:

14. Review of Systems - Please circle any of the following problems which you now have or which you have had in the past six months.

Allergic/Immunologic
1. Rashes
2. Itching
3. Wheezing
4. None

Cardiovascular
1. Chest Pain, Tightness
2. Palpitations
3. None

Constitutional
1. Weight Gain
2. Weight Loss
3. Appetite Change
4. Marked Fatigue
5. Unexplained High Fever
6. Night Sweats
7. Difficulty Sleeping
8. None

Hematology/Endocrinology
1. Swelling
2. Bruising
3. Bleeding
4. None

Gastrointestinal
1. Persistent/Recurring Belly Pain
2. Uncontrolled Loss of Stool
3. Diarrhea
4. Blood in Stool
5. Heartburn
6. Constipation
7. Yellow Jaundice
8. Pain with Bowel Movement
9. None

Integumentary
1. Discoloration of Skin
2. Pain
3. None

Musculoskeletal
1. Joint Pain Left
2. Joint Stiffness
3. Joint Redness
4. Joint Swelling
5. Loss of Strength
6. Weakness
7. None

Neurological
1. Headaches
2. Change in Sensation to Lower Extremities
3. Numbness in Extremities
4. None

Psychological
1. Psychological Difficulties
2. Mood Changes
3. None

Respiratory
1. Shortness of Breath with Normal Activities
2. Wheezing
3. Recurring Cough
4. None

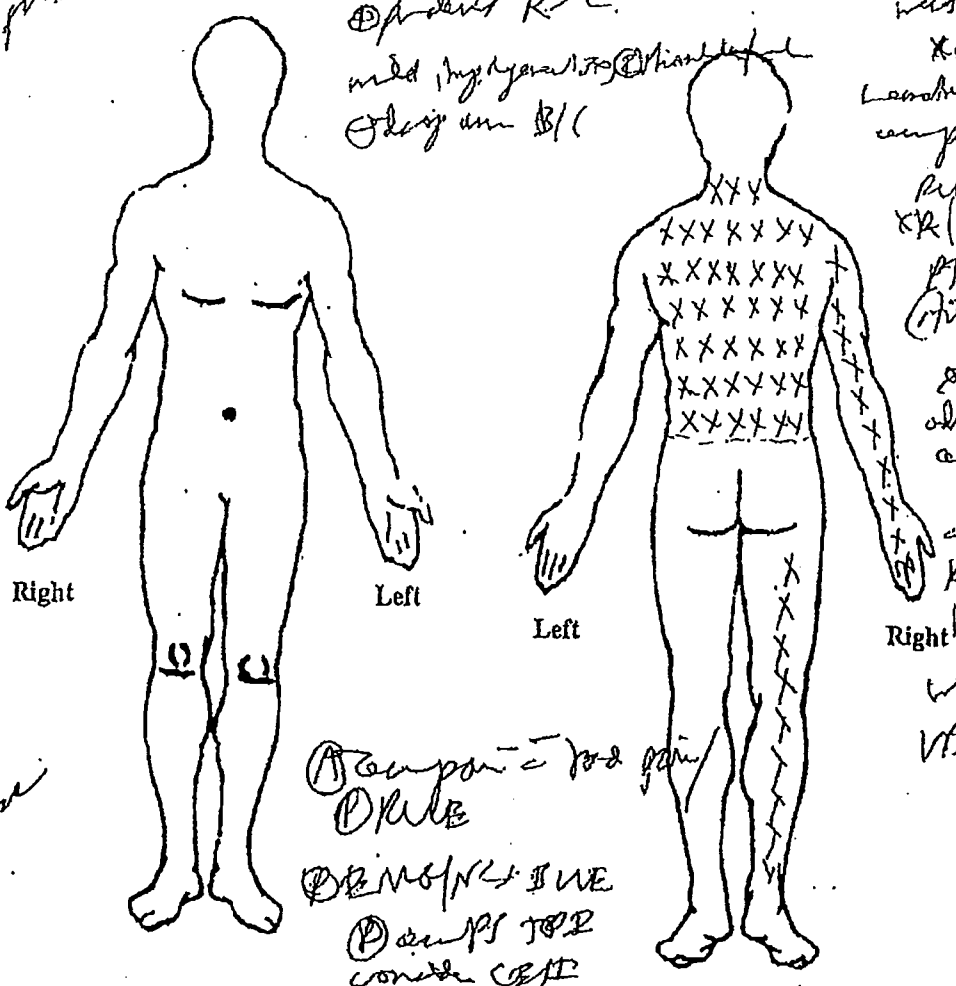
Urological
1. Difficulty with Urination
2. Blood in Urine
3. None

Physician Signature(s) — Date(s) Reviewed: 7/27/06

58

NAME Sara Y. Wilson DATE 7/27/06

Mark the areas on the diagram below where you feel the majority of your pain. Use "Xs" (xxx) to designate each location.



SPINE & ORTHOPAEDIC SPECIALISTS of South Carolina PA

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Hartsville, SC 29550

843-856-9669 • 888-856-9669 • Fax 843-856-9161

WILSON, SARA
DOB [redacted]/43
CHART # 2136
07/27/06

CHIEF COMPLAINT: Cervical/right upper extremity pain.

HPI: Ms. Wilson is seen today in initial consultation per the very kind referral of Dr. Dennis for evaluation status post work injury 05/09/06. She was employed at Charleston County School District in data entry x 12 years at time of insult. Reportedly was knocked into a marble top counter by two 12-year-old boys that were fighting. She subsequently struck her right upper extremity, chest wall, and thigh region. Evaluated in the ER the same day with unremarkable plain films. Developed hematuria with negative ultrasound. Cervical and right upper extremity symptoms started approximately 2 weeks after date of insult. Treatment to date has included plain film and MRI. Continues PT with temporary benefit. No injections. Advised against operative measures by Dr. Dennis at this time. Patient continues to have intermittent pain/paresthesias radiating into the right upper extremity to the level of the hand. Occasional subjective weakness. Current VAS is a 7/10. Symptoms aggravated with prolonged sitting or walking. Some relief with lying supine or with PT.

Patient denies previous history of cervical or right upper extremity pain/paresthesias prior to work injury 05/09/06. Also denies having seen a physician, chiropractor, or physical therapist for aforementioned symptoms prior to date of insult.

ALLERGIES: DEMEROL, PENICILLIN, SULFA, DARVON.

CURRENT MEDS: Toprol, Micardis, Premarin, Nexium, Ativan, Zoloft, Lanoxin, Librax. Denies anticoagulants.

PAST MEDICAL HISTORY: Cholecystectomy, hysterectomy, lumpectomy, C-section, osteopenia, OA, IBS.

SOCIAL HISTORY: Patient is widowed, data technician x 12 years. Has not worked since date of injury 05/09/06. Denies tobacco and ethanol use.

FAMILY HISTORY: Significant for heart disease, depression, diabetes.

loc

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REVIEW OF SYSTEMS: Significant for cervical and right upper extremity pain, paresthesias, headaches, difficulty sleeping, night sweats, weight gain, palpitation, rashes, pruritus, hematuria. ROS sheet reviewed with patient.

PHYSICAL EXAM: Well-nourished, well-developed, 62-year-old, 4'11", 114 pound African-American female in mild discomfort subjectively. Cervical exam with tenderness segmentally C4 through C7, right-sided, as well as over the superior trapezius. Mild tenderness superior thoracic region T1 through T4, again right-sided. Increased discomfort with cervical flexion, extension, and right lateral rotation. Negative Spurling's bilaterally. Motor, sensory, and DTRs intact bilateral upper extremities. Hoffmann's negative bilaterally. Mildly positive Tinel's bilateral median nerve distribution, negative ulnar nerve. Positive Phalen's bilaterally, right greater than left.. Mild impingement signs on active and passive range of motion right shoulder, negative on the left. Negative drop arm bilaterally.

IMAGING: MRI cervical 05/25/06 significant for disc desiccation/protrusion C6-7 with resultant right-sided recess stenosis. No definitive selective nerve impingement.

ASSESSMENT:
1. Cervical pain with right upper extremity pain/paresthesias. MRI with right paracentral disc protrusion C6-7.
2. Mild impingement signs right shoulder exam.

PLAN:
1. Performed right cervical paraspinal injection with lidocaine, Marcaine, and Depo-Medrol. Verbal consent obtained and sterile technique utilized throughout.
2. Continue PT regimen.
3. We will schedule patient for electrodiagnostic examination bilateral upper extremities to further evaluate potential etiology of reported pain/paresthesias.
4. Consider possible cervical epidural under fluoroscopy if she fails to respond to more conservative measures.

(continued)

61

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Dr. Dennis, thank you for the kind referral and the opportunity to assist in the care of Sara Wilson.

With kindest regards.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: R. Blake Dennis, M.D.
Worker's Comp.

FAXED 8/4
Glenn Martin

61

SPINE AND ORTHOPAEDIC SPECIALISTS OF SOUTH CAROLINA PA

843-856-9669

Dr. J. Robert Alexander, Jr.

Dr. Chris P. Tountas

WORK STATUS

Patient's Name Sara Wilson

Employed by: _____

The above employee was seen: 7-27-06

Return to work with no restrictions: _____

Return to work on Aug 3, 2006 with restrictions: ✓

Sedentary duty / 3-4 HRS. per day

Lifting not to exceed _____

Full time ☐ Other _____

Part-time ☑

Follow-up visit: Aug 3, 2006

MMI _____ PPI _____

Physician: J. Robert Alexander Jr MD Date 7-27-06

6

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WILSON, SARA
DOB [redacted]/43
CHART # 2136
08/03/06

CHIEF COMPLAINT:

HPI: Mr. Wilson is seen today in follow-up from 07/27/06. She states PT regimen and cervical injection did prove beneficial. She was doing fairly well until 2 days ago when she had a slow return of discomfort. Continues to have intermittent right upper extremity pain/paresthesias.

Initial history and physical findings reviewed with patient and she reports no new complaints. Scheduled to restart work today.

ASSESSMENT: Cervical pain with right upper extremity pain/paresthesias. Disc desiccation/protrusion C6-7 on MRI.

PLAN:

1. Performed electrodiagnostic examination bilateral upper extremities for comparative purposes and focal EMG needle exam right upper extremity and cervical paraspinals. Unremarkable findings without evidence of cervical radiculopathy, peripheral sensory motor polyneuropathy, or peripheral nerve entrapment neuropathy. Results discussed with patient. Please see report for details.
2. Initiate Voltaren and Ultram p.r.n. trial.
3. Follow up in the a.m. for repeat cervical paraspinal injection. If she fails this additional measure, have discussed possibility of a cervical epidural under fluoroscopy. Patient is amenable if she fails to get long-term response with the second in-office injection.
4. Continue work restrictions as described on initial visit.

Plan discussed with patient and she agrees.

J. Robert Alexander, Jr., M.D.

JRA/ts

FAXED 8/9
Glenn

cc: R. Blake Dennis, M.D.
Worker's Comp.

64

SPINE AND ORTHOPAEDIC SPECIALISTS OF SOUTH CAROLINA PA

843-856-9669

Dr. J. Robert Alexander, Jr.

Dr. Chris P. Tontz

WORK STATUS

Patient's Name Lisa Wilson

Employed by:

The above employee was seen: 8/3/06

Return to work with no restrictions: [illegible]

Return to work on 8/3/06 with restrictions:

Lexington duty Sitting or standing only with frequent position changes, needed

Lifting not to exceed No lifting

Full-time ☒ Other 3-4 hours/day

Part-time ☐

Follow-up visit:

MMI PPI

Physician: [signature] Date 8/3/06

SPINE AND ORTHOPAEDIC SPECIALISTS OF
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843-856-9669

Dr. J. Robert Alexander, Jr. Dr. Chris P. Tontis

WORK STATUS

Patient's Name Sara Wilson

Employed by:

The above employee was seen: 8/3/06

Return to work with no restrictions:

Return to work on 8/3/06 with restrictions:

No change in previous restrictions

Lifting not to exceed

Full time ☐ Other

Part-time ☑

Follow-up visit:

MMI PPI

Physician: Date 8/3/06

256 606

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WILSON, SARA
08/04/06

HPI: Ms. Wilson is seen today in follow-up from 08/03/06. She had unremarkable electrodiagnostic examination. Continues to have cervical and right upper extremity pain/paresthesias.

PHYSICAL EXAM: Tenderness right cervical paraspinal region to palpation.

ASSESSMENT: Cervical pain with right upper extremity pain/paresthesias and right paracentral disc protrusion C6-7. Unremarkable EMG.

PLAN:

1. Performed repeat right cervical paraspinal injection today with lidocaine, Marcaine, and Depo-Medrol. Verbal consent obtained and sterile technique utilized throughout. Follow up in 1 week. Consider cervical epidural under fluoroscopy if she fails to respond to continued more conservative measures.
2. Continue PT regimen.
3. Continue sedentary work status with part-time 3 to 4 hour days.

J. Robert Alexander, Jr., M.D.

JRA/ls

cc: Worker's Comp.

FAXED 8/9
Glenn

SPINE & ORTHOPAEDIC SPECIALISTS of South Carolina PA

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WILSON, SARA
DOB
CHART # 2136
08/10/06

HPI: Ms. Wilson is seen today in follow-up from 08/04/06. Cervical injections were beneficial for 3 days in duration and then symptoms returned. Current VAS is an 8/10.

Initial history and physical findings reviewed with patient and she reports no new complaints. Multiple questions about work status today. She states her job is unable to accommodate her working with restrictions at this time, despite previously telling her that they were able to do so. Patient verbalized to me that given her continued pain, she does not feel like she can work full-time hours currently.

PHYSICAL EXAM: Tenderness right cervical paraspinal region.

ASSESSMENT: Cervical pain with intermittent right upper extremity pain/paresthesias. Right paracentral disc protrusion C6-7. Unremarkable EMG.

PLAN:

1. Given continued symptoms, we will schedule patient for a cervical epidural under fluoroscopy to be performed 08/18/06. Risks and benefits presented to patient and she decided to proceed. Follow up 2 weeks after block.
2. Continue PT regimen given this has proven markedly beneficial per the patient.
3. Continue sedentary work status with part-time 3 to 4 hour days.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.

FAXED 8/16
Glenn Martin

68

SPINE AND ORTHOPAEDIC SPECIALISTS OF
SOUTH CAROLINA PA
843-856-9669

Dr. T. Robert Alexander, Jr.

Dr. Chris P. Tountas

WORK STATUS

Patient's Name Sara Wilson

Employed by: _____

The above employee was seen: 8/10/06

Return to work with no restrictions: _____

Return to work on 8/11/06 with restrictions: ✓

No change in previous restrictions

Lifting not to exceed _____

Full time ☐ Other 3 - 4 hours/day

Part-time ☑

Follow-up visit: 3 weeks

MMI _____ PPI _____

Physician: _____ Date 8/10/06

69

EAST COOPER REGIONAL MEDICAL CENTER
1200 Johnnie Dodds Blvd.
Mt. Pleasant, SC 29464
(843) 881-0100

REPORT OF OPERATION

Patient Name: WILSON, SARA Y
DOB: [redacted]/1943
MRN: 553-07-32
Pt. Class: O
Room/Bed: -

Surgeon: John R. Alexander, M.D.

Date of Operation: 08/18/2006
Anesthesia: @@
Anesthetist:

Assistants: @@
Preoperative DX: Cervical radiculopathy, cervical degenerative disc disease.
Postoperative DX: @@
Operation Title: Cervical epidural steroid injection C7-T1 under fluoroscopy.

DATE OF OPERATION: 8/18/06

PROCEDURE: The patient was brought to the operating room, placed prone on the fluoroscopic table. Skin was cleaned with Betadine and soft tissues were anesthetized with 1% Lidocaine. A 20 gauge 3 1/2 inch Tuohy needle was then advanced to the C7-T1 interlaminar space utilizing a slightly right oblique approach. Then utilizing hanging drop technique with confirmation by loss of resistance technique, needles were further advanced to the epidural space. Negative heme and negative CSF aspiration. On lateral view, needle appeared slightly pass the spinal laminar line but this was secondary to patient positioning and that she was not placed perfectly flat on the fluoroscopic table due to her inability to fully relax secondary to mild discomfort. We then injected a very small amount of Omnipaque with revealed epidural flow. After negative repeat heme and CSF aspiration, solution containing 80 mg of Depo-Medrol in combination with 3 cc of preservative free normal saline was slowly injected into the epidural space without resistance. Tuohy was then moved to the soft tissues where an additional 4 cc of 1% preservative free Lidocaine was injected after negative aspiration for anesthesia purposes. Tuohy was then completely removed. The patient tolerated the procedure well, remained hemodynamically stable throughout. She was communicative and reported no discomfort throughout the entire procedure. No sedation was provided except for 25 mg of Benadryl IV secondary to questionable dye allergy.

JOHN R. ALEXANDER, M.D.

DD: 08/18/2006 14:38:23 DT: 08/19/2006 10:08:50 Job #: 475472 MT #: 6212828

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WILSON, SARA
DOB [redacted]/43
CHART # 2136
09/07/06

HPI: Ms. Wilson is seen today in follow-up from 08/18/06 status post cervical epidural. She states that this was beneficial for one week in duration, but then symptoms essentially returned to her baseline level. Current VAS is a 6/10 with a maximum of 8/10. Continues to report intermittent right upper extremity radicular pain.

PHYSICAL EXAM: Tenderness right cervical paraspinal region.

ASSESSMENT: Cervical pain with intermittent right upper extremity pain/paresthesias. Right paracentral disc protrusion C6-7. Unremarkable EMG.

PLAN:

1. Patient has only had very short-term relief with 3 cervical injections to date. She requested that we perform a repeat cervical paraspinal injection today given that it does provide her at least temporary relief given she remains unsure about operative intervention. We decided to proceed and perform with lidocaine, Marcaine, and Depo-Medrol. Verbal consent obtained and sterile technique utilized throughout.
2. Given only minimal relief with interventional measures, do not recommend repeat cervical epidural at this time. Patient offered a referral back to Dr. Dennis for potential operative measures, but she wants some more time to decide. Follow up in 3 weeks.
3. Recommend home traction and TENS unit given that this has proven beneficial during therapeutic sessions.
4. Continue sedentary work status with part-time hours.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.

FAXED 9/13/06
to Glenn Martin

71

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843-856-9669

Dr. J. Robert Alexander, Jr.

Dr. Chris P. Tountas

WORK STATUS

Patient's Name Sara Wilson

Employed by: _____

The above employee was seen: 9/7/06

Return to work with no restrictions: _____

Return to work on 9/7/06 with restrictions: ✓

No change in previous restrictions

Lifting not to exceed _____

Full time ☐ Other _____

Part-time ☒

Follow-up visit: 3 wks

MMI _____ PPI _____

Physician: _____ Date 9/7/06

FAXED 9/13/06 to Glenn Hurdis 72

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WILSON, SARA
DOB [redacted]/43
CHART # 2136
09/28/06

HPI: Ms. Wilson is seen today in follow-up from 09/07/06 status post cervical injection. She states unfortunately this was only beneficial for again one week in duration and then symptoms essentially returned to baseline. Current VAS is a 6-7/10. Intermittent right upper extremity radicular complaints. Home traction, TENS unit, and PT also proved temporarily beneficial.

PHYSICAL EXAM: Tenderness right cervical paraspinal region.

ASSESSMENT: Cervical pain with intermittent right upper extremity pain/paresthesias with right paracentral disc protrusion C6-7 on MRI. Unremarkable EMG, but she certainly has symptoms consistent with cervical radiculitis.

PLAN:

1. Patient has only had very short-term relief with multiple cervical injections to date, including epidural. Symptoms consistently return after 1 to 2 weeks. She is now amenable to possible operative measures. She states Dr. Dennis was unsure as to potential efficacy and prior to proceeding she wants to have a surgical second opinion to determine if a repeat evaluation would prove more optimistic concerning potential outcome. I do not think this is unreasonable. Will see patient in 4 weeks after surgical reevaluation. Consider referral back to Dr. Dennis if patient ultimately decides on operative measures.
2. Continue sedentary work status with part-time hours.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.

FAXED 10/2/06
Dr. Dennis - 10/11/06
Glenn Martin
937-4990

7

SPINE AND ORTHOPAEDIC SPECIALISTS OF SOUTH CAROLINA PA

843-856-9669

Dr. J. Robert Alexander, Jr. Dr. Chris P. Tountas

WORK STATUS

Patient's Name Sara Wilson

Employed by: _____

The above employee was seen: 9/28/06

Return to work with no restrictions: _____

Return to work on _____ with restrictions: _____

No change in previous restrictions

Lifting not to exceed _____

Full time ☐ Other _____

Part-time ☐

Follow-up visit: _____

MMI _____ PPI _____

Physician: J. Robert Alexander Jr MD Date 9/28/06

FAXED 9/29/06 to Glen Martin

74

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WILSON, SARA
DOB [redacted]/43
CHART # 2136
10/25/06

HPI: Ms. Wilson is seen today in follow-up from 09/28/06. States that the surgical second opinion that patient specifically requested was reportedly denied by worker's comp. She continues to have pain with a VAS of 4/10, but she states overall she is improved with nonoperative treatment that we provided. Describes side effects with Lortab and requested returning to Ultram dosing.

PHYSICAL EXAM: Tenderness right cervical paraspinal region.

ASSESSMENT: Cervical pain with intermittent right upper extremity pain/paresthesias. Right paracentral disc protrusion C6-7 on MRI. Unremarkable EMG, but symptoms suggestive of cervical radiculitis.

PLAN:

1. Patient has demonstrated some improvement with multiple cervical injections to date, including epidural, but is not asymptomatic. Offered reevaluation with Dr. Dennis, but she declines at this time stating he felt surgical measures would likely not provide her with considerable benefit. I explained to her that this remains an option and she understands. Given she is undecided, we will see her in 3 weeks. If she continues to decline further surgical evaluation, consider placement at MMI.
2. Refilled Ultram.
3. Patient reported to me that she is retired and does not plan on returning to work.
4. Discontinue formal PT and transition to home exercise program.
5. If patient is to obtain further employment, recommend sedentary work status.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.
R. Blake Dennis, M.D.

FAXED 11/01/06
Glenn Martin
Dr. Dennis

75

SPINE AND ORTHOPAEDIC SPECIALISTS OF
SOUTH CAROLINA PA
843-856-9669

Dr. J. Robert Alexander, Jr. Dr. Chris P. Tountas

WORK STATUS

Patient's Name Sara Wilson

Employed by:

The above employee was seen: 10/25/06

Return to work with no restrictions:

Return to work on 10/25/06 with restrictions: ✓

Sedentary duty, part time

Lifting not to exceed

Full time ☐ Other

Part-time ☑

Follow-up visit: 3 weeks

MMI PPI

Physician: J. Robert Alexander Jr. MD Date 10/25/06

76

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Chris P. Tountas, M.D.

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843-856-9669 • 888-856-9669 • Fax 843-856-9161

WILSON, SARA
DOB [redacted]/43
CHART # 2136
11/16/06

HPI: Ms. Wilson is seen today in follow-up from 10/25/06. She had surgical second opinion with Dr. Stovall who advised her about potential risks and benefits of operative measures. States that it is an option that he feels would likely help with her right upper extremity symptoms, but may not help with her cervical axial discomfort. Patient states she prefers to hold off on operative intervention at this time.

Initial history and physical findings reviewed and she reports no new complaints.

PHYSICAL EXAM: Tenderness right cervical paraspinal region.

ASSESSMENT: Cervical and intermittent right upper extremity pain/paresthesias with right paracentral disc protrusion C6-7 on MRI. Unremarkable EMG.

PLAN:

1. Patient has had two operative evaluations with Dr. Dennis and Dr. Stovall. She has decided against surgical measures at this time. Subsequently determined to be at MMI given she has undergone exhaustive nonoperative conservative measures. Will utilize AMA guides to determine impairment rating.
2. Continue diclofenac and Ultram on a p.r.n. basis. Also continue TENS and home traction.
3. Continue home exercise program.
4. Recommend permanent restrictions of sedentary work status. Of note, patient is retired, however.
5. Individual will likely require periodic interventional measures, including injections, p.o. medications, and PT in the future depending on level of symptomatology. Operative measures also remain an option. Patient understands she can contact our office on a p.r.n. basis any major changes in current status.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.
R. Blake Dennis, M.D.

FAXED 11/29
Glenn 77

SPINE AND ORTHOPAEDIC SPECIALISTS OF SOUTH CAROLINA PA

843-856-9669

Dr. J. Robert Alexander, Jr. Dr. Chris P. Tountas

WORK STATUS

Patient's Name Dara Wilson

Employed by: _____

The above employee was seen: 11/16/16

Return to work with no restrictions: _____

Return to work on 11/16/16 with restrictions: ✓

sedentary duty

Lifting not to exceed _____

Full time ☐ Other _____

Part-time ☐

Follow-up visit: as needed

FAXED 11/29

MMI ✓ PPI Glenn

Physician: _____ Date 11/16/16

78

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WILSON, SARA
DOB [redacted]/43
CHART # 2136
11/17/06

Ms. Wilson was determined to be at maximum medical improvement on office visit 11/16/06. Utilizing AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, she is determined to fall in DRE cervical category II given cervical and radicular symptoms with paracentral disc protrusion on MRI. Unremarkable neurologic and electrodiagnostic examination. Given non-verifiable radicular complaints, she is subsequently determined to have an eight percent impairment rating of the whole person.

J. Robert Alexander, Jr., M.D.

JRA/ts

cc: Worker's Comp.

FAXED 11/29
Glenn

CHARLESTON NEUROSCIENCE INSTITUTE
IMAGING

DIAGNOSTIC IMAGING, NEURORADIOLOGY, IMAGE-GUIDED PROCEDURES

David D. Goltra, Jr., M.D. Beverly M. Genez, M.D.

Ant 1/25

PATIENT NAME: WILSON, SARA

W 89612

PATIENT ID#: 114222

DATE OF BIRTH: [redacted]/1943

JKH

DATE OF EXAM: 01/16/07

TYPE OF EXAM: MAGNETIC RESONANCE IMAGING (MRI) LUMBAR SPINE

REFERRING PHYSICIAN: DR. AYMOND

CLINICAL HISTORY: Pain in the back and both legs with weakness in the right legs. The patient gives a history of scoliosis.

TECHNIQUE: Coronal T1, sagittal T2, sagittal T1, sagittal fat sat proton density, STIR, axial T1 and axial T2, sagittal STIR.

FINDINGS:
SPINE OVERVIEW: There is scoliosis of the lumbar spine, which is convex to the patient's left, blending into a thoracic scoliosis which is convex to the patient's right. Signal intensity in the proximal femurs is normal. There is no anterolisthesis or retrolisthesis of the spine. The conus medullaris terminates normally. No congenital anomaly of the lumbar spine is identified. A rounded, hyperintense lesion of L1 is consistent with a hemangioma. There reactive changes in the endplates at multiple levels.

FINDINGS BY LEVEL:
L1-2: There is mild circumferential bulging of the annulus and mild facet arthropathy without significant stenosis.

L2-3: No significant abnormality.

L3-4: There is minimal facet arthropathy without significant stenosis.

582 Long Point Road, Mount Pleasant, SC 29464
Phone: (843) 352-0674 (CNI) Fax: (843) 971-8832
www.cnimd.com

88

CHARLESTON NEUROSCIENCE INSTITUTE
IMAGING

DIAGNOSTIC IMAGING, NEURORADIOLOGY, IMAGE-GUIDED PROCEDURES

David D. Goltra, Jr., M.D. Beverly M. Genez, M.D.

PATIENT NAME: WILSON, SARA
PATIENT ID#: 114222
DATE OF BIRTH:
DATE OF EXAM: 01/16/07

L4-5: There is mild circumferential bulging of the annulus and facet arthropathy. There is mild bilateral foraminal narrowing.

L5-S1: There is bilateral facet arthropathy with joint effusions and osteophytes. There is hypertrophy of the ligamentum flavum, particularly on the left side. There is mild central, lateral recess, and bilateral foraminal narrowing.

IMPRESSION: Lumbar spine Magnetic Resonance Imaging (MRI) shows scoliosis as described above. No congenital anomaly of the spine is identified. There are mild changes of spinal stenosis without evidence for focal protrusion of disk material.

Beverly McGenez MD
Beverly Genez, M.D.

REVIEWED AND APPROVED BY:
Dr. David Goltra David D Goltra Jr.

Dictated: 01/17/2007 22:26:59 EST
Typed: 01/18/2007 12:22:50 EST
Transcriptionist: sg

582 Long Point Road, Mount Pleasant, SC 29464
Phone: (843) 352-0674 (CNI) Fax: (843) 971-8832
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89

AGENCY I.D.
SCO 160100

INCIDENT REPORT
CHARLESTON POLICE DEPARTMENT 13B

OCA 0 1 0 5 1 9 0 6 0 0 1 1 1 1
ARR

NCIC NO. ENTD.

EVENT

INCIDENT TYPE	COMPLETED	FORCED ENTRY	PREMISE TYPE	UNITS ENTERED	TYPE VICTIM
1. ASSAULT X 1	☒YES ☐NO	☐YES ☒NO	SCHOOL	0	☒Individual ☐Business ☐Financial Inst. ☐Government ☐Relig. Org. ☐Soc./Public ☐Other ☐Unknown ☐Police Off.
2.	☐YES ☐NO	☐YES ☐NO			
3.	☐YES ☐NO	☐YES ☐NO			

INCIDENT LOCATION (SUBDIVISION, APARTMENT AND ROOM#, STREET NAME AND NUMBER): 741 KING ST. (JAMES SIMMONS) CHARLESTON SC — ZIP CODE: 29403 — WEAPON TYPE:

INCIDENT DATE	24 HR CLOCK	TO	DATE	24 HR CLOCK	DISPATCH DATE/TIME 24 HR CLOCK: DISP. DATE	DISP. TIME	TIME ARRIVED	DEPART TIME	LOCATION NO.
05.09.06	1150		05.09.06	1155	05.19.06	0830	0840	0900	1/1

COMPLAINANT'S NAME (LAST, FIRST, MIDDLE): SAME AS VICTIM #1 — RELATIONSHIP TO SUBJECT #1 #2 #3: — RESIDENT: JSOU — RACE — SEX — AGE — ETH. — DAYTIME PHONE: H B — EVENING PHONE: H B

ADDRESS — CITY — STATE — ZIP CODE — LOCATION NO. 1/1

VICTIM NO. 1

VICTIM'S NAME (LAST, FIRST, MIDDLE): WILSON, SARA YOUNG — RELATIONSHIP TO SUBJECT #1: ACQ — #2 — #3 — RESIDENT: OSOU — RACE: B — SEX: F — AGE: 63 (was 63) — ETH.: N — DAYTIME PHONE: H 805-6715 — EVENING PHONE: H [redacted] B

HEIGHT	WEIGHT	HAIR	EYES	FACIAL HAIR, SCARS, TATTOOS, GLASSES, CLOTHING, PHYSICAL PECULIARITIES, ETC.
511	112	BLK	BRO	

ADDRESS: [redacted] — CITY: CHARLESTON — STATE: SC — ZIP CODE: [redacted] — LOCATION NO.

VISIBLE INJURY (VICT. 1) ☒YES ☐NO EXPLAIN: BRUISING - ARM, LEG, CHEST, HIP, HEMATOMA ON KIDNEY — DISPOSITION OF ANY NON-ARRESTEE INJURIES: ☐Yes ☐NO

VICTIM (NO. 1) USED: ALCOHOL ☐YES ☐NO ☒UNK ☐ — DRUGS ☐YES ☐NO ☒UNK ☐ TYPE:

TWO-WAY VER. — ONE-WAY VER. ☐ DETECTIVE/SPL. ASST. ☐ OTHER ☐ — ALONE ☐ — ASSISTED ☐ — J—This Jurisdiction, S—State, O—Out of State, U—Unknown

SUBJECT NO. 1

☒SUSPECT ☐RUNAWAY ☐WANTED ☐WARRANT ☐ARREST ☐JUV. ☐JUVENILE

NAME (LAST, FIRST, MIDDLE): [redacted] — DATE OF BIRTH — HEIGHT — WEIGHT — HAIR — EYES

FACIAL HAIR, SCARS, TATTOOS, GLASSES, CLOTHING, PHYSICAL PECULIARITIES, ETC.

ADDRESS — CITY: [redacted] — STATE — ZIP CODE — LOCATION NO.

SUBJECT (NO. 1) USED: ALCOHOL ☐YES ☐NO ☒UNK ☐ — DRUGS ☐YES ☐NO ☒UNK ☐ TYPE: — ARRESTED AT OR NEAR SCENE ☐YES ☐NO ☒ — TOTAL # ARRESTED: NONE — DISPOSITION OF ARRESTEE — DATE/TIME OF ARREST

NARRATIVE

ON 05.19.06, AT APPROX 0830 HOURS R/O WAS DISPATCHED TO 126 W. POPLAR IN REF TO AN ASSAULT THAT TOOK PLACE ON 05.09.06, AT APPROX 1150 HOURS. UPON ARRIVAL R/O SPOKE WITH THE COMP/VIC WHO STATED THAT TWO STUDENTS (SUSP. #1 [redacted] 5TH GRADE, SUSP. #2 [redacted]) ENGAGED IN A SHOVING MATCH IN THE MAIN OFFICE. WHEN THE SITUATION ESCALATED VICTIM (WILSON, SARA B/F DOB 11.27.43) ATTEMPTED TO INTERVENE, HOWEVER, INADVERTANTLY GOT SHOVED INTO THE FRONT COUNTER. THE MARBLE COUNTER CAUSED BRUISING TO HER RIGHT LEG, ARM, HIP AND RIBS. AFTER SEEING A PHYSICIAN, IT WAS DISCOVERED THAT SHE HAD A HEMATOMA ON HER KIDNEY. VICTIM IS NO ON WORKERS COMP AND WOULD LIKE TO PRESS CHARGES.

JURISDICTION OF OFFICE, LAW ENFORCEMENT AGENCY: — JURISDICTION OF RESIDENCE, LAW ENFORCEMENT AGENCY:

PROPERTY EST.

TYPE (GROUP)							TOTAL VALUE
STOLEN							
DAMAGED							
BURNED							
RECOVERED							
SEIZED							

ADMINISTRATIVE

SUBJECT IDENTIFIED ☒YES ☐NO — SUBJECT LOCATED ☐YES ☒NO — ☐ACTIVE ☐ADM. CLOSED ☐UNFOUNDED — ☐ARRESTED UNDER 18 ☐ARRESTED 18 AND OVER — ☐EX-CLEAR UNDER 18 ☐EX-CLEAR 18 AND OVER

REASON FOR EXCEPTIONAL CLEARANCE: 1. ☐OFFENDER DEATH 2. ☐NO PROSECUTION 3. ☐EXTRADITION DENIED 4. ☐VICTIM DECLINES COOPERATION 5. ☐JUVENILE-NO CUSTODY

REPORTING OFFICER(S)	DATE	UNIT NUMBER	APPROVING OFFICER	DATE	UNIT NUMBER
PAT. S. GESSNER	05.19.06	B46	Cpl. [signature]	5-19-06	0975
			FOLLOW-UP OFFICER		

AGENCY SCO 1000100

SUPPLEMENTAL INCIDENT REPORT
CHARLESTON POLICE DEPARTMENT

OCA [redacted]
ARR

NCIC NO. | ENTD.

☒ ORIGINAL REPORT ☐ SUPPLEMENTAL REPORT ☐ ADDITIONAL VICTIMS ☐ ADDITIONAL STOLEN PROPERTY
☐ MODIFIES ORIGINAL ☐ CASE STATUS CHANGE ☐ ADDITIONAL OFFENDERS ☐ ADDITIONAL RECOVERED PROPERTY
PAGE 2 of 2 PAGES

VICT./SUBJ. I.D. OVERFLOW

☐ COMPLAINANT ☐ VICTIM # ☒ SUBJECT # 2 ☐ RUNAWAY ☐ WANTED ☐ WARRANT ☐ ARREST ☐ JAIL ☐ SUMMONS ☐

NAME (LAST, FIRST, MIDDLE) [redacted] | VICTIM RELATIONSHIP TO SUBJECT #1 #2 #3 | RESIDENT | RACE | SEX | AGE | D.O.B. | ETH. N

PHYSICAL HAIR, SCARS, TATOOS, GLASSES, CLOTHING, PHYSICAL PECULIARITIES, ETC. [redacted]

ADDRESS [redacted] | CITY [redacted] | STATE | ZIP CODE | LOCATION NO. | DAY PHONE H B | EVENING PHONE H B

☐ VICTIM NO ——— VISIBLE INJURY ☐ NO ☐ YES | COMPLAINT OF NON-VISIBLE INJURIES ☐ NO ☐ YES | VICTIM USING ALCOHOL ☐ NO ☐ YES ☐ UNK DRUGS ☐ NO ☐ YES TYPE ☐ UNK | ☐ TWO-MAN VEHICLE ☐ ONE-MAN VEHICLE ☐ DETECTIVE/SPLASH ☐ OTHER | ☐ ALONE ☐ ASSISTED
EXPLAIN

☒ SUBJECT NO. 2 USING ALCOHOL ☒ NO ☐ YES
USING DRUGS ☒ NO ☐ YES → TYPE ☐ UNK

VICT./SUBJ. I.D. OVERFLOW

☐ COMPLAINANT ☐ VICTIM # ☐ SUBJECT # ☐ RUNAWAY ☐ WANTED ☐ WARRANT ☐ ARREST ☐ JAIL ☐ SUMMONS ☐

NAME (LAST, FIRST, MIDDLE) | VICTIM RELATIONSHIP TO SUBJECT #1 #2 #3 | RESIDENT J S O U | RACE | SEX | AGE | D.O.B. | ETH.

HEIGHT | WEIGHT | HAIR | EYES | PHYSICAL HAIR, SCARS, TATOOS, GLASSES, CLOTHING, PHYSICAL PECULIARITIES, ETC.

ADDRESS | CITY | STATE | ZIP CODE | LOCATION NO. | DAY PHONE H B | EVENING PHONE H B

☐ VICTIM NO ——— VISIBLE INJURY ☐ NO ☐ YES | COMPLAINT OF NON-VISIBLE INJURIES ☐ NO ☐ YES | VICTIM USING ALCOHOL ☐ NO ☐ YES ☐ UNK DRUGS ☐ NO ☐ YES TYPE ☐ UNK | ☐ TWO-MAN VEHICLE ☐ ONE-MAN VEHICLE ☐ DETECTIVE/SPLASH ☐ OTHER | ☐ ALONE ☐ ASSISTED
EXPLAIN

☐ SUBJECT NO. ——— USING ALCOHOL ☐ NO ☐ YES
USING DRUGS ☐ NO ☐ YES → TYPE ☐ UNK

NARRATIVE

ASSOCIATION OF THEFT LAW ENFORCEMENT AGENCY | ASSOCIATION OF RECOVERY LAW ENFORCEMENT AGENCY

VEH./GUN/ETC. 1

STATUS: ☐ STOLEN ☐ RECOVERED ☐ FOUND ☐ TOWED ☐ SUSPECT ☐ VICTIM
TYPE: ☐ VEHICLE ☐ GUN ☐ BOAT ☐ LICENSE PLATE ☐ SECURITIES/BONDS, STOCKS ☐ ARTICLE

VIN AND/OR LICENSE NO | BOAT HULL NO. AND/OR REG. NO
SERIAL AND/OR OWNER APPLIED NO. | STATE
YEAR OF REGISTRATION | YEAR OF EXPIRATION | YEAR | MAKE | TYPE
MODEL | STYLE | COLOR | SERVICE/USE | CALIBER
ITC NO | DENOMINATION | ISSUER | SECURITIES DATE
MISCELLANEOUS

PROPERTY EST.

TYPE (GROUP)							TOTAL VALUE
STOLEN							
DAMAGED							
BURNED							
RECOVERED							
SEIZED							

ADMINISTRATIVE

SUBJECT IDENTIFIED ☒ YES ☐ NO | SUBJECT LOCATED ☐ YES ☒ NO | ☐ ACTIVE ☐ ADM CLOSED ☐ UNFOUNDED | ☐ ARRESTED UNDER 18 ☐ ARRESTED 18 AND OVER | ☐ EX-CLEAR UNDER 18 ☐ EX-CLEAR 18 AND OVER

REASON FOR EXCEPTIONAL CLEARANCE: 1. ☐ OFFENDER DEATH 2. ☐ NO PROSECUTION 3. ☐ EXTRADITION DENIED 4. ☐ VICTIM DECLINES COOPERATION 5. ☐ JUVENILE - NO CUSTODY

REPORTING OFFICER(S)	DATE	UNIT NUMBER	APPROVING OFFICER	DATE	UNIT NUMBER
PVT GESSNER	05-19-06	1346	[signature]	5-19-06	0175

FOLLOW-UP INVESTIGATION ☐ YES ☐ NO ☐ OFFICER

91

F-274

CHARLESTON COUNTY
SCHOOL DISTRICT

ELECTION FORM
TO ELECT OR DECLINE USE OF SICK LEAVE
IN CONJUNCTION WITH WORKERS' COMPENSATION BENEFITS

DATE: May 22, 2006

TO: Joe R. House
CCSD RISK MANAGEMENT OFFICER

FROM: Sara Y. Wilson
(Print employee's name)

Option "A": I understand that under the S.C. Workers' Compensation Law, (section 42-9-200) I will receive no worker's Compensation Temporary Total Disability (TTD) benefits should my disability last less than seven (7) consecutive days or less. Should my disability last eight (8) consecutive days, or longer, I will receive TTD payments at the rate prescribed by the South Carolina Workers' Compensation Commission. Should my disability last longer than fourteen (14) days, then my first seven days of disability will be compensated (unless accrued sick time was used) at the rate prescribed by the South Carolina Workers' Compensation Commission.

Option "B": I understand that I may elect to use my available accrued sick leave from DAY ONE through day seven so that I do not suffer a loss in pay. After Day Seven, I understand that I will receive only the allowable Workers' Compensation benefits due me. If I decline to use my sick leave, I understand my compensation will be limited to benefits available under the South Carolina Workers' Compensation Law.

I UNDERSTAND IT IS MY RESPONSIBILITY TO MAINTAIN MY PERSONAL MEDICAL COVERAGE WHILE RECEIVING TEMPORARY TOTAL DISABILITY (TTD) BENEFITS AND NOT DRAWING A CCSD PAYCHECK. Initial: SYW

Check one:
I hereby elect Option "A" _____ to claim Workers' Compensation benefits for lost wages under the S.C. Workers' Compensation Law.

I hereby elect Option "B" √ to use my sick leave from Day One through Day Seven so that I do not suffer a loss in pay.

Sara Y. Wilson
Signature

5/22/06
Date

James Simons Elem.
School/Department

CCSD/WC Sick Leave Election doc Revision 01/06

RECEIVED
MAY 25 2006
BY:.....

92

08/21/2006
14:28 EM

Charleston County School District
DETAIL CHECK HISTORY
BY EMPLOYEE NAME
06/19/2006 to 08/25/2006

PG 1
prhisrpt

ORG	OBJ	PROJ	LOC	JOB	CHECK	PAY TYPE	HOURS	AMOUNT	DED TYPE	EMPLOYEE	EMPLOYER
[redacted]-6756 WILSON, SARA						LOC: 0707 ORG: 70712331					
Check Date: 06/28/2006											
70712331	115		0166	0463	000865975	136 CLAS10	68.15	927.64			
CHECK 06/28/2006 TOTALS:					NET:	927.64	68.15	927.64		0.00	0.00
Check Date: 06/30/2006											
70712331	115		0166	0463	000000000	136 CLAS10	-11.85	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
70712331	115		0166	0463	000000000	511 WORK C	8.00	0.00			
CHECK 06/30/2006 TOTALS:					NET:	.00	68.15	0.00		0.00	0.00
Check Date: 07/14/2006											
70712331	115		0166	0463	001331807	136 CLAS10	0.00	387.95			
CHECK 07/14/2006 TOTALS:					NET:	387.95	0.00	387.95		0.00	0.00
Check Date: 08/11/2006											
70712331	115		0166	0463	001343681	136 CLAS10	71.08	1,004.13			
CHECK 08/11/2006 TOTALS:					NET:	1,004.13	71.08	1,004.13		0.00	0.00
Check Date: 08/25/2006											
70712331	115		0166	2170	001348468	136 CLAS10	71.08	1,004.13			
CHECK 08/25/2006 TOTALS:					NET:	1,004.13	71.08	1,004.13		0.00	0.00
EMPLOYEE TOTALS:					NET:	3,323.85	278.46	3,323.85		0.00	0.00
GRAND TOTALS:					NET:	3,323.85	278.46	3,323.85		0.00	0.00

** END OF REPORT - GENERATED BY BETH MCBRAYER **

CHARLESTON COUNTY SCHOOL DISTRICT
ACCIDENT/INCIDENT REPORT

This Portion of Form To Be Completed By Individual Who Witnessed or Was Made Aware of Incident

Carole Dimond Sarah Wilson
SCHOOL OR OFFICE NAME OF INJURED

☐ Male DOB
☐ Female Age

Incident Date 5-9-06
Incident Time 11:50 am
Report Date 5-9-06

Indicate Status of Injured Party
☐ Student ☑ Employee ☐ Visitor ☐ Other
COMPLETE THIS SECTION FOR EMPLOYEES ONLY
EMPLOYEE'S POSITION
POTENTIAL EXPOSURE TO BLOOD OR BODY FLUID CONTACT? ☐ YES ☐ NO

Nature of Incident		PART OF BODY INJURED				Location of Incident	
		Indicate Side	Indicate Side				
☐ Abrasion	☐ Dislocation	Left Right	X in Right	☐ Face	☐ Lip	☐ Bus	☐ Stairs
☐ Bite	☐ Fracture	☐ ☐ Ankle	☐ ☐ Foot	☐ Back	☐ Neck	☐ Classroom	☐ Cafeteria
☐ Burn	☐ Laceration	☐ ☐ Ear	☐ ☐ Hand	☐ Chest	☐ Nose	☐ Hallway	☐ Gym/Field
☐ Bruise	☐ Puncture	☐ ☐ Elbow	☐ ☐ Knee	☐ Groin	☐ Scalp	☐ Lunch Room	☐ Parking Lot
☐ Contusion	☐ Sprain	☐ ☐ Eye	☐ ☐ Leg	☐ Head	☐ Abdomen	☐ PE Class	☐ Food Room
☐ Dental	☐ Other	☐ ☐ Finger	☐ ☐ Shoulder	☐ Hip	☐ Other	☐ Playground	☑ Other
			☐ ☐ Wrist				

Describe the incident and/or injury Ms. Wilson was pushed against the counter in office. C/O pain to (L) side and (L) hip.

Name of Individual who witnessed or was made aware of the Incident

This Portion of Form To Be Completed and Signed By Individual Who Rendered Assistance/First Aid

Describe First Aid Given: referred to Emergency Room.

RECEIVED
MAY 18 2006
RISK MANAGEMENT DIVISION
CHARLESTON COUNTY SCHOOL DISTRICT

Who was notified? ☐ Parent/Guardian Name ☐ Other:

Injured Taken: ☐ Back To Class by
☐ Home ☐ MD ☐ Dentist ☐ Hospital ☐ Other

Injured Transported by: Name ☐ Parent/Guardian ☐ EMS ☐ Supervisor

Signature of Individual Rendering Assistance/First Aid
Signature of Principal or Supervisor

FAX TO 937-6468 OR SEND WHITE COPY BY COURIER TO RISK MANAGEMENT

94

EMPLOYEE SERVICES FORM
CHARLESTON COUNTY SCHOOL DISTRICT
HUMAN RESOURCE DEPARTMENT

1. Employee's Name: Sara Y. Wilson 2. SS #: [redacted]
3. Position: Data Entry Clerk 4. Position Control Number 10723441
(See back for Standardized Position Control description)
5. Date of Hire: __/__/__ 6. Hours per Day: __
7. School/Department: James Simons Elem 8. REV#: _____
9. Please check all boxes that apply:
☐ New Position ☐ Transfer ☐ Reg. Retiree Transfer within CCSD; To: _____
☐ Full Time ☐ Part Time ☐ TERI Retiree ☐ Temporary
10. Please check the appropriate funding:
☐ Local/GOF ☐ Non-Local Specify: _____
☐ IDEA ☐ FRCS ☐ RCS ☐ PERKINS ☐ TITLE I
11. Account Number: If applicable... _____ ORG _____ OBJ _____ PROJ FTE: __ __
12. Termination Date: 09/11/06 Termination Code: 18 ⇒
13. ASSIGNMENT CHANGE IN CONTRACT OR IN POSITION FROM _____ TO _____
14. Employee's Signature: Sara Y Wilson Date: __/__/__
ADDITIONAL:
15. FROM ACCT #: _____ FTE: _____
TO ACCT #: _____ FTE: _____
16. FROM ACCT #: _____ FTE: _____
TO ACCT #: _____ FTE: _____
18. Principal/Dept. Head Signature 10,03,06 Date
Additional Signature 10,03,06 Date

TERMINATION CODES	
10-LA	31-EXCESS ABS
11-DRAB	32-PER REAS
12-OTH WK	33-FAIL REPOR
13-FAIL	34-NO REAS
14-UNSAT	35-PROBAT
15-NL	36-LACK PTE
16-INSUF PAY	37-3PAY CHK
17-MOVE	38-OTHER SC
18-RETIRE	39-MILITARY
19-SUSPEND	40-MAX LEAVE
20-DEPT PROB	41-NO TRANSP
21-NO CERTIF	42-REFUSED ORI
22-TERM END	43-VIOLATION
23-DECEASE	44-TARDINESS
24-RIF	45-FALSE STAT
25-MISCON	46-ALCOHOL
26-TRANS DSB	47-PERM AGENT
27-WK CONF	48-UNSATISFAC
28-DEATH	49-OTHER VOL
29-VIOLATIX	50-TERI
30-SCHOOL	

EMPLOYEE SERVICES ONLY:	PAYROLL ONLY:
Employee Number: _____	
Gr/Band: __/__	
Salary: $ _____	

White-EMPLOYEE SERVICES Yellow-PAYROLL Pink-SCHOOL/DEPT.

CERTIFICATE OF APPRECIATION

for

Sara Wilson
Data Entry Clerk

James Simons Elementary School

In Recognition of Valuable Service to

the

Charleston County School District

Awarded June 6, 2006

Celeste Kanto
Public Accounting Officer

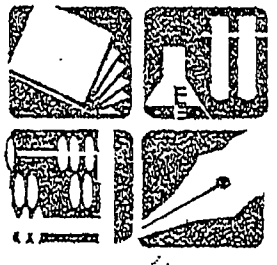
Donna Deramaya
Pupil Accounting Technician

Jackie Felder
Pupil Accounting Technician

Phyllis Sheppard
Pupil Accounting Technician

"We're making Charleston PROUD of its Public Schools!"

CERTIFICATE OF APPRECIATION



This certificate is awarded to

Sara Wilson

For consistently accurate and up-to-date SASI data for the 2005-2006 school year!

"Pursuing Excellence...Creating Our Future"

Elaine J Ruckenbrocker — 6-5-06
Technical Support Officer — Date

Randall A Klunge — 6/5/06
Data Management Officer — Date

126 West Poplar Street
Charleston, SC 29403
September 29, 2006

Mr William C. Dixon, Jr., Principal
James Simons Elementary School
741 King Street
Charleston, SC 29403

Dear Mr. William Dixon,

This letter comes regretfully to inform you of my retirement from James Simons Elementary School, effective September 11, 2006. Because of the injury I received on May 9, 2006, I am no longer able to work, I am saddened by the manner of my retirement, as I had anticipated working an additional 2-3 years. I had envisioned an amiable relationship assisting you in building James Simons once again to a school of high standards.

Retiring due to injury was something that had never entered my mind. Retirement should be a time of jubilation and celebration with family and friends, of a job well done. Because of bodily injury this was not afforded to me.

I wish you well and if there are any questions related to my duties, do not hesitate to call.

Have a successful school year.

Respectfully,
Sara Y. Wilson

CC: Attorney Tiffany R. Spann-Wilder
Annette Heyward, Personnel
Kathy Smalls, Benefits

Form 6253
Revised 04/04/2002
Print or type in black ink

EMPLOYER'S DISABILITY EMPLOYMENT STATUS REPORT

To Be Completed by Applicant's Payroll/Benefits Officer
State Budget and Control Board, Employee Benefits Division
South Carolina Retirement Systems
Attention: Customer Services Annuity Claims
PO Box 11960, Columbia, SC 29211-1960

☑ SCRS ☐ PORS ☐ GARS

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.

Employee Name: Sara Y. Wilson | Social Security Number: [redacted]

Employer: Charleston County School District | Employer Code: 810.01

Position Title: Student Data Clerk

1. Is the position title shown above correct?
☑ Yes ○ No (please explain)

2. Annual salary on date of disability:
$ 26,107.44

3a. Is the employee currently working?
☑ No (last day physically worked): 5-9-06 MM-DD-YYYY (skip to Question 4a)
○ Yes (proceed to Question 3b)

3b. Is the employee performing all regular duties?
○ Yes (skip to Question 8a)
○ No (proceed to Question 3c)

3c. In what capacity is the employee currently working?
○ Light duty* ○ Diminished capacity* ○ Leave without pay (not terminated) (attach copy of Personnel Policy)
○ Reduced hours
○ Other (please explain)

*Attach letter explaining current duties in relation to normal work functions.

3d. Date member was placed in status shown at left: MM-DD-YYYY

4a. Is this employee terminated?
○ No (skip to Question 5)
☑ Yes (date of termination): 9-11-06 MM-DD-YYYY (proceed to Question 4b)

4b. Last day compensation was earned (including pay continuation, using annual and sick leave):
9-11-06 MM-DD-YYYY

4c. Amount of lump-sum payments for unused leave
Annual leave $
Sick leave $

4d. Number of days of unused leave: (complete and proceed to Question 6a)
Annual leave 0
Sick leave 9.37 days

5. Employee's current payroll status (check one and indicate appropriate date):
○ On annual leave (date leave began): MM-DD-YYYY
○ On leave without pay (date leave began): MM-DD-YYYY
○ On sick leave (date leave began): MM-DD-YYYY
○ Applied for leave under sick leave bank, (date leave begins): MM-DD-YYYY
☑ Other (please explain): Retirement 9-11-06

6a. Was this employee injured on the job?
○ No ☑ Yes (date of injury) MM-DD-YYYY

6b. Is employee on leave without pay (not terminated) pending settlement of a Workers' Compensation claim?
☑ No ○ Claim settled (date): MM-DD-YYYY
○ Yes

I hereby certify that to the best of my knowledge, the information above correctly reflects the records of the employing entity.

Prepared by Annette M. Heyward Title HR Technician

Signature Annette M. Heyward Date 10-2-06 Telephone 843-937-6866

Return completed form to the SC Retirement Systems (address above).
Please call SC Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800

09

Form 6254
Revised 04/04/2002
Print or type in black ink

EMPLOYER'S DESCRIPTION OF DISABILITY APPLICANT'S JOB

(TO BE COMPLETED BY APPLICANT'S SUPERVISOR)
State Budget and Control Board: Employee Benefits Division
South Carolina Retirement Systems ATTENTION: CUSTOMER SERVICES ANNUITY CLAIMS
PO Box 11960, Columbia SC 29211-1960

Retirement System: ☒ SCRS ☐ PORS ☐ GARS

The individual indicated below has applied for disability retirement benefits. Please complete the information on the remainder of this form, and return it to the address listed above as soon as possible. Upon receipt of this completed form, the employee's application will be processed.

DISABILITY APPLICANT/EMPLOYEE INFORMATION

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number
Wilson	Sara.	[redacted]

4. Position Title	5. Employer	6. Employer Code
Clerk	Charleston Cty. Sch Dist	840.01

Date employee started this position: 08/28/1992 (MM-DD-YYYY)

Date employee stopped work in this position because of disability: 5-9-2006

IN THIS JOB DID THE EMPLOYEE:

A. Use machines, tools, or equipment of any kind? ● Yes ○ No
B. Use technical knowledge of any kind? ● Yes ○ No
C. Do any writing, complete reports, or perform similar duties? ● Yes ○ No
D. Have supervisory responsibilities? ○ Yes ○ No

DESCRIBE BASIC DUTIES OF JOB BELOW AND ATTACH EMPLOYEE'S POSITION DESCRIPTION.
ALSO, EXPLAIN ALL "YES" ANSWERS ABOVE BY GIVING A *FULL DESCRIPTION* OF:
A. Type of machines, tools, or equipment used, and exact operations performed.
B. The technical knowledge or skills involved.
C. Type of writing done and nature of reports.
D. The number of people supervised and the extent of supervision.

Mrs. Wilson's position called for her to use computers, copiers, printing, telephones, and forms for day-to-day SAST Data Clerk duties for Student data. Mrs Wilson record duties included but not limited to Data Verification for State department as well as Charleston County School District.

DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY THIS JOB INVOLVED DURING A TYPICAL DAY, IN TERMS OF:

A. *CHECK NUMBER OF HOURS A DAY:*

	1	2	3	4	5	6	7	8
WALKING	○	○	●	○	○	○	○	○
STANDING	●	○	○	○	○	○	○	○
SITTING	○	○	○	●	○	○	○	○

B. *CHECK HOW OFTEN:*

BENDING	○ NEVER	○ OCCASIONALLY	○ FREQUENTLY	● CONSTANTLY
REACHING	○ NEVER	○ OCCASIONALLY	○ FREQUENTLY	● CONSTANTLY

C. *LIFTING AND CARRYING*

THIS EMPLOYEE OCCASIONALLY (UP TO 1/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES:

● LESS THAN 10 LBS.	Kinds of objects lifted: Student Records and files.
○ 10 LBS.	Kinds of objects lifted:
○ 20 LBS.	Kinds of objects lifted:
○ 30 LBS.	Kinds of objects lifted:
○ 50 LBS.	Kinds of objects lifted:
○ 50 LBS. OR MORE	Kinds of objects lifted:

THIS EMPLOYEE FREQUENTLY (1/3 TO 2/3 OF AN 8-HOUR DAY) LIFTS AND/OR CARRIES:

○ LESS THAN 10 LBS.	Kinds of objects lifted:
○ 10 LBS.	Kinds of objects lifted:
○ 20 LBS.	Kinds of objects lifted:
○ 30 LBS.	Kinds of objects lifted:
○ 50 LBS. OR MORE	Kinds of objects lifted:

NAME OF SUPERVISOR (PLEASE PRINT)	TITLE	
William C. Dixon, Jr.	Principal	
PHONE: 843-805-6714	DATE: 8-28-06	SIGNATURE: [signature]

Position Description Attached ○ Yes ○ No

Return completed form to the SC Retirement Systems (address above).
Retirement Systems Customer Service with any questions: 1-800-868-9002 (in state) or 803-737-6800

CHARLESTON COUNTY
SCHOOL DISTRICT

LETTER OF INTENT FOR CLASSIFIED (NON-ADMINISTRATIVE) PERSONNEL

On behalf of the Employee listed below, this letter is to advise the Employee of the Employer's intent to re-employ during the 2006-2007 school term. The position, as indicated below, will be held for you, pending provision for the same in the approved 2006-2007 budget.

Employer: Charleston County School District

Employee: SARA WILSON

WITNESSETH:

The Employee possesses the qualifications prerequisite to the position indicated. Failure to maintain such prerequisite qualifications during the employment period shall automatically terminate employment as of the time of the disqualification. Subject to any conditions set forth below, the employee agrees to faithfully discharge the duties of the said position for the scholastic year of 2006-2007, as required by the laws of South Carolina and by the Employers' policies, procedure, and regulations, which have the effect of law. It is further understood that acceptance of this letter indicates that the Employee agrees that the job offer is a cyclical assignment with scheduled non-work periods; therefore the Employee is not entitled to Unemployment Compensation from the Employer during these scheduled non-work periods.

This is not a contractual position and Employee acknowledges that he/she is an employee at will of Employer and that Employer has the right to terminate, or reduce the works hours of, Employee at any time.

Please indicate your decision to accept this assignment by returning a copy of this form to your principal/supervisor on or before Thursday, May 25, 2006. Failure to sign and return this form by the due date will constitute a resignation.

Position: STUDENT DATA CLERK Hours: 8 Days: 230

Location: JAMES SIMONS ELEM

SPECIAL CONDITIONS:

Sara Y Wilson 5/18/06
EMPLOYEE'S SIGNATURE DATE

5/18/06
RECOMMENDED BY: Principal/Supervisor's Signature DATE

Carl N. Chord 5/30/06
AUTHORIZED BY: Associate Superintendent for Constituent District Or Division Head's Signature DATE

CHARLESTON COUNTY
SCHOOL DISTRICT

LETTER OF INTENT FOR CLASSIFIED (NON-ADMINISTRATIVE) PERSONNEL

On behalf of the Employee listed below, this letter is to advise the Employee of the Employer's intent to re-employ during the 2005-2006 school term. The position, as indicated below, will be held for you, pending provision for the same in the approved 2005-2006 budget.

Employer: Charleston County School District

Employee: SARA Y WILSON

WITNESSETH:

The Employee possesses the qualifications prerequisite to the position indicated. Failure to maintain such prerequisite qualifications during the employment period shall automatically terminate employment as of the time of the disqualification. Subject to any conditions set forth below, the employee agrees to faithfully discharge the duties of the said position for the scholastic year of 2005-2006, as required by the laws of South Carolina and by the Employers' policies, procedure, and regulations, which have the effect of law. It is further understood that acceptance of this letter indicates that the Employee agrees that the job offer is a cyclical assignment with scheduled non-work periods; therefore the Employee is not entitled to Unemployment Compensation from the Employer during these scheduled non-work periods.

The Employer promises to pay the above named Employee for services rendered during the life of this assignment, the sum to which he/she is entitled under local, state, or federal allotments or any combination of these. This is not a contractual position and he/she is subject to termination or reduction in hours if there are insufficient funds allocated to the program in which the employee is working; if funding for the position is not appropriated; if funding for the position is appropriated but later reduced; or if the Employee fails to meet and maintain appropriate employment standards. Said salary shall be paid in accordance with the plans established by the District.

Please indicate your decision to accept this assignment by returning a copy of this form to your principal/supervisor on or before Tuesday, May 24, 2005. Failure to sign and return this form by the due date will constitute a resignation.

Position: STUDENT DATA CLERK

Location: JAMES SIMONS ELEMENTARY

SPECIAL CONDITIONS: **Teacher Assistants and Instructional Aides in Title I schools must be "highly qualified" by January 8, 2006 as required by the No Child Left Behind Act. Teacher Assistants and Instructional Aides in all remaining schools must be "highly qualified by the end of the 2005-2006 school year.**

Sara Y Wilson — 5/23/05
EMPLOYEE'S SIGNATURE — DATE

RECOMMENDED BY: Principal/Supervisor's Signature — 5/26/05 — DATE

AUTHORIZED BY: Associate Superintendent for Constituent District Or Division Head's Signature — 5/25/05 — DATE

102

CHARLESTON COUNTY
SCHOOL DISTRICT

LETTER OF INTENT FOR CLASSIFIED (NON-ADMINISTRATIVE) PERSONNEL

On behalf of the Employee listed below, this letter is to advise the Employee of the Employer's intent to re-employ during the 2003-2004 school term. The position, as indicated below, will be held for you, pending provision for the same in the approved 2003-2004 budget.

Employer: Charleston County School District

Employee: Sara Wilson

WITNESSETH:

The Employee possesses the qualifications prerequisite to the position indicated. Failure to maintain such prerequisite qualifications during the employment period shall automatically terminate employment as of the time of the disqualification. Subject to any conditions set forth below, the employee agrees to faithfully discharge the duties of the said position for the scholastic year of 2003-2004, as required by the laws of South Carolina and by the Employers' policies, procedure, and regulations, which have the effect of law. It is further understood that acceptance of this letter indicates that the Employee agrees that the job offer is a cyclical assignment with scheduled non-work periods; therefore the Employee is not entitled to Unemployment Compensation from the Employer during these scheduled non-work periods.

The Employer promises to pay the above named Employee for services rendered during the life of this assignment, the sum to which he/she is entitled under local, state, or federal allotments or any combination of these. This is not a contractual position and may be terminated if funding for the position is not appropriated; if funding for the position is appropriated but later reduced; or if the Employee fails to meet and maintain appropriate employment standards. Said salary shall be paid in accordance with the plans established by the District.

Please indicate your decision to accept this assignment by returning a copy of this form to your principal/supervisor on or before May 16, 2003. Failure to sign and return this form by the due date will constitute a resignation.

Position: Student Data Clerk **Hours: 8** **Days: 229**
Location: James Simons Elementary

SPECIAL CONDITIONS:

Sara Y Wilson — 5/12/03
EMPLOYEE'S SIGNATURE — DATE

[signature] — 5/12/03
RECOMMENDED BY: Principal/Supervisor's Signature — DATE

Revalatine Gadsden — May 14, 2003
AUTHORIZED BY: Associate Superintendent for Constituent District Or Division Head's Signature — DATE

103

CHARLESTON COUNTY
SCHOOL DISTRICT

LETTER OF INTENT FOR CLASSIFIED (NON-AMINISTRATIVE) PERSONNEL

On behalf of the Employee listed below, this letter is to advise the Employee of the Employer's intent to re-employ during the 2002-2003 school term. The position, as indicated below, will be held for you, pending provision for the same in the approved 2002-2003 budget.

Employer: Charleston County School District

Employee: SARA WILSON

WITNESSETH:

The Employee possesses the qualifications prerequisite to the position indicated. Failure to maintain such prerequisite qualifications during the employment period shall automatically terminate employment as of the time of the disqualification. Subject to any conditions set forth below, the employee agrees to faithfully discharge the duties of the said position for the scholastic year of 2002-2003, as required by the laws of South Carolina and by the Employers' policies, procedure, and regulations, which have the effect of law. It is further understood that acceptance of this letter indicates that the Employee agrees that the job offer is a cyclical assignment with scheduled non-work periods; therefore the Employee is not entitled to Unemployment Compensation from the Employer during these scheduled non-work periods.

The Employer promises to pay the above named Employee for services rendered during the life of this assignment, the sum to which he/she is entitled under local, state, or federal allotments or any combination of these. This is not a contractual position and may be terminated if funding for the position is not appropriated; if funding for the position is appropriated but later reduced; or if the Employee fails to meet and maintain appropriate employment standards. Said salary shall be paid in accordance with the plans established by the District.

Please indicate your decision to accept this assignment by returning a copy of this form to your principal/supervisor on or before May 22, 2002. Failure to sign and return this form by the due date will constitute a resignation.

Position: ~~CLERK/TYPIST~~ Student Data Clerk Hours: 8 Days: 231
Location: JAMES SIMONS ELEMENTARY

SPECIAL CONDITIONS:

Sara Wilson 5/29/02
EMPLOYEE'S SIGNATURE DATE

RECOMMENDED BY: Principal/Supervisor's Signature 5/29/02 DATE

AUTHORIZED BY: Associate Superintendent for Constituent District Or Division Head's Signature Peter Middleton 6/04/02 DATE

286 INL

TO: Dr. James O. Gray
Area Superintendent

FROM: B. T. Williams
Principal

SUBJECT: Request to Change Position Allocation and to Hire an Attendance Clerk

DATE: August 2, 1994

This memo is to request permission to change the position allocation of Clerk/Typist to Attendance Clerk for James Simons.

Currently, I have on staff Mrs. Sara Y. Wilson who meets the job description requirements for an Attendance Clerk.

Please note the following:

- She has had four levels of OSIRIS training.
- She has taken a college level computer literacy course.
- She has served as a substitute for Ms. Cathy Savage (former Clerk/Typist)
- Her knowledge of the community would be an asset to the office staff.

I am hereby requesting permission to hire Mrs. Sara Y. Wilson as Attendance Clerk. Your immediate response will be greatly appreciated.

APPROVED
8-9-94
Gray

CHARLESTON COUNTY SCHOOL DISTRICT

EMPLOYEE PERFORMANCE REVIEW
CLASSIFIED (NON-ADMINISTRATIVE EMPLOYEES)

Type of Review: Annual X Probationary__ Terminal__

Wilson Sara — Library Clerk — [redacted]

Employee Name (Last, First) — *Position* — *Social Security No.*

James Simons — From: 8-29-93 To: 6-10-94

Department or School — *Rating Period Covered*

KEY: O = Outstanding; MS = More Than Satisfactory; S = Satisfactory; N = Needs Improvement; U = Unsatisfactory

NOTE: For items rated NI (Needs Improvement) or U (Unsatisfactory) the supervisor will prepare an Employee Improvement Plan.

1. KNOWLEDGE OF JOB: consider employee's understanding of all phases of the position and related matters that are required for successful job performance. O✓MS__S__NI__U__

2. QUANTITY OF WORK: consider the amount of acceptable work produced and promptness based on specific job requirements. Consider ability to meet volume levels over which the employee has control. O✓MS__S__NI__U__

3. QUALITY OF WORK: consider accuracy, thoroughness, and ability to perform the required functions of the position. O✓MS__S__NI__U__

4. RELATIONSHIPS WITH OTHERS: consider the employee's ability to get along with others (peers, supervisors, other district employees and the public). Consider the use of tact, diplomacy and self control. O✓MS__S__NI__U__

5. DEPENDABILITY: consider the manner in which the employee follows in carrying out assigned tasks. Consider amount of direct supervision that is required and sense of responsibility. O✓MS__S__NI__U__

6. ATTENDANCE: consider the frequency of absences, punctuality, adherence to work hours and effect on work performance. O✓MS__S__NI__U__

7. ADAPTABILITY: consider the employee's ability to perform assigned work under changing conditions. O✓MS__S__NI__U__

8. JUDGEMENT: consider judgement used in making day to day decisions. Does the employee demonstrate the ability to think and act logically and appropriately? O✓MS__S__NI__U__

9. UTILIZATION OF DISTRICT ASSETS: consider care given to use of equipment, tools, and materials provided by the District. O✓MS__S__NI__U__

106

CHARLESTON COUNTY SCHOOL DISTRICT

EMPLOYEE PERFORMANCE REVIEW
CLASSIFIED (NON-ADMINISTRATIVE EMPLOYEES)

Type of Review: Annual_X Probationary__ Terminal__

Wilson, Sara	Library-Aide	[redacted]
Employee Name (Last, First)	*Position*	*Social Security No.*

James Simons Elementary	From: 5-14-92	To: 5-14-93
Department or School	*Rating Period Covered*	

KEY: O = Outstanding MS = More Than Satisfactory
S = Satisfactory N = Needs Improvement U = Unsatisfactory

NOTE: For items rated NI (Needs Improvement) or U (Unsatisfactory) the supervisor will prepare an Employee Improvement Plan.

1. KNOWLEDGE OF JOB: consider employee's understanding of all phases of the position and related matters that are required for successful job performance. O✓MS__S__NI__U__

2. QUANTITY OF WORK: consider the amount of acceptable work produced and promptness based on specific job requirements. Consider ability to meet volume levels over which the employee has control. O✓MS__S__NI__U__

3. QUALITY OF WORK: consider accuracy, thoroughness, and ability to perform the required functions of the position. O✓MS__S__NI__U__

4. RELATIONSHIPS WITH OTHERS: consider the employee's ability to get along with others (peers, supervisors, other district employees and the public). Consider the use of tact, diplomacy and self control. O✓MS__S__NI__U__

5. DEPENDABILITY: consider the manner in which the employee follows in carrying out assigned tasks. Consider amount of direct supervision that is required and sense of responsibility. O✓MS__S__NI__U__

6. ATTENDANCE: consider the frequency of absences, punctuality, adherence to work hours and effect on work performance. O__MS__S✓NI__U__

7. ADAPTABILITY: consider the employee's ability to perform assigned work under changing conditions. O✓MS__S__NI__U__

8. JUDGEMENT: consider judgement used in making day to day decisions. Does the employee demonstrate the ability to think and act logically and appropriately? O✓MS__S__NI__U__

9. UTILIZATION OF DISTRICT ASSETS: consider care given to use of equipment, tools, and materials provided by the District. O✓MS__S__NI__U__

CHARLESTON COUNTY SCHOOL DISTRICT CLASSIFIED (Non-Administrative) EMPLOYEE INSTRUMENT

NAME: Sara Y. Wilson SCHOOL/DEPT: James Simons Elementary

EVALUATION PERIOD: August, 2000-May, 2001 DATE OF PRELIMINARY CONFERENCE: September 20, 2000

POSITION: Clerk Typist CYCLE: ☑ Formal ☐ Informal ☐ Other, Please Specify: _____

EMPLOYEE'S SIGNATURE: Sara Y. Wilson DATE: 9/20/2000

SUPERVISOR'S SIGNATURE: Brenda J. Williams DATE: 5-22-01

SUPERVISOR'S SIGNATURE: _____ DATE: _____

Monitoring Record

Type of Review (Circle Please)	Date of Review	Signature Employee	Signature Supervisor
Interim Other	9/20/00	Sara Y. Wilson	Brenda J. Williams
Interim Other Final	12/09	Sara Y. Wilson	Brenda J. Williams
Interim Other Final	5/31/01	Sara Y. Wilson	Brenda J. Williams

RATING: Reading/Math _____ Professional Development _____ Skill Sets _____

Overall _____

REVIEWED IN PERSONNEL BY: Ellis Lee PA Officer Date: 10/8/01

Name Position

Notes/Comments:

Appendix 293

98

CLASSIFIED (Non-administrative) EMPLOYEE PERFORMANCE APPRAISAL INSTRUMENT (PAI)		
As Clerk Typist in the Administrative Office at James Simons Elementary School, I will contribute to student achievement in reading and math by performing the following major activities as assigned by my supervisor and related to my job description: 1. Keep the OSIRIS Database current. 2. Maintain an accurate reporting system for the following reports: a. Quarterly Reports b. Daily Attendance c. Special Codes Report d. Codes for off-level testing on PACT		
Strategy/Initiatives: We will fully implement a schoolwide Reading Language Arts Program that includes the use of the adopted basal series and the Cunningham Six/Four Blocks Model in grades K-5.		
Major Activity	Accomplishments	Rating: EXC/Meets/NI/DNM
Keep the OSIRIS Database current	Quarterly Reports	Exceeded
Maintain an accurate reporting system for the following reports: 1. Quarterly Reports 2. Daily Reports (Attendance) 3. Special Codes 4. Codes for off-level testing on PACT	1. Special Codes Report 2. Daily Attendance Report 3. Codes for off-level testing on PACT Report	Exceeded
Overall Accomplishment for Interim Performance Goal		Overall Rating for Interim Goal Exceeded

109

Wilson

Rodney E. LeBoeuf, Ed.D.
Superintendent

Barbara D. Dilligard, Ed.D.
Deputy Superintendent

The Center, Room 224
(Old Citadel Building)
Meeting & Hutson Sts.
Charleston, SC 29403

CHARLESTON COUNTY
SCHOOL DISTRICT

Division of Personnel Services

Administrative Dept.
(803)724-7713
Benefits and Compensations
(803) 724-7774
Department of Employment
(803) 724-7708
Personnel Action Office
(803) 724-7701
Staff Development Dept.
(803) 724-7731

FAX (803) 724-7772

SUBSTITUTE TEACHER EVALUATION FORM

Each principal (or his/her designee) will observe and rate substitute teachers who:

A. Are on a "Preferred Call List";
B. Serve as long term substitute teachers
C. Work at any given school in excess of twenty (20) days.

The rating sheet should be forwarded to the Substitute Teacher Office of Personnel by June 30.

RATING SCALE:

1. UNSATISFACTORY 2. NEEDS IMPROVEMENT 3. SATISFACTORY
4. MORE THAN SATISFACTORY 5. OUTSTANDING

Sara Y. Wilson ← Wilson
PRINTED NAME OF SUBSTITUTE TEACHER

This substitute teacher was used as: (more than one may apply)
1. Long term substitute ( )
2. Preferred Call List ( )
3. Worked over 20 days ( )

RATING AREAS:

1. Ability to implement/adjust teacher lesson plans.
   1 2 3 4 (5)

2. Ability to use audio/visual aids when required.
   1 2 3 4 (5)

3. Classroom management ability.
   1 2 3 4 (5)

4. Knowledge of subject matter.
   1 2 3 4 (5)

5. Utilization of classroom time.
   1 2 3 4 (5)

6. Written material is legible and free of grammatical errors.
   1 2 3 4 (5)

110

7. Oral communication is free of errors in grammar.
1 2 3 4 (5)

8. Personal Appearance.
1 2 3 4 (5)

9. Displays enthusiasm for substitute teaching.
1 2 3 4 (5)

10. Dependability
1 2 3 (4) 5

OVERALL RATING
1 2 3 4 (5)

SPECIFIC COMMENTS ARE REQUIRED FOR AN OVERALL RATING OF 1, 2, OR 5.

COMMENTS: Mrs. Wilson performs like she was trained, prepared and born to teach Art. If the system allowed it, I would hire her permanently.

Dara U. Wilson
SIGNATURE OF SUBSTITUTE TEACHER

5-19-91
DATE

Nathaniel R Washington
SIGNATURE OF PRINCIPAL (DESIGNEE)

5-19-91
DATE

James Simons
NAME OF SCHOOL

A10-0199 FILING OF THIS REPORT IS REQUIRED IN COMPLIANCE WITH RULE 67-6

SOUTH CAROLINA INDUSTRIAL COMMISSION

COLUMBIA, SOUTH CAROLINA

EMPLOYER'S FIRST REPORT OF INJURY

(EVERY QUESTION MUST BE ANSWERED)

PLEASE PRINT OR TYPE

I.C. File No.....
Emp. Code No.....
Carrier Code No... SF926
Policy Year.....
Carrier File No.....
This report cannot be processed unless it has been coded by the carrier.

DO NOT WRITE IN THIS COLUMN

CITY COUNTY

DATE OF ACCIDENT

TIME OF ACCIDENT

CONJUG. COND. AND SEX

WEEKLY WAGE

COMPENSABLE RATE

ACCIDENT CAUSE

NATURE

LOCATION

CLOSED BY

TIME LOST

PAY LAG

KIND OF CASE CODE

COMPENSATION

MED. AND HOSP.

SUB. TOTAL

TOTAL

REPORT LAG

YEAR CLOSED

NO. OF FIRST AID CASES

CODED BY

(1) Name Charleston County School District (School/Dept.) James Simons 0707 724-7763
(Give name under which concern does business) (Telephone #)

(2) Office address: No. and Street 2100 Leeds Avenue City Charleston State SC 29405

(3) Nature of business Public Schools
(List principal product or service of the concern)

(4) Accident occurred where? Charleston, S.C. (5) On employer's Premises? Yes
(City, County and State) (Yes or No)

(6) Date of accident January 7 19 87 Day of week Wednesday Hour 2:30 A.M. P.M.

(7) Date disability began January 8, 1987 (8) Was injured paid in full for this day? Yes

(9) When did you or foreman first know of injury? 1-7-87 Name of foreman Nathaniel R. Washington

(10) Name Sara (First Name) (Middle Initial) Wilson (Last Name) 249-72-6756 (S.S.)

(11) Address no. and street 336 Sumter St. City Charleston State S. C. 29403

(12) Age 43 (13) How long employed by you? Substitute (13a) Department Substitute Teacher

(14) Check (✓): Single Married X Divorced Widowed Male Female X

(15) Number of hours worked per day 7 (16) Number of days worked per week Varies

(17) Wages: per hour per day $ 35.40 per week $ If board, lodging, fuel or other advantages were furnished additional to wages, give estimated value per week: $ per month $

(18) What was employee doing when accident occurred? Tiding up a table
(Describe fully, such as: loading truck)

operating a drill press; threading die; painting with spray gun; etc.)

(19) Occupation Substitute teacher aide

(20) How long employed by you in this occupation? Substitute for 2 years

(21) What machine, tool, substance or object was most closely connected with the accident? Shelf
(Name the machine, tool, appliance, gas, liquid, etc., involved)

(22) If machine or vehicle, what part of it? N/A
(State if gears, pulley, motor, etc.)

(23) How did the accident happen Students pushed a shelf that fell on the substitute teacher aide
(Describe the accident fully, stating whether the injured fell

or was struck, etc., and all the factors contributing to the accident, use other side of report for additional space)

(24) In what way was the machine, tool or object defective? None

(25) How can you prevent this type of accident? Could not be prevented
(Specify the remedial measure, such as: better illumination, better ventilation,

providing goggles, providing a better guard, better supervision, etc.)

(26) Were mechanical guards, or other necessary safeguards (such as goggles) provided? N/A

(27) Was injured using them? N/A

(28) How could the injured have prevented the accident? N/A
(Do not say "by being more careful," but specify what employee should or should not have done. For instance

should not have used defective ladder; should have worn goggles, etc.)

(29) Names and addresses of witnesses Deborah Washington-1133 Happyland Blvd, Mt. Pleasant, S.C.

(30) (Describe in detail the nature of the injury and the part of the body affected. For instance:
The employee's lower back was injured
amputation of right arm, crushing injury to chest, head peritonitis, dermatitis or right arm and hand, etc.)

(31) Name and address of physician Dr. Stone-St Francis Hospital

(32) Name and address of hospital St. Francis- Rutledge Ave.

(33) Probable length of disability Unknown

(34) Has employee returned to work? No (35) If so, give date N/A (36) At what weekly wage? $

(37) Did injury result in death? No (38) If so, give date N/A

(39) In case of death, give name and address of nearest relative

(40) Name and address of workmen's compensation insurance carrier ALEXSIS, Inc.
P.O. Box 7997, Columbia, SC 29201

(41) Date of this report 1-13-87 Made out by Nathaniel R. Washington
Official position Principal

School/Dept. Name & phone number: James Simons 0707 724-7763

112

THIS REPORT MUST BE TRANSMITTED TO THE COMMISSION THROUGH YOUR INSURANCE CARRIER

294

Mark Sanford, Chairman
Governor

Grady L. Patterson, Jr.
State Treasurer

Richard Eckstrom
Comptroller General

State Budget and Control Board
South Carolina Retirement Systems

Hugh K. Leatherman, Sr.
Chairman,
Senate Finance Committee

Daniel T. Cooper
Chairman,
Ways and Means Committee

Frank W. Fusco
Executive Director

(803) 737-6800

Peggy G. Boykin, CPA
Director

1-800-868-9002

September 28, 2006

SARA Y WILSON
[redacted]
CHARLESTON SC [redacted]

RE: XXX-XX[redacted]

Dear Payee:

We are pleased to provide information regarding the monthly benefit check you are to receive from the South Carolina Retirement Systems. Your benefit may be estimated until information is available to finalize your record. You will be notified if changes are made to your retirement account.

The first check you receive may be more, or less, than your normal monthly benefit amount depending on the date of retirement. Your check may include more than one month's benefit or, if your date of retirement is other than the first day of the month, you may receive benefits for only part of the month.

Status of Account:	Estimated Benefits
Date of Retirement:	09-11-2006
Monthly Benefit:	$368.77
Option Selected:	A (see explanation below)
Type of Retirement:	Service
Service Credit:	13 years, 11 months, and 0 days
Average Final Compensation (AFC):	$19,551.70
(highest 12 consecutive quarters of salary)	

Contributions-Tax Paid:	$ 0.00
Contributions-Deferred:	12,351.06
Interest:	4,575.02
Total Contributions plus Interest:	16,926.08

You selected the maximum benefit formula which provides the largest monthly benefit available to be paid to you as a retired member for your life. If you should die prior to recovering the total amount in your member account, the remaining balance of any unexhausted contributions plus interest will be refunded in one payment to the designated beneficiary(ies).

XXX-XX-[redacted] SARA Y WILSON

Beneficiary selection for lump sum payment:
LATOYA WILSON KAYDEN NILES WILSON

Beneficiary selection for Group Life Insurance payment:
LATOYA WILSON KAYDEN NILES WILSON

The Retirement Systems is committed to serving members promptly and efficiently. If you have any questions or need additional information regarding your retirement benefits, you may call our Customer Service Department at (803) 737-6800 or toll free in SC at (800) 868-9002.

Sincerely,

Benefits Payroll Department

Enclosure: SCRS Information for Retired Members

114

RETIREMENT BENEFIT CHECK

SOUTH CAROLINA RETIREMENT SYSTEMS

COLUMBIA, SOUTH CAROLINA

DETACH AND RETAIN FOR YOUR RECORDS

DATE PAID 09/29/06 DOCUMENT NUMBER 002662562

NAME SARA Y WILSON NET PAY 244.80

SOCIAL SECURITY NUMBER	GROSS PAY	FEDERAL TAX	STATE TAX		
XXX-XX-[redacted]	245.80		1.00		
AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
YTD GROSS	YTD FED. TAX	YTD ST. TAX	YTD PAYMENTS	YTD OTHER	YTD NET

VOLUNTARY DEDUCTIONS

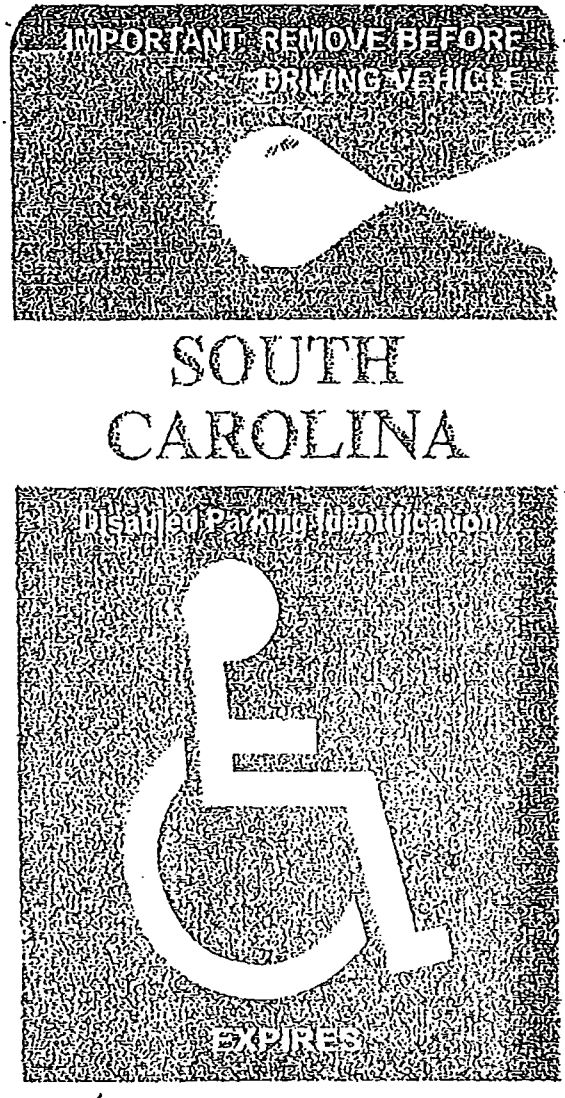
THIS CHECK REPRESENTS BENEFITS DUE TO YOU OR YOUR RETIREMENT ACCOUNT THROUGH 09/29/2006. IF YOU ARE CURRENTLY ON DIRECT DEPOSIT, MONTHLY BENEFITS WILL CONTINUE TO BE DEPOSITED INTO YOUR ACCOUNT. RETIREMENT CHECKS ARE NORMALLY ISSUED OR DEPOSITED THE LAST BUSINESS DAY OF EACH MONTH.

IN THE EVENT OF DEATH OF PAYEE PRIOR TO ENDORSEMENT, CHECK IS TO BE RETURNED TO THE SOUTH CAROLINA RETIREMENT SYSTEMS FOR RE-ISSUE, IF APPLICABLE. NOT TO BE ENDORSED BY EXECUTORS, ADMINISTRATORS OR ASSIGNS UNLESS SO MADE PAYABLE.

rec'd 10/2/06

RECEIVED Rec'd 5/08

115


IMPORTANT REMOVE BEFORE
DRIVING VEHICLE
SOUTH
CAROLINA
Disabled Parking Identification
EXPIRES
6-2-2007
0154790
TEMPORARY

Delta

WILSON/SARA

BOARDING PASS
ELECTRONIC TICKET
2 006 2190970119 4
RV11D6

T14H1NBV

FLIGHT	DATE	CLASS	ORIGIN	DEPARTS
DL688	20DEC	T	ATLANTA	230P

OPERATED BY
DELTA AIR LINES INC

COACH

DESTINATION
WAS-R REAGAN NA

SEAT 14E ZONE 8

DEPARTURE GATE A05 **SUBJECT TO CHANGE**
WHEELCHAIR REQUESTED

BAGS 02

CHS036D1B/WL

BOARDING PASS
******* ET *******
WILSON/SARA

SEAT 14E ZONE 8

FLIGHT DL688 DATE 20DEC
ORIGIN
ATLANTA
DESTINATION
WAS-R REAGAN NA
OPERATED BY DELTA AIR LINES INC

BAGS 02

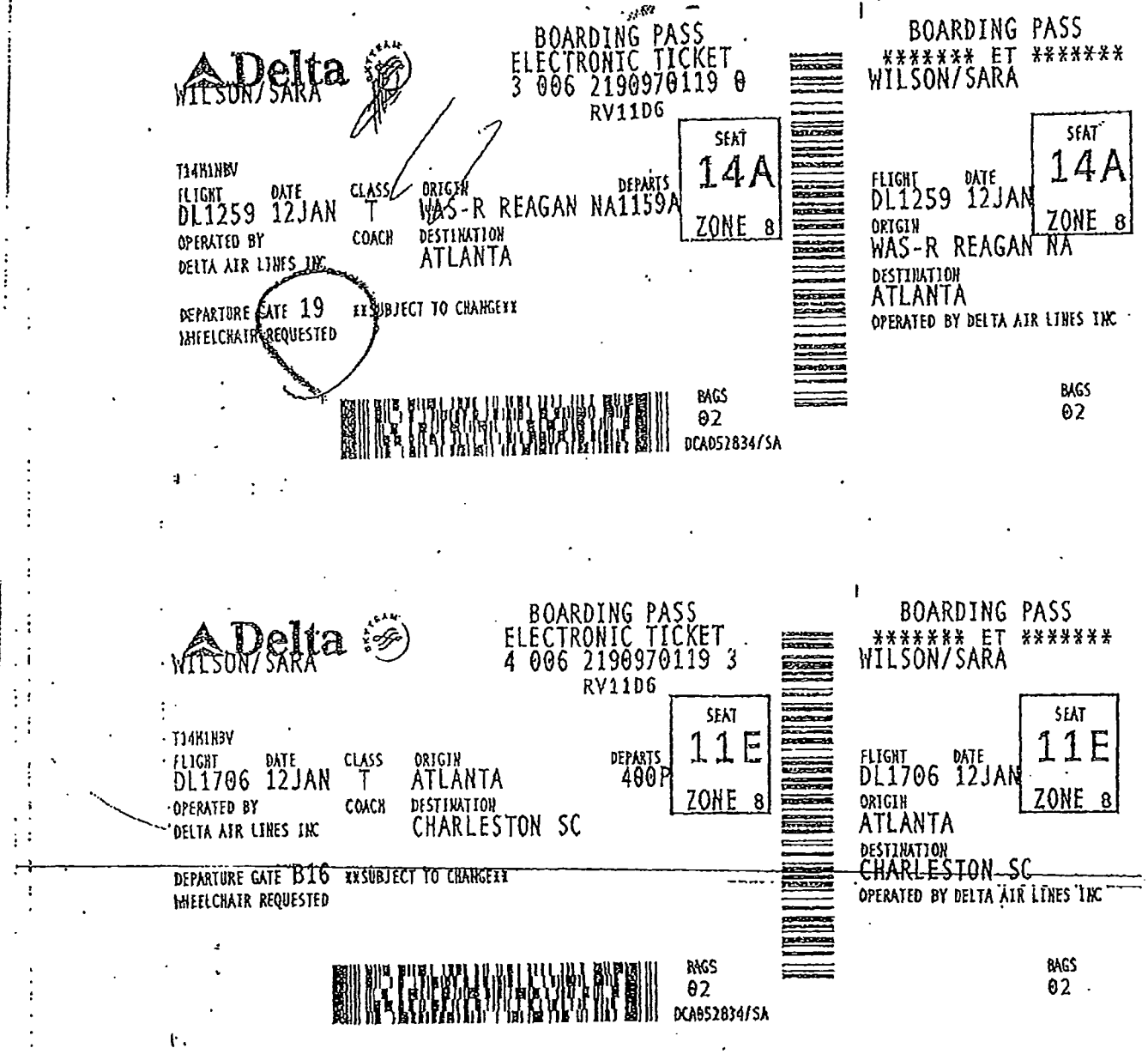
BOARDING PASS
******* ET *******
WILSON/SARA

SEAT 13E ZONE 8

FLIGHT DL630 DATE 20DEC
ORIGIN
CHARLESTON SC
DESTINATION
ATLANTA
OPERATED BY DELTA AIR LINES INC

Computer problems
Tore ticket
Wheelchair
requested BAGS 02

117



Delta

WILSON/SARA

BOARDING PASS
ELECTRONIC TICKET
3 006 2190970119 0
RV11DG

T14H1N8V

FLIGHT	DATE	CLASS	ORIGIN	DEPARTS
DL1259	12JAN	T	WAS-R REAGAN	NA1159A

OPERATED BY
DELTA AIR LINES INC

COACH

DESTINATION
ATLANTA

SEAT 14A
ZONE 8

DEPARTURE GATE 19 **SUBJECT TO CHANGE**
WHEELCHAIR REQUESTED

BAGS 02

DCA052834/SA

BOARDING PASS
******* ET *******
WILSON/SARA

SEAT 14A
ZONE 8

FLIGHT DL1259 DATE 12JAN
ORIGIN
WAS-R REAGAN NA
DESTINATION
ATLANTA
OPERATED BY DELTA AIR LINES INC

BAGS 02

Delta

WILSON/SARA

BOARDING PASS
ELECTRONIC TICKET
4 006 2190970119 3
RV11DG

T14K1N3V

FLIGHT	DATE	CLASS	ORIGIN	DEPARTS
DL1706	12JAN	T	ATLANTA	400P

OPERATED BY
DELTA AIR LINES INC

COACH

DESTINATION
CHARLESTON SC

SEAT 11E
ZONE 8

DEPARTURE GATE B16 **SUBJECT TO CHANGE**
WHEELCHAIR REQUESTED

BAGS 02

DCA052834/SA

BOARDING PASS
******* ET *******
WILSON/SARA

SEAT 11E
ZONE 8

FLIGHT DL1706 DATE 12JAN
ORIGIN
ATLANTA
DESTINATION
CHARLESTON SC
OPERATED BY DELTA AIR LINES INC

BAGS 02

118

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-171
(803) 737-5700
www.wcc.sc.gov

PRE-HEARING BRIEF

WCC FILE NO. 0608517

Sara Y. Wilson	[redacted]		Charleston County School District		
Claimant's Name	SSN		Employer's Name		
[redacted]			75 Calhoun Street		
Charleston, SC [redacted]			Charleston, SC 29401		
Address City	State	Zip	Address	City	State Zip
()	()		Charleston County School District		
Home Phone	Work Phone		Insurance Carrier		

Leslie M. Whitten — (843) 724-6642
Preparer's Name — Phone #

A claim for workers' compensation benefits is made based on the following grounds:
☒Injury ☐ Illness ☐Repetitive Trauma

1. Comp. Rate: $ 335.26 2. AWW: $ 502.87 Date of Injury: 5/9/2006

3. Type of injury and body part(s) Neck

4. Facts in controversy: Whether the Workers' Compensation Commission has jurisdiction to hear this matter pursuant to the claimant's failure to comply with SC Code Ann § 42-17-90 and Regulation 67-602 (C); whether the claimant's change of condition claim is barred under the doctrine of *Laches*; whether the claimant's change of condition claim is barred under the statute of limitations; whether the claimant has proven a change of condition within twelve months from the date of the last payment of compensation.

5. Legal issues involved: See Facts in Controversy.

6. Unusual aspects: The claimant requested/received reports from Dr. Rosen and Dr. Aymond on May 3, 2011 and May 11, 2011, respectively, indicating a change of the condition, more than three years after the last date of payment of compensation. The employer/self-insured objects to these reports as irrelevant and, in the alternative, requests that the record be left open for the depositions of both doctors.

7. Witnesses (designate if expert)* Heather Erdmann, Dana Enck, and another representative of Charleston County School District

8. Exhibits: Updated deposition transcript of claimant to be submitted at the hearing; Defendent's Memorandum of Law to Deny Claimant's Change of Condition Claim

9. Medical evidence: (indicate report pursuant to R.67-612; deposition or appearance):

   Rely on the submissions of the claimant. However, records from Dr. Oliverio to be submitted upon receipt in accordance with *Morgan v. JPS*.

10. Name, address, and specialty, if any, of the treating physician: Dr. Alexander; Dr. Aymond

11. Impairment rating(s); body part(s); physician and date of opinion: 8% to the whole person relative to the cervical spine by Dr. Alexander on November 16, 2006; 5% to the whole person relative to the lumbar spine by Dr. Aymond in his deposition on 9/11/07; 23% impairment to the cervical spine on 7/20/07; Dr. Aymond also indicated on October 21, 2008 that the claimant remains at maximum medical improvement with "the same previously noted impairment rating."

12. I am amending my Form 50/51 in the following manner: Not applicable

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

Signature: _____ Email: lwhitten@ycrlaw.com
Leslie M. Whitten

Date of hearing: 5/25/2011 Time needed for hearing: 30 – 45 minutes

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.

WCC Form # 58
Rev. 9/07

58

PRE-HEARING BRIEF

STATE OF SOUTH CAROLINA)	BEFORE THE
)	SOUTH CAROLINA WORKERS'
COUNTY OF CHARLESTON)	COMPENSATION COMMISSION
SARA Y. WILSON,)	WCC FILE NO. 0608517
Claimant,)	
)	
vs.)	
)	
CHARLESTON COUNTY SCHOOL DISTRICT,)	NOTICE OF WITNESSES AND WRITTEN REPORT(S)/PHYSICIAN OR OTHER EVIDENCE TO BE INTRODUCED ON BEHALF OF DEFENDANTS
Employer/Self-Insured)	
)	
)	
Defendants.)	

To: South Carolina Workers' Compensation Commission
Tiffany R. Spann-Wilder, Esquire

YOU ARE HEREBY NOTIFIED that the Defendants, pursuant to the provisions of the South Carolina Workers' Compensation Act and S.C. Code Ann. §1-23-330, (1985), herewith submits the following reports/physician or other evidence on behalf of the Defendants, to wit:

Name Of Report/Physician or Other Evidence	Date of Report(s)	Pages

Rely on the submissions of the claimant. However, records from Dr. Oliverio to be submitted upon receipt in accordance with *Morgan v. JPS*.

Exhibits:

Exhibit #B-Defendant's Memorandum of Law to Deny Claimant's Change of Condition Claim (Pgs. 152-157)

Updated deposition transcript of claimant to be submitted at the hearing

YOU ARE FURTHER HEREBY NOTIFIED that you have the right of 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 purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be submitted at the Hearing before the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Defendant.

YOU ARE FURTHER HEREBY NOTIFIED that the following witnesses may be called on behalf of the Defendants. Heather Erdmann, Dana Enck, and another representative of Charleston County School District

Leslie M. Whitten
Attorney for Employer/Carrier

May 13, 2011

BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NUMBER 0608517

Sara Y. Wilson, Claimant, vs. Charleston County School District, Self-Insured Defendant	**DEFENDANT'S MEMORANDUM OF LAW TO DENY CLAIMANT'S CHANGE OF CONDITION CLAIM**

STATEMENT OF THE CASE

This matter comes before the South Carolina Workers' Compensation Commission pursuant to the Claimant's Form 50 hearing request alleging a change of condition. This matter was originally heard on October 7, 2007. In an Order filed on November 29, 2007, the Single Commissioner found that the Claimant sustained 45% permanent disability to her back. The Form 19 was filed on January 25, 2008. On January 7, 2009, the Claimant filed a Form 50 not requesting a hearing, but alleging a change of condition. Attached to this hearing request were two medical reports, neither of which indicated that the Claimant had sustained a change of condition in relation to her work injury. On March 29, 2011, the Claimant filed another Form 50, this time requesting a hearing on the change of condition claim. She attached the same two reports as had been attached to the January 7, 2009 hearing request and still did not attach a medical report indicating a change of condition.

The Employer/Self-Insured denied that the Claimant had proven a change of condition for the worse and further denied this claim based on the Statute of Limitations, Laches, and the Claimant's

non-compliance with Regulation 67-602(C). The Employer/Self-Insured respectfully submits this memorandum to address those issues.

ARGUMENT RE STATUTE OF LIMITATIONS/JURISDICTION

The issues here revolve around the question of whether the filing of the Claimant's Form 50 for a hearing involving a change of condition was done properly within the one year statutory time limit and if the failure to comply with the requirements should result in the running of the one year statutory period, barring any claim by the Claimant for a change of condition. The portion of the statute the question arises under is SC Code Ann § 42-17-90. The statute says in pertinent part:

> Upon its own motion or upon the application of any party in interest on the ground of a change in condition, the Commission may review any award and on such review may make an award ending, diminishing or increasing the compensation previously awarded, subject to the maximum or minimum provided in this Title, and shall immediately send to the parties a copy of the order changing the award. No such review shall affect such award as regards any moneys paid and *no such review shall be made after twelve months from the date of the last payment of compensation pursuant to an award under this Title.*
>
> (emphasis added)

The statute provides the proper procedure in a regulation, promulgated by the Worker's Compensation Commission and approved by the Legislature, through which a case can be contested. The statute provides in Regulation 67-602 (C):

> In a claim involving a change of condition, the moving party must attach to the hearing request form a medical report(s) *indicating a change in the claimant's condition.*
>
> (emphasis added)

A regulation which is a "legislative rule" is one which, generally, has the force of law and becomes an integral part of the statute. Faile v. South Carolina Employment Sec. Commission, 230 S.E.2d 219 (1976). The general rule in South Carolina Worker's Compensation cases regarding statutory construction and interpretation is that the cardinal rule is to ascertain and give effect to the intent of the legislature. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Charleston County Sch. Dist. v. State Budget and Control Bd., 313 S.C. 1, 437 S.E.2d 6 (1993)). If a statute's language is plain, unambiguous, and conveys a clear meaning "the rules of statutory interpretation are not needed and the court has no right to impose another meaning." Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000)). The courts are further bound by precedent to strictly construe statutes in derogation of the common law. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003) (citing Gilfillin v. Gilfillin, 344 S.C. 407, 544 S.E.2d 829 (2001)). Workers' compensation statutes provide an exclusive compensatory system in derogation of common law rights. *See* Caughman v. Columbia YMCA, 212 S.C. 337, 47 S.E.2d 788 (1948). As such, when reading a workers' compensation statute we strictly construe its terms, leaving it to the Legislature to amend and define its ambiguities. Wigfall v. Tideland Utilities, 354 S.C.100, 580 S.E.2d 100 (2003).

The initial question in interpretation is whether the statute's directives are mandatory or discretionary. In Wigfall, the court interpreted the term "shall" to be mandatory. Id. South Carolina's Supreme Court has also held the word "must" to indicate the legislature's intent to enact a mandatory requirement. Collins v .Doe, 352 S.C. 462, 574 S.E.2d 739 (2002). In the present case, the word *must* was used in the sentence pertaining to attaching medical reports *"indicating a change of condition"* to the Form 50 in requesting a hearing for a change of

condition. The claimant in the present case did not comply with the mandatory requirements under the statute and the failure to do so resulted in the expiration of the one year time limit in SC Code Ann § 42-17-90. It also means that the Workers' Compensation Commission has no jurisdiction to hear this matter under Regulation 67-602 (C). As a result, the change of condition hearing should not have been granted and no additional impairment should be granted to the Claimant. The Claimant did not comply with the directives set forth within the statutory period and the change of condition application for review must be made within one year after the last payment of compensation. Wallace v. Campbell Limestone Co., 198 S.C. 196, 17 S.E.2d 309 (1941).

ARGUMENT RE LACHES

Assuming, arguendo, that the Claimant complied with 67-602 (C), the fact that she did not actually request a hearing for more than three years after the date of last compensation should bar her claim under the doctrine of Laches. Laches is neglect for an unreasonable and unexplained length of time, under circumstances affording the opportunity for diligence, to do what in law should have been done. Muir v. C.R. Bard, Inc., 336 S.C. 266, 519 S.E.2d 583, 598 (Ct. App. 1999).

To prevail on the defense of Laches, the party asserting the doctrine must prove (1) unreasonable delay by the adverse party, resulting in (2) material prejudice to the moving party. In the case of Richey v. Becton Dickinson, 359 S.C. 609, 598 S.E.2d 307 (Ct. App. 2004), the court first held that that the claimant could not adequately explain the lengthy delay in requesting a hearing by arguing that he could not find a good lawyer. Secondly, they found that the defendants were materially prejudiced because the delay made proximate cause difficult to ascertain.

In the present matter, the Claimant cannot even allege that that she delayed requesting a hearing because she was looking for an attorney. She has retained the same attorney since before the first hearing, so her excuse for her three year delay, whatever that may be, cannot even rise to the level of the claimant's excuse in Richey. The fact that she still did not have a medical report indicating a change of condition when she finally requested a hearing in March of 2011 only further shows that there was no excuse for this lengthy delay.

As to the second Laches requirement, the Defendant's prejudice in this matter is precisely the same prejudice as outlined in Richey. The two medical records attached to both Forms 50 are (1) a note showing an injection the Claimant received and (2) a report from Dr. Sam Rosen on May 18, 2008 indicating that the Claimant was concerned with her finances because her temporary total disability checks had stopped, but that he could not actually diagnose her with depression or recommend any medications. Not only is there no indication that the Claimant had sustained a physical change condition in either report, there is no indication that the Claimant had any depression from her physical injury. At this point, there is no doctor to depose about the Claimant's condition in 2008 or within a year of the last payment of compensation. No doctor saw her or performed any updated diagnostic tests at that time, so even if she now saw a doctor who indicated her physical condition had worsened, it would be extremely difficult for them to opine one way or another whether the change occurred within a year of her last date of compensation, let alone whether the condition was causally related to her injury in May of 2006.

Based on the foregoing arguments, the Employer/Self-Insured respectfully requests that the Claimant's claim for a change of condition be dismissed for lack of jurisdiction and the Claimant's failure to file her claim properly with one year of the last date of payment of compensation. In the alternative, the Commission should deny this claim under the doctrine of Laches.

Respectfully submitted,

YOUNG CLEMENT RIVERS LLP

By: _____
Leslie M. Whitten
P. O. Box 993
Charleston, SC 29402-0993
Attorney for the Employer/Self-Insured

Charleston, South Carolina
Dated:

South Carolina Workers' Compensation Commission
1612 Marion Street • P.O. Box 1715
Columbia, SC 29202-1715

(803) 737-5723
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 0608517

Claimant's Name: Sara Y. Wilson — Employer's Name: Charleston County School District

Address: [redacted] — Address: 75 Calhoun Street

City: N. Charleston State: SC Zip: [redacted] — City: Charleston State: SC Zip: 29401

Home Phone: [redacted] Work Phone ( ) — Insurance Carrier: CorVal Corp

Preparer's Name: Tiffany R. Spann-Wilder — Law Firm: The Spann-Wilder Law Firm, LLC — Preparer's Phone#: (843) 266-7792

A claim for Workers' compensation benefits is made on the following grounds:
■ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $ 370.93 2. AWW: $ 556.37 Date of Injury: 5/9/2006

3. Type of injury and body part(s): right arm, shoulder, neck/back, right/left leg, psyche, left arm "change of condition"

4. Facts in controversy: See Attached Addendum.

5. Legal issues involved: (1) Change of Condition established with compensability to the psyche, right shoulder/arm, neck, back and left arm as a result of the change;(2) That she be provided TTD benefits from May 16, 2008 - present until at MMI; (3)Additional medical treatment Dr. Geer (injections), Dr. Jervey (all care needed for denervation relief) and for regular visits with Dr. Rosen at the carrier's expense; (4) If deemed to be at MMI then a finding that she is now permanently and totally disabled under §42-9-10, or if not permanently, then partially disabled under §42-9-20; (5) Continued Lifetime Medical Treatment and prescriptions for the neck and back and lifetime care and medication for the psyche; (6) Subrogation to Claimant and insurance carrier for visits to Dr. Rosen & Dr. Jervey mileage and all other benefits under the Act; (6) Payment of award in a lump sum; (7) The inclusion of UTICA Language; and (8) Continued medical care under Dodge v. Bruccoli, Clark, Layman, Inc. and Companion Property & Casualty Co. 514 SE 2nd 593.

6. Unusual aspects: N/A

7. Witnesses (designate if expert):* Claimant, Cynthia Sweeney, Florence Neal, and all others listed by Defendants.

8. Exhibits: Medical records
9. Medical Evidence (indicate report pursuant to R.67-612;deposition or appearance):
APA (1) Orthopaedic Specialists of Charleston, James Aymond, MD & John Ernst, MD (medical records) 10/21/08 - 5/10/11) (17 pages)
APA (2) Andrew Geer, MD, (medical records) (1/14/08 -11/13/08) (28 pages)
APA (3) Palmetto Orthopaedics of Charleston, James DeMarco, MD (medical records) (2/23/09) (4 pages)
APA (4) St. Francis Hospital (medical records) 2/18/03 -2/20/03) (11 pages)
APA (5) Carolina Neurological Clinic, Charles Jervey, MD (medical records) (1/25/09 -3/17/11) (16 pages)
APA (6) Samuel H. Rosen, MD, (medical records) (5/18/08 - 4/7/11) (24 pages)
APA (7) Charleston Physical Therapy (medical records) (3/3/09 -5/6/09) (16 pages)
APA (8) W. Pettigrew Clare, Sr., MD (medical records) (5/12/06 -11/20/06) (7 pages)
APA (9) Lowcountry Medical Associates, Robert Oliverio, MD (medical records) (4/22/09-2/16/11) (20 pages)
EXHIBIT (A) Deposition of James Aymond, MD (Taken 9/11/2007) (8 pages)

10. Name, address, and specialty, if any of treating physician: Charles Jervey, MD, Carolina Neurological Clinic, 125 Doughty Street, Ste. 460, Charleston, SC, Samuel H. Rosen, MD, 2093 Henry Tecklenburg Blvd., Ste. 303E, Charleston, SC 29414; John Ernst, MD & James Aymond, MD, Orthopaedics Specialists of Charleston, 2093 Henry Tecklenburg Dr.s Ste. 200E, Charleston, SC; James DeMarco, MD, Palmetto Orthopaedics of Charleston, 180 Wingo Way, Ste. 301, Mt. Pleasant, SC 29464

11. Impairment rating(s); body part(s); physician and date of opinion: PREMATURE - Not at MMI
12. I am amending my Form 50/51 in the following manner:
I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: [signature] Email: tiffany@spannwilderlawfirm.com
Date of Hearing: May 25, 2011 Time needed for hearing: 1.5 hours
On behalf of X Claimant ☐ Employer

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

WCC Form # 58
Rev. 9/07

PRE-HEARING BRIEF

58

ADDENDUM Question # 4
-----WCC Form 58 - Pre-Hearing Brief
Sara Y. Wilson v. Charleston County School District
WCC File No. 0608517

The Claimant is currently sixty-seven (67) years of age, widowed and has a high school diploma. She was employed with Charleston County School District since 1986 and retired under State Disability from the school district in 2006 as a result of this injury. She worked in various capacities such as Substitute Teacher, Clerk Typist and lastly as a Data Technician at James Simons Elementary School, concentrating on Attendance matters but essentially assisted the Principal "for other duties assigned" whether that be school secretary, preparing bulletin boards, running errands throughout the school, classroom monitor or monitor to children who were not able to reside in the mainstream classes and had "special needs". On May 9, 2006 the Claimant who stands 4'11" and 115 pounds was assaulted when 2 male students (who were overaged for Elementary School) engaged in fight and their fight pushed them into the Claimant. Her body hit the Secretary's desk along her right side and she landed with her body laid half across the marble countertop. She was found to have compensable injuries to her cervical and lumbar spine. Dr. Aymond performed a cervical fusion and rated her at 23% and 5% to the lumbar spine. This claim was adjudicated before the S. C. Workers' Compensation Commission and an Order was issued dated November 29, 2007 providing for lifetime care to the neck and back. The Claimant appealed the decision in December 2007 but the appeal was thrown out by the Commisison *sua sponte* in May 2, 2008 on the basis of being untimely filed. By Form 19 dated May 7, 2008, the claimant accepted the award of the Commissioner. The claimant filed a Form 50 alleging physical and psychiatric change of condition for the worse overtime on January 6, 2009. An Amended Form 50 was filed on April 14, 2011 adding the left arm as part of the change of condition as a direct result of the already continued care for the neck. The claimant request that the commission hear this matter and determine whether the claimant has experienced a "change of condition for the worse" together with her entitlement to statutory benefits attendant thereto. Her neck/arm pains were increasingly bothersome and through a series of referrals a diagnosis was finally reached, that of denervation resulting from her cervical fusion. Claimant would further show that an examination of the EMG/NCS performed, the need for lumbar injections (increased pain) and the psychiatric issues clearly demonstrates a change of condition for the worse overtime.

Claimant is seeking to have the Hearing Commissioner find:

(1) Change of Condition established with compensability to the psyche, right shoulder/arm, neck, back and left arm as a result of the change;
(2) That she be provided TTD benefits from May 16, 2008 - present until at MMI;
(3) Additional medical treatment Dr. Geer (injections), Dr. Jervey (all care needed for denervation relief) and for regular visits with Dr. Rosen at the carrier's expense;
(4) If deemed to be at MMI then a finding that she is now permanently and totally disabled under §42-9-10, or if not permanently, then partially disabled under §42-9-20;
(5) Continued Lifetime Medical Treatment and prescriptions for the neck and back and lifetime care and medication for the psyche;
(6) Subrogation to Claimant and Insurance carrier for visits to Dr. Rosen & Dr, Jervey mileage and all other benefits under the Act;
(6) Payment of award in a lump sum;
(7) The inclusion of UTICA Language; and (8) Continued medical care under **Dodge v. Bruccoli, Clark, Layman, Inc. and Companion Property & Casualty Co.** 514 SE 2nd 593.

STATE OF SOUTH CAROLINA) COUNTY OF CHARLESTON)	BEFORE THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION WCC FILE NO.: 0608517
Sara Y. Wilson, Claimant, vs. Charleston County School District, Employer, and Corvel, The Schaffer Co. LTD, Carrier, Defendants.	NOTICE OF WITNESSES AND WRITTEN MEDICAL REPORTS TO BE INTRODUCED AS DIRECT EVIDENCE ON BEHALF OF CLAIMANT

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION and LESLIE WHITTEN, ESQUIRE, ATTORNEY FOR THE DEFENDANTS:

YOU ARE HEREBY NOTIFIED that the Claimant, pursuant to the provision of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended) herewith submits the following medical reports as direct evidence on behalf of the Claimant, to wit:

APA (1) Orthopaedic Specialists of Charleston, James Aymond, MD & John Ernst, MD (medical records) 10/21/08 - 5/10/11) (17 pages)

APA (2) Andrew Geer, MD, (medical records) (1/14/08 -11/13/08) (28 pages)

APA (3) Palmetto Orthopaedics of Charleston, James DeMaroo, MD (medical records) (2/23/09) (4 pages)

APA (4) St. Francis Hospital (medical records) (2/18/03 -2/20/03) (11 pages)

APA (5) Carolina Neurological Clinic, Charles Jervey, MD (medical records) (1/25/09 -3/17/11) (16 pages)

APA (6) Samuel H. Rosen, MD, (medical records) (5/16/08 - 4/7/11) (24 pages)

APA (7) Charleston Physical Therapy (medical records) (3/3/09 -5/6/09) (16 pages)

APA (8) W. Pettigrew Clare, Sr., MD (medical records) (5/12/06 -11/20/06) (7 pages)

APA (9) Lowcountry Medical Associates, Robert Oliverio, MD (medical records) (4/22/09-2/16/11) (20 pages)

EXHIBIT (A) Deposition of James Aymond, MD (Taken 9/11/2007) (8 pages)

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 depositions of any of the physicians, whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission, for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Employee/Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant: **The Claimant, Cynthia Sweeney, Florence Neal and all other witnesses listed by the Defendants.**

The Spann-Wilder Law Firm, L.L.C.
2131 Dorchester Road
P.O. Box 70488
N. Charleston, SC 29415
(843) 266-7792

Tiffany R. Spann-Wilder, Esquire
Attorney for the Claimant

This 11th day of May, 2011.
North Charleston, South Carolina

STATE OF SOUTH CAROLINA) BEFORE THE SOUTH CAROLINA
) WORKERS' COMPENSATION COMMISSION
COUNTY OF CHARLESTON) W.C.C. FILE NO. 0608517

Sara Y. Wilson, Employee/Claimant

vs.

Charleston County School District, Employer, and

CorVel/The Schaffer Companies, LTD., Carrier

APA SUBMISSIONS

HEARING ON DATE - May 25, 2011 at 2:30 p.m.

Commissioner Derrick L. Williams

	PHYSICIAN	PRACTICE	DATES OF SERVICE	PAGE NUMBERS
1.	James Aymond, MD & John M. J. Ernst, MD	Orthopaedics Specialists of Charleston	10/21/08 - 5/10/11	Pages 1 - 17
2.	Andrew Geer, MD	Roper St. Francis Healthcare	1/14/08 - 11/13/08	Pages 18 - 45
3.	James DeMarco, MD	Palmetto Orthopaedics of Charleston	2/23/09	Page 460-049
4.		St. Francis Hospital	2/18/03 - 2/20/03	Pages 50 - 60
5.	Charles Jervey, MD	Carolina Neurological Clinic	1/25/09 - 3/17/11	Pages 61 - 76
6.	Samuel H. Rosen, MD	Roper St. Francis Healthcare	5/16/08 - 4/7/11	Pages 77 - 100
7.		Charleston Physical Therapy	3/3/09 - 5/6/09	Pages 101 - 116
8.		W. Pettigrew Clare Sr., MD	5/12/06 - 11/20/06	Pages 117 - 123
9.	Robert Oliverio, MD	Lowcountry Medical Associates		Pages 124 - 143

EXHIBIT	ORGANIZATION/DOCUMENTS	DATES OF SERVICE	PAGE NUMBERS
A	Deposition Transcript of James Aymond, MD	9/11/2007	Pages 144 - 151

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612
SSN: [redacted] DOB: [redacted]1943 AGE: [redacted]

01/16/2007 JAMES K AYMOND MD

INITIAL EVALUATION

CHIEF COMPLAINT: 1. Posterior neck pain and right upper extremity dysesthesias
2. Lower back with bilateral hip pain

PRESENT ILLNESS: Ms. Wilson is a [redacted]-year-old female, who is seen at this time for any further recommendations regarding a work-related injury that she sustained in May, 2006, while working at an elementary school. The patient states that she was pushed into a countertop at work during an altercation between two students in May, 2006. She was initially evaluated by her primary care physician, Dr. Clare, and was subsequently evaluated by physicians at Doctors Care. She has undergone MRI scan of the cervical spine on two occasions, as well as films of the thoracolumbar spine in May, 2006. The patient states that she has undergone physical therapy at Private Physical Therapy. She has had injection treatment with Dr. Robert Alexander, including an epidural steroid injection in August, 2006, as well as what she describes as a possible independent medical evaluation by Dr. Don Stovall of Lowcountry Orthopedics. The patient is here under her own insurance at the recommendation of her attorney. We have no notes available for review, with the exception of an MRI scan report performed at Tri-County Radiology in late May, 2006, ordered by Dr. Darren Morris of Doctors Care.

The patient states that she is having lower back pain, stabbing type and muscle spasm pain in her lower back as well as both hip areas. She is also having neck pain as well as intrascapular pain, right greater than left and radiating pain into the right upper extremity.

PAST MEDICAL HISTORY: Past medical history, past surgical history, review of systems, medications, allergies, social history, and family history are well outlined per the attached medical information sheet completed January 16, 2007. The patient has a history of scoliosis since adolescent years, but has not had any back problems along the way at any point.

REVIEW OF SYSTEMS: No history of hematological or lymphatic systems, no recent weight change, no recent fever, no cardiovascular problems, no respiratory symptoms, and no visual complaints. Patient also denies any gastrointestinal symptoms, no genitourinary symptoms and no psychiatric problems.

COMPREHENSIVE EXAMINATION:

Pulse Rate: 74 Respiratory Rate: 16
Height: ~~5'4"~~ 4'10" Weight: ~~140 lbs.~~ 120 lbs

The patient is a well-developed female, appearing stated age, having a relatively normal body habitus without limb deformities. Head and neck exams reveal a normal cephalic head without signs of trauma; no enlarged lymph nodes noted. Pupils are equally round and reactive to light. Throat is clear without erythema, and tongue is without lesions. Neck has slight limitation of motion and is nontender to palpation anteriorly. Thyroid is not enlarged and is nontender.

Respiratory and cardiovascular exams reveal normal and symmetric inspiration. Lungs are clear without wheezing. Heart is regular rate. Carotid arteries are without bruits. Abdomen is without pulsatile mass.

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612
SSN: [redacted] DOB: [redacted] AGE: [redacted]

01/16/2007 JAMES K AYMOND MD

Femoral arteries are normal, as well as brachial, radial, dorsalis pedis, and posterior tibial pulses.

Skin/integument exam reveals no rashes or skin ulcers. There is no clubbing of the digits and there is no evidence of pretibial edema.

Neuropsychiatric exam reveals patient to be awake, alert, oriented to person, place, time and situation. Attention span, memory and knowledge intact. Cranial nerve II-XII function is intact.

NEUROMUSCULAR EXAM: The patient has slightly limited range of motion of the cervical spine, secondary to guarding. Deep tendon reflexes are 2+ of the patella and achilles tendons. Sensory examination is diminished in the right C7 dermatome distribution. Manual motor testing does not reveal any form of weakness. Range of motion of the lumbar spine is limited secondary to guarding. she has evidence of a right thoracolumbar and left lumbar curvature, with slight accentuation of the rib hump upon forward bending. Straight leg raise produces lower back pain. Hip range of motion is nontender.

RADIOGRAPHIC EVALUATION: Films of the thoracolumbar spine from May 20, 2006, are reviewed. These reveal a right thoracolumbar scoliosis with compensatory lumbar scoliosis. MRI scan of the cervical spine from July 6, 2006, reveals evidence of a right paracentral disc herniation at C6-7 level, with slight cord involvement and compression of the anterior epidural space on the right side at C6-7.

IMPRESSION: 1. Cervical disc herniation at C6-7 level.
2. Aggravation of pre-existing lumbar scoliosis with muscular and buttock pain

RECOMMENDATIONS: The patient has failed to obtain relief with nonoperative management of her cervical spine. It is my opinion, to a reasonable degree of medical certainty, that the patient would benefit from an anterior cervical discectomy and fusion, C6-7 level, for her residual and persistent neck pain as well as right upper extremity dysesthesias. I would recommend MRI of the lumbar spine to determine if there is any acute finding superimposed on her chronic lumbar scoliosis that could be the source of her ongoing lower back pain.

We will plan to see Ms. Wilson in follow-up after the MRI scan has been completed. Hopefully, we can get further information from her attorney, as this will be necessary prior to any surgery scheduling. There will likely be a conflict between her private insurance and her worker's compensation insurance.

James K. Aymond, MD
JKA/lmm 1/24/07

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612WC
SSN: [redacted] DOB: [redacted] AGE: [redacted]

04/27/2007 JAMES K AYMOND MD

FOLLOW UP

Ms. Wilson is four weeks status post cervical fusion, C6-7 level.

She is having some residual soreness in her throat. Her upper extremities are feeling much better. She does have limited mobility in rotation as well as flexion and extension. She is encouraged to continue to improve her range of motion as she should be able to return back to full mobility without any difficulty. She is also having some complaints of low back pain where a previous MRI scan has revealed no evidence of disc herniation or canal stenosis.

RADIOGRAPHS: Radiographs of the cervical spine reveal good position of the interbody fusion graft and cervical plate fixation, C6-7 level.

PLAN: We will allow Ms. Wilson to begin physical therapy for both her neck as well as her lower back. She will remain out of work and I will see her in follow-up in four weeks. I have given her a prescription for Mepergan Fortis as the Percocet was making her nauseated.

JKA/sml 05/04/07

Schaffer Company WC (75500)
Charleston County School (E0011443)

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612WC
SSN: [redacted] DOB: [redacted] AGE: [redacted]

06/08/2007 JAMES K AYMOND MD

FOLLOW UP

Ms. Wilson is ten weeks status post cervical fusion, C6-7 level. Overall, she is doing very well. She is having less posterior neck-pain and also improvement with respect to her lower back. She has been given exercises at home and has been released to perform her exercises at home.

Her examination reveals near normal range of motion of the cervical spine in rotation, but slightly limited in extension. Straight leg raise is negative.

Radiographs reveal further excellent healing of the interbody fusion graft, C6-7 level, with good position of the plate.

RECOMMENDATIONS: We will have Ms. Wilson continue with her exercises at home. She will remain on sedentary activities and I will see her in follow-up in approximately 5-6 weeks.

JKA/jns 6/18/07
c: Schaffer Company WC (75500)
Charleston County School (E0011443)

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612WC
SSN: [redacted] DOB: [redacted] AGE: [redacted]

07/20/2007 JAMES K AYMOND MD

FOLLOW UP

Ms. Wilson is four months status post cervical fusion at the C6-7 level. Overall she continues to do very well. She is not having any further neck discomfort. She continues to have some degree of lower back discomfort secondary to what was found to be mild to moderate osteoarthritis of the facet joints at L4-5 and L5-S1 level.

Range of motion of the cervical spine is 90% of normal. Motor and sensory exam are normal.

Radiographs of the cervical spine reveal complete consolidation of the arthrodesis, C6-7 level.

RECOMMENDATIONS: At this time we will recommend that Ms. Wilson continue with activities of daily living. I would have her remain on a lifting restriction of 20 lbs. or less and she should avoid repetitive overhead activities. She is considered at maximum medical improvement with respect to her cervical spine and I would rate her impairment to be 23% impairment of the whole person as it relates to her cervical disc altered motion segment integrity. I will plan to have her notify us if she desires to proceed with facet injections performed in her lumbar spine.

JKA/lfs 07/23/07
Schaffer Company WC (75500)
Charleston County School (B0011443)

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612WC
SS#: [redacted]

11/13/2007 JAMES K AYMOND MD

FOLLOW UP

Ms. Wilson was rated and released approximately four months ago. She states that she began having insidious onset of posterior cervical pain approximately 10-12 days ago. She has not returned to any gainful employment and does not recall any specific activity that began her symptoms. She is presently eight months status post cervical fusion, C6-7 level.

PHYSICAL EXAMINATION: Range of motion of the cervical spine is approximately 80-90% of normal. Motor and sensory exam are normal. She has mild tenderness to palpation over the lower cervical and cervicothoracic junction.

RADIOGRAPHS: Radiographs reveal complete consolidation of the arthrodesis, C6-7 level.

RECOMMENDATIONS: I have prescribed Zanaflex as needed for muscle spasm and recommended the use of ice. She will remain on the same restrictions. I will see her in follow-up as needed.

JKA/sml 11/20/07
c: Schaffer Company WC (75500)
Charleston County School (E0011443)

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

SARA WILSON
CHART#: W89612WC
SSN: [redacted]

12/07/2007 JAMES K AYMOND MD

FOLLOW UP

Ms. Wilson is seen in follow-up. She continues to have aching type pain in her lower back, as well as occasional mid back discomfort. A previous MRI scan has revealed very minimal changes in the lumbar spine. She is not a candidate for any form of surgical intervention.

Her examination reveals good range of motion of the cervical spine. Motor and sensory exams are normal.

We will recommend referral for evaluation and treatment for pain management for her lower back. We will see her in follow-up as needed.

JKA/dmr 12/14/07
c: Schaffer Company WC (75500)
Charleston County Schools
Glen Martin Adj

ORTHOPAEDIC SPECIALISTS OF CHARLESTON James K. Aymond, MD Patient Name: WILSON, SARA DOB: [redacted] CHART #: 89012	2093 Henry Tecklenburg Drive Suite 200 East Charleston, SC 29414 Telephone (843) 958-2500 Fax (843) 958-2680 Date of Service: 10/21/2008

FOLLOW-UP

Ms. Wilson is seen at this time. She was last evaluated November of 2007, 11 months ago. Ms. Wilson continues to have some intermittent posterior neck discomfort. Her last episode was approximately within the last 1 to 2 weeks. She had undergone previous cervical fusion C6-7 level, performed late March of 2007, 18 months ago. She also complains of intermittent lower back discomfort and remains under the care of Dr. Geer for this.

Her examination reveals cervical spine to be approximately 80 to 90% normal range of motion. Motor and sensory examinations are normal. Reflexes are normal.

Radiographs are obtained and reveal complete consolidation of the arthrodesis at the cervical level of C6-7.

I have informed Ms. Wilson that she will continue to have intermittent lower back discomfort. It is my opinion to a reasonable degree of medical certainty that her current symptoms are from her previous work-related injury and subsequent surgery, and this is not a new problem for her. The patient remains at maximum medical improvement and with the same previously noted impairment rating.

James K. Aymond, MD

JKA/kbs

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DT: 10/23/2008 10:22:19 AM
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Orthopaedic Specialists of Charleston
ROPER ST. FRANCIS PHYSICIANS

(843) 958-2500

James K. Aymond, M.D.
Kenneth M. Caldwell, M.D.
John M.J. Ernst, M.D.
John M. Graham, M.D.

Blake L. Ohlson, M.D.
James Price, M.D.
Kelly Bailey Kruse, PA-C
Erin N. Watrobski, PA-C

Date: 10-21-08 Chart # W896l2wc

Patient: Sara Wilson Diagnosis: _____

Please be advised that the above named patient:
[ ] Was seen in this office on the following date(s): 10/21/08

[ ] May return to full duty on _____

[ ] May return to light duty on _____

[ ] May not return to work/school until _____

[ ] May not participate in _____ until _____

Add'l Comments _____

NEXT APPOINTMENT _____ TESTS REQUIRED _____

RESTRICTIONS (circle choices)

✓ Avoid

_____ Avoid repetitive

Bending	Excessive Walking
Twisting	Excessive Running & Cutting
Squatting	Prolonged Sitting/Standing
Climbing	Horizontal Lifting
Stooping	Overhead Activities

No Lifting Over 1, 5, 10, 15, 20, 25, 50 lbs. Sedentary Work Only

Jan K Aym
Physician's Signature

Mt Pleasant Office
Building 6
594 Lone Tree Drive
Mt. Pleasant, SC 29464

North Charleston Office
Trident Medical Campus
2891-A Tricom St.
N. Charleston, SC 29406

West Ashley Office
St. Francis Medical Office
2093 Henry Tecklenburg Dr., Ste 200
Charleston, SC 29414

(Original – Chart Copy 1 - WC Coordinator Copy 2 – Patient)

S. Wilson Brief 9

ORTHOPAEDIC SPECIALISTS OF CHARLESTON
James K. Aymond, MD

2093 Henry Tecklenburg Drive
Suite 200 East
Charleston, SC 29414
Telephone (843) 958-2500
Fax (843) 958-2680

Patient Name: WILSON, SARA
DOB: [redacted]
CHART #: 89612

Date of Service: 5/8/2009

FOLLOW-UP

Ms. Wilson was last evaluated 10/21/2008. Since this time, she had some pain in her left shoulder and was evaluated by Dr. Oliverio and subsequently by Dr. DeMarco. The patient was begun on some physical therapy. Later on, in February of this year, the patient began having the insidious onset of left upper extremity dysesthesias. She has not had any workup of this with respect to her cervical spine. She has had some plain films of her shoulder and these reveal a cyst in the humeral head as well as some acromioclavicular joint arthrosis.

The patient states that she has aching type radiating pain into her left forearm as well as her hand.

Her past history is significant for a previous cervical diskectomy and fusion procedure at the level of C6-7 performed just over 2 years ago in March of 2007.

Her examination reveals a well-healed incision. Range of motion of the cervical spine is slightly limited secondary to guarding. Deep tendon reflexes are 2+ in the biceps, brachioradialis, and triceps tendons. Sensory examination is intact in the C5, C6, and C7 dermatomes.

Radiographs of the cervical spine reveal complete consolidation of the cervical fusion C6-7 level.

IMPRESSION: Upper extremity dysesthesias with symptoms consistent with cervical radiculopathy.

RECOMMENDATIONS: The patient's present symptoms necessitate further imaging studies. The differential diagnosis of upper extremity pain and dysesthesias, including cervical disk pathology to include disk bulge or herniation as well as shoulder pathology and peripheral nerve disorders, including median and ulnar nerve pathology. The patient will undergo magnetic resonance imaging of the cervical spine. Other evaluations including electromyography and nerve conduction velocity studies may be necessary in the future. The patient will be seen after the study has been completed. Work status is in the chart.

James K. Aymond, MD

JKA/kbs

DD: 5/8/2009 11:59:00 AM
DT: 5/11/2009 1:44:18 PM
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cc: Robert Oliverio, MD, Low Country Medical Associates, Fax #577-0455 (local).
This document was electronically signed by James Aymond, MD
Date and Time: 5/11/2009 4:06:33 PM

TRICOUNTY RADIOLOGY ASSOCIATES

(843) 529-0800
North Charleston
Summerville
West Ashley

5/15 WAM

PATIENT: Wilson, Sara
DOB: [redacted]
MRN: 495581
PHYSICIAN: James Aylward, MD
EXAM DATE: 5/11/2009

EXAM: MRI OF THE CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Left arm pain and tingling in left hand and fingers since February 2009. Radiculopathy prior C6 level.

COMPARISON STUDIES: Report of MRI dated 5/25/2006.

TECHNIQUE: Sagittal T1, T2 and STIR and axial T2 GRE MR images of the cervical spine obtained on high-field 1.5 Tesla MRI.

FINDINGS: The visualized portions of the brain parenchyma are unremarkable. The signal intensity of the cervical cord is unremarkable. Postoperative change C5 through C7 not well seen secondary to blooming metallic artifact. Findings suggest mild grade I retrolisthesis of C5 on C6. Recommend correlation with plain films. The craniocervical junction is unremarkable.

C2-3: No significant disc bulge or protrusion. No significant neural foraminal narrowing. No definite neural contact or impingement.

C3-4: Mild to moderate left-sided neural foraminal narrowing. No significant right-sided neural foraminal narrowing. Moderate left-sided facet hypertrophic changes. Possible contact of the exiting nerve roots at the level of the neural foramen. Mild broad-based disc bulge narrows the CSF anterior to the cervical cord. No cord contact. Possible contact of the exiting left nerve roots. No neural impingement.

C4-5: Broad-based disc osteophyte complex comes very near and may contact the anterior aspect of the cervical cord. Mild to moderate bilateral neural foraminal narrowing, left greater than right. Possible contact of the exiting left nerve roots. No definite neural impingement. Mild facet hypertrophic changes, left greater than right. Mild central spinal stenosis.

C5-6: Broad-based disc osteophyte complex comes very near the anterior aspect of the cervical cord. Possible contact. Grade I retrolisthesis of C5 on C6 is suggested. Mild bilateral neural foraminal narrowing. Contact of the exiting nerve roots at the level of the neural foramen. No definite neural impingement. Mild central spinal stenosis. Mild facet hypertrophic changes.

C6-7: No significant disc bulge or protrusion. No significant neural foraminal narrowing. No definite neural contact or impingement. Blooming metallic artifact limits the sensitivity of this for evaluating this level.

C7-T1: No significant disc bulge or protrusion. No significant neural foraminal narrowing. No definite neural contact or impingement.

T1-2: This level is partially visualized in the axial plane. No significant neural foraminal narrowing. No definite neural contact or impingement. No significant disc bulge or protrusion. Mild bilateral neural foraminal narrowing noted.

IMPRESSION:
1. Straightening and mild reversal of the normal cervical lordosis. Findings suggesting grade I retrolisthesis of C5 on C6. Recommend correlation with plain films.
2. Examination limited by blooming metallic artifact. Neural contact without convincing evidence for neural compression as noted above.

ORTHOPAEDIC SPECIALISTS OF CHARLESTON
James K. Aymond, MD

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Fax (843) 958-2680

Patient Name: WILSON, SARA
DOB: [redacted]
CHART #: 89612

Date of Service: 5/15/2009

FOLLOW-UP

Ms. Wilson is seen in follow-up with the MRI scan. This study reveals previous fusion at the C6-7 level. There was no evidence of disc degeneration or caudal to her level of surgery.

At this point, we will recommend that she undergo an electrical diagnostic study of the left upper extremity. We will see her in follow-up after this has been completed.

James K. Aymond, MD

JKA/lmg

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Date and Time: 5/19/2009 8:03:03 AM

ORTHOPAEDIC SPECIALISTS OF CHARLESTON
James K. Aymond, MD

2093 Henry Tecklenburg Drive
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Patient Name: WILSON, SARA
DOB:
CHART #: 89612

Date of Service: 06/02/2009

FOLLOW-UP

Ms. Wilson is seen in followup with the electrical diagnostic study of the left upper extremity. She continues to have aching pain from the elbow to the tips of all of her fingers. The electrical study reveals evidence of sensory neuropathy affecting the median and ulnar sensory nerves of the left upper extremity. Previous MRI scan has revealed no evidence of disk abnormality of the cervical spine, as she has undergone previous cervical fusion C6-7 level.

At this time, I am at a loss of why the patient is having upper extremity dysesthesias, although she does have a positive Tinel's test of the left wrist and slightly of the left cubital tunnel.

I would recommend that the patient undergo an upper extremity consultation with Dr. Ernst regarding possible median neuropathy as well as ulnar neuropathy, based on her electrical diagnostic studies of the left upper extremity.

James K. Aymond, MD

JKA/kbs

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This document was electronically signed by James Aymond, MD
Date and Time: 6/5/2009 7:47:44 AM

ORTHOPAEDIC SPECIALISTS OF CHARLESTON John M. J. Ernst, MD	2093 Henry Tecklenburg Drive Suite 200 East Charleston, SC 29414 Telephone (843) 958-2500 Fax (843) 958-2680
Patient Name: WILSON, SARA DOB: [redacted] CHART #: 89012WC	Date of Service: 6/19/2009

INITIAL EVALUATION

PRESENT ILLNESS: This 65-year-old, right-hand dominant female is kindly referred by Dr. Aymond for evaluation of left arm complaints since 11/2008. The patient underwent nerve studies by Dr. Jervey on 05/19/2009. The report indicates left median sensory nerve is 2.4/<2.2 normal and motor is 4/4.4 normal. Ulnar sensory is slightly elevated at 2.3/<2.2 normal. Ulnar motor normal. Radial sensory normal. EMG showed 1+ paracervicals upper, 2+ mid, and 2 to 3+ lower. She had upper extremity EMGs that were normal including APB, FDI, triceps, biceps, and deltoid.

The patient reports that she has persistent neck pain with some moderation since surgery. It is increased by right lateral rotation, flexion, and extension. She has pain diffuse in the left more than right arm. She reports it is quite generalized. It is mostly in the upper arm sparing around the elbow and then extends into the forearm and the hand. She has some global tingling sensations dorsal and volar left hand, off and on, transient. No particular aggravating events or sequelae. No specific temporal or nocturnal relationship. No dermatomal involvement. No other aggravating or alleviating factors.

PAST MEDICAL HISTORY:

MEDICAL: Hypertension, environmental allergies, moderate depression secondary to pain, severe anxiety, elevated cholesterol, and irritable bowel syndrome.
SURGICAL: C-section, hysterectomy, cholecystectomy, lumpectomy, and cervical fusion C6-7 in 2007.
MEDICATIONS: Cymbalta, Toprol, Crestor, lisinopril, Premarin, AcipHex, and diazepam.
ALLERGIES: All cillins, sulfa, and Demerol
FAMILY HISTORY: Colon cancer and diabetes.
SOCIAL HISTORY: Smoking negative. Alcohol negative.

PHYSICAL EXAMINATION: Constitutional: Height and weight noted. No apparent distress. Age appropriate. Well nourished. Normal mental status. The patient's psychomotor is depressed. On examination, she has normal sudomotor evaluation and lymphatics. Symmetrical muscle bulk. No focal atrophy. Ratcheting on left arm motion elbow and wrist. Nonspecific aching in the ulnar forearm not involving the elbow. No focal tenderness of the medial or lateral condyle flexor or extensor origin, radial tunnel, cauda equina, or wrist carpus. Wrist motion full. Finger motion full. Negative Tinel's. She reports some palmar aching. No paresthesias. Phalen's yields neck aching.. Symmetrical thenar and hypothenar eminence. Symmetrical FPL and FDP. Normal pulp, refill, and color to light touch. Normal two-point discrimination to all digits.

IMPRESSION:

1. History of cervical radiculopathy status post C6-7 fusion.
2. Residual global left arm aching with no signs of dystrophy.
3. Minor changes in left median sensory latency, but actually normal internerve values compared to the ulnar. No abnormalities of amplitude, unlikely of clinical significance. Residual EMG changes in paraspinal, fibrillations, and increased insertional activity.
4. No signs of cubital tunnel syndrome.
5. Carpal tunnels negative. The patient's history, clinical examination, and nerve conduction studies are not consistent with this diagnosis at this time. I do not believe there is sufficient evidence and there is sufficient concern because of contraindication to clinical trial of carpal tunnel injection.

PLAN: We will defer to Drs. Jervey and Aymond for symptomatic management. I seen no indications for surgical intervention of the carpal canal.

ORTHOPAEDIC SPECIALISTS OF CHARLESTON John M. J. Ernst, MD Patient Name: WILSON, SARA DOB: [redacted] CHART #: 89612WC	2093 Henry Tecklenburg Drive Suite 200 East Charleston, SC 29414 Telephone (843) 958-2500 Fax (843) 958-2680 Date of Service: 6/19/2009

DISCUSSION: We discussed at length the patient's findings. I do not believe there is additional to add as far as peripheral upper extremity treatment.

John M. J. Ernst, MD

JMJE/kbs

DD: 6/19/2009 4:36:00 PM
DT: 6/25/2009 8:47:52 AM
9379739

cc: Dr. Jervey
This document was electronically signed by John Ernst, MD
Date and Time: 6/26/2009 4:37:25 PM

3-92-02-7



The Spann-Wilder Law Firm, LLC

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May 3, 2011

BY WAY OF PERSONAL DELIVERY
Dr. James K. Aymond
Orthopaedic Specialists of Charleston
2093 Henry Tecklenburg Dr., Ste. 200 East
Charleston, SC 29414

RE: Claimant: Sara Y. Wilson
Employer: Charleston County School District
WCC No.: [redacted] Date of Injury: May 9, 2006)

Dear Dr. Aymond:

Please be advised that I represent Ms. Sara Wilson as a result of her work related accident on May 9, 2006. On or about November 29, 2007 the S. C. Workers Compensation Commission issued an Order finding that Ms. Wilson suffered work related injuries to her neck and back. After that time, I filed a petition (Amended Form 50) alleging that Ms. Wilson's physical and psychological condition changed for the worse over time. In that regard, it is my understanding that you were the authorized treating physician who placed her at MMI in July 2007. As such, I would ask that you respond to the following questions: (Please check "yes" or "no" and provide an explanation if necessary).

1. That I treated Ms. Sara Wilson for injuries to her neck and back since January 2007. I released her at MMI on July 20, 2007.

✓ Yes _____ No

2. In a deposition taken on September 11, 2007 (pg. 13, ll. 10-17) I confirmed that Ms. Wilson was at MMI for her lumbar spine and that the only care that could be further provided for this non-surgical problem was injections if her condition worsened.

✓ Yes _____ No

Explanation, if necessary: _____

3. That Ms. Wilson presented to my office on November 12, 2007 with complaints of neck pain and again on December 7, 2007 with back pain. It was my recommendation that she be seen for pain management for the lower back and referred her to Dr. Andrew Geer for lumbar injections.

✓ Yes ____ No

4. Based upon my continued examinations and evaluations of Ms. Wilson since her MMI for her back in July 2007, it is my medical opinion that "most probably and to a reasonable degree of medical certainty" (greater than 50% probability) that Ms. Wilson's low back condition has continued to worsen resulting in her need for injections and that her symptoms are from her previous work-related injury and subsequent surgery. (See 10/21/08 office note).

✓ Yes ____ No

Explanation, if necessary:_____

5. I recommended Ms. Wilson to see Dr. John Ernst for her continued complaints of left arm pain stemming from her neck. Per Dr. Ernst, I referred care to Dr. Charles Jervey (Neurologist) who determined that she suffered from scattered denervation in the left cervical paraspinal region (See office notes of Dr. Jervey of 5/1909 & 6/26/09 of which I was cc'd). Based on Ms. Wilson's complaints of arm pain, it is my medical opinion that "most probably and to a reasonable degree of medical certainty) [greater than 50% probability] her denervation is related to her C6-7 cervical fusion.

✓ Yes ____ No

Explanation, if necessary:_____

_____

6. In my medical judgment, Dr. Jervey is best suited to handle her denervation condition.

✓ Yes ____ No

7. In my medical judgment, Ms. Wilson will continue to need low back injections as provided by Dr. Geer for ongoing pain management.

✓ Yes ____ No

Dr. James K. Aymond — 5/10/11 Date

ST FRANCIS HEALTHCARE

ADMISSION RECORD

MED REC #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM/BD	PAT TYPE	F.C.	BL/ACCT #
[redacted]	01/14/08 0001	N/A		MED	OPC		OPU	W	08014-00369

PATIENT

LOCATION(S)	REL	PAT. CLA	PUBVAL	LNG	SEX	RACE	ETH	DATE OF BIRTH	AGE
PRM	HMT		/ N	E	F	B	H	10/27/43	64Y

PATIENT NAME AND ADDRESS	SOC SEC NO	PATIENT EMPLOYER	TELEPHONE NO.
WILSON, BARA Y [redacted] CHARLESTON SC 29403	[redacted] PRI TELEPHONE NO. [redacted]	RETIRED EMP STAT SC	

GUARANTOR

GUARANTOR NAME AND ADDRESS	SOC SEC NO	GUARANTOR EMPLOYER	TELEPHONE NO.
WILSON, BARA Y [redacted] CHARLESTON SC 29403	[redacted] (843)577-2447 RELATION SELF	RETIRED SC	

EMPLOYERS

INSURANCE

INSURANCE 1	INSURANCE 2
[redacted] SUITE 140 CHARLESTON SC 29401 0706000554 WILSON, BARA Y APPROVED	

MISC

IN CASE OF EMERGENCY NOTIFY	SPOUSE
ROBINSON [redacted] OTHER HO [redacted] WKI	NOT GIVEN OTHER EMI WKI

ADM DX/PRECEDING COMPLAINT	ARRIVAL MODE	ADM TYPE/SOURCE
THORACIC LUMBAR PAIN	WALKIN/A	3 / 1

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
GILER-MD, ANDREW E	GILER-MD, ANDREW E	RAYMOND-MD, JAMES K	CLARK JR-MD, W PITTIGREW

ALERTS	PREVIOUS ADM DATE	OPT OUT	DIR	FND	NXT	PHI MSG	PRIMARY	ALT.		BY
NO NOTE	10/30/06	OPT OUT	No		XXX	PHI MSG	Yes			

FOR EMERGENCY DEPARTMENT USE ONLY
ALLERGIES | LNP# | TEMP # | RESP# | PULSE# | BP# | TIME | SIGNATURE

PRINCIPLE DIAGNOSIS | DRG

OTHER DIAGNOSIS(ES) | CODE(S)

PRINCIPAL OPERATION/PROCEDURE:

OTHER OPERATION(S)/PROCEDURE(S):

Outpatient

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED PHYSICIAN SIGNATURE: _____ DATE _____

Roper Hospital, 316 Calhoun Street, Charleston SC 29401 | Bon Secours St Francis Hospital, 2095 Henry Tecklenburg Drive, Charleston, SC 29414 | Roper Rehabilitation Hospital, 316 Calhoun Street, Charleston, SC 29401 | Roper Berkeley Day Hospital, 750 Stony Landing Road, Moncks Corner, SC 29461

S. Wilson Brief 18

PATIENT COPY

12/11/2007 10:41 8438[illegible]861 CSO MRN: 0008098886 OPC
12/[illegible] 11:28 18439582682 ORTHOPAEDIC SPECIAL. WILSON DOB: PHYS: [illegible]NEW,E
ACCT#:

Dr. Gear 723-3941 ORTHOPAEDIC SPECIALISTS W891

EVALUATION

Name Sean Wilson Date 12/7/07

Dx | Procedure | Dose | Qua | Rx | Refills

Rx: Pain Management Eval + Treatment

M.D. M.D.

Dispense as written Subordinate Signature

James K. Aycock, M.D.
Spine Surgery
Board Certified

[illegible] Loop Trail Dr.
Mt. Pleasant, S.C. 29464
843-[illegible]

[illegible] Towne Dr.
N. Charleston, S.C. 29420
843-[illegible]

2550 Henry Tecklenburg Dr Ste 200
Charleston, S.C. 29414
843-[illegible]

* Please call Pt & Inf
leaving 12/12/07
Out of town fil
1/4/08

12/11 auth ...
Glenn Martin, Adj:
937-4900

NOT SIGNED

ROPER ST FRANCIS HEALTHCARE

( ) Roper Hospital
(✓) Don Secours St. Francis Hospital
( ) Roper Berkeley

[redacted]
PHYS: GEER-MD, ANDREW E
ACCT#: [redacted]

PHYSICIAN'S ORDER SHEET

DATE & TIME		USE	DO NOT USE
1-11-08 @ 1350	Evaluate and treatment Accepted Dr. Andrew Geer (Jackie Davis)	Daily or Every other day	qd (1) or qod
1-14-08 1525		UNITS	IU OR U
1-14-08 1525	Permit Lumbar Lateral Joint Injections Dr. Andrew Geer (Little Rock)	UNITS	U
		10 mg	10.0 mg
		0.2 mg	2 mg
		Morphine Sulfate	HS, MSO4
		Magnesium Sulfate	MgSO4
		both ears, left ear, right ear	AU, AS, AD
		both eyes, left eye, right eye	OU, OS, OD
		HS (bedtime)	HS
		Microgram	
		sliding scale	BS or ss
		3 days or 3 doses	X3d

Physician Signature/Time/Date

(DOS Revised 0210)

S. Wilson Brief 20

[redacted]
PHYS: GEER-MD,ANDREW E

ROPER ST FRANCIS HEALTHCARE

☐Roper Hospital ☐St. Francis Hospital ☐Roper Berkeley

Outpatient History and Physical Report

Pertinent history (as appropriate to the patient's condition) _____

Physical Examination	Normal	Abnormal	If Abnormal, Explain Below
1. Mental Status			
2. Heart			
3. Chest/Lungs			

	Normal	Abnormal	Deferred	If Abnormal, Explain Below
4. Abdomen				
5. HEENT				
6. Neurological				
7. Lymph Glands				
8. Neck				
9. Breasts				
10. Genitalia/Vaginal				
11. Rectal				
12. Musculo-Skeletal				
13. Skin				
14. Other				

Anesthesia Assessment and Plan of Care

Assessment	Plan of Care
Previous problems(s) with sedation and/or anesthesia? ☐No ☐If Yes, describe: _____	☐ Local ☐ Moderate sedation ☐ Moderate sedation with local anesthesia ☐ If General, see Anesthesia Record

Principal/preoperative diagnosis: _____

Comorbid conditions: _____

Course of action planned: _____

Physician Signature: _____ Date: _____

Origin Date: 6/02, Revised: 1/05, Revised: 7/05

ROPER ST FRANCIS HEALTHCARE

MRN: 00808888 OPC
WILSON,SARA
DOB: [redacted]
PHYS: [redacted]
ACCT# [redacted]

Informed Consent for Operation/ Procedure/Anesthesia EXCLUDING Blood and Blood Products

1. I give my permission to Dr. (include any assistants) Andrea Lee
(to perform the following procedure (s) Bilateral Lumbar Facet Joint Injections
on Sara Wilson (patient's name)
2. I understand that during the procedure(s) new findings or conditions may appear and require an additional procedure(s) for proper care.
3. My doctor has discussed with me the items listed below:
   (a) the nature of my condition;
   (b) the nature and purpose of the procedure(s) that I am now authorizing;
   (c) the possible complications and side effects that may result, problems which may be experienced during recuperation, and the likelihood of success;
   (d) the benefits to be reasonably expected from the procedure(s);
   (e) the likely result of no treatment; and
   (f) the available alternatives, including the risks and benefits.
   (g) My physician has also explained that, in addition to the specific risks involved in the procedure(s), there are other possible risks that accompany any surgical and diagnostic procedure.

   _____
   (for physician use to add any specific risks if he/she deems necessary)
   I acknowledge that neither my physician nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the procedure(s) that I am now authorizing.
   (h) I know that other clinical staff may help my doctor during the procedure(s) and have been told of any surgical assistants that will assist my doctor.
4. I understand that the procedure(s) may require that I undergo some form of anesthesia, which may have its own risks. My doctor or a representative from the department of anesthesiology has informed me of the course of anesthesia that is recommended (if any) along with its possible risks and alternatives.
5. Any tissue or specimens taken from my body as a result of the procedure(s) may be examined and disposed of, retained, preserved, or used for medical, scientific, or teaching purposes by the hospital.
6. I understand that my procedure(s) may be photographed or videotaped and that observers may be present in the room for the purpose of advancing medical care and education.
7. I do not consent to blood and/or blood products as noted on the Blood Transfusion Release Liability form.
8. I understand what my doctor has explained to me and I have had all my questions fully answered.
9. Additional comments:

_____

Having talked with my doctor and having the opportunity to read this form, my signature below acknowledges my consent to the performance of the procedure(s) described above.

Signature of Patient or Legal Representative Sara G Wilson Date 1/14/08 Time 3:17 pm

If Legal Representative, Relationship to Patient _____

Witness _____

Verbal or Telephone Consent

Name of Legal Representative _____ Relationship to Patient _____ Date _____ Time _____

Witness _____ Witness _____

1. I have explained the risk, benefits, potential complications, and alternatives of the treatment to the patient and have answered all questions to the patient's satisfaction, and he/she has granted consent to proceed.
2. I have initialed the site with the patient and/or family for procedures that involve laterality, multiple structures or level.

Physician's Signature _____

Rev3/06 S. Wilson Brief 22

(ROPER / ST FRANCIS) ( ) Roper Hospital ( ) St Francis Hospital

MR#: 0005098886 OPC

[redacted]

PRE-PROCEDURE RECORD

Pre-Procedure Care (Day of Procedure)

Date: 1-14-08 Time: 1340

☐ NPO Since: _____ Voided: ☐ Yes ☐ No

Valuables: (√ if present O if removed)

☐ Clothing ☐ Dentures ☐ Glasses ☐ Contact Lens
☐ Hearing Aid ☐ Hair Piece/Wig ☐ Jewelry
☐ Other _____
☐ Patient informed Hospital not responsible for lost valuables

Signature of Person Responsible for Valuables _____

Disposition if no one present: _____

☐ Responsible adult available to accompany patient at discharge
☐ TED Hose ☐ SCD/Plexi Pulse
☐ Skin Prep _____ By: _____

Completed by: DH (initial)

Medication given prior to procedure:

_____ Time: _____ Initial _____
_____ Time: _____ Initial _____
_____ Time: _____ Initial _____
_____ Time: _____ Initial _____
_____ Time: _____ Initial _____
_____ Time: _____ Initial _____
_____ Time: _____ Initial _____
Douche/Enema _____ Time: _____ Initial _____
☐ IV gauge # ____ Site ____ Fluid ____ Rate ____ Initial ____
☐ Heparin # ____ Site ____ Fluid ____ Rate ____ Initial ____

OR Checklist: (Initial when completed)

DH I.D. Bracelet Correct
DH Informed Consent
DH H & P
DH Site / Procedure verified with schedule/MD order; consent and patient/representative
Site Marked by Physician ☑ Yes ☐ No ☐ N/A

Completed by: DH (Initial)

Diagnostic Studies
(O if ordered √ if on chart)

☐ CBC	☐ Sed Rate	☐ Hcg	☐ Liver Profile
☐ Chemistry	☐ Urine C&S	☐ Potassium	☐ Amylase
☐ PT,PTT	☐ U/A	☐ T & S	☐ Lipase
☐ EKG	☐ X-rays	☐ Creatinine	☐ BUN

☐ T & C _____ units available
☐ Pregnancy ☐ _____
☐ Bedside Glucose _____
☐ Abnormal results called to MD

Completed by: _____ (Initial)

Assessment

Alert and Oriented: ☑ Yes ☐ Yes (See supplemental Nurses Notes)
Suspected Abuse: ☑ No ☐ Yes (See supplemental Nurses Notes)
Learning Barriers: ☑ No Barriers ☐ Physical ☐ Religious ☐ Cultural ☐ Cognitive ☐ Emotional ☐ Language (See supplemental Nurses Notes)
Pain: ☑ No Pain ☐ Yes Location: _____ Quality: _____ Duration: _____ Intensity: _____ (1-10) Quick Chart/Flowsheet Pattern: _____
Alleviating Factors: _____ Aggravating Factors: _____ Affects on ADL: _____ Reviewed by: _____
Diabetic/Special Diet? ☑ No ☐ Yes (See supplemental Nurses Notes)
Recent Mobility Limitations? ☑ No ☐ Yes (See supplemental Nurses Notes)

Completed by DH RN (Initial)

Plan of Care

Clinical Pathway Initiated

Potential for Fear and/or Anxiety (Pain) Goal: Reduction of fear and anxiety ☑ Goal Met	Potential for Injury Goal: Patient free from injury ☐ Goal Met
☑ Procedures explained to patient & family	Side Rails Up: ☐ X 2 ☐ X 4 Bed Position ☐ Low ☐ High
☐ Patient & family encouraged to verbalize concerns and questions	☑ Instructed patient to call for assistance
☐ Patient & family's questions answered	Potential for Alteration in Fluid Volume Goal: Fluid volume is within normal limits ☐ Goal Met
☐ Age appropriate emotional support provided	☐ IV access present, no infiltration noted
Knowledge Deficit Related to Procedure/Disease Goal: Demonstrates adequate verbalization of knowledge ☑ Goal Met	Potential for Infection Goal: Free from infection ☐ Goal Met
☐ Patients' level of learning assessed and instructions modified to meet needs	☐ Confidentiality of patient records, discussions, procedure maintained
☐ Reviewed printed discharge instructions with patient and family	☐ Personal items safeguarded during preparation
☐ Pearls for Progress reviewed with patient	Potential Alteration in Cardiopulmonary Function Goal: Hemodynamically Stable ☐ Goal Met
☐ Cough, turn, deep breath	☐ Continuous cardiac monitoring ☐ Continuous heart rate monitoring
☑ PRN Pain Medications/Pain Scale	Potential alteration in Gas Exchange Goal: Adequate Air Exchange ☐ Goal Met
☐ Patient/family verbalizes understanding of instructions	☐ Continuous pulse oximetry in use ☐ Oxygen therapy initiated as ordered
☐ Age appropriate approach used in education	

INITIAL/SIGNATURE: DB INIT. Debbie Brunish

INITIAL/SIGNATURE: DH INIT. Deborah Hunter

_____ INIT

_____ INIT

(990028 (Revised 11/04)

Wilson, Sara Y.

[redacted]

PRE-PROCEDURE RECORD (page 2)

Pediatrics (neonate through 17 years of age)

☐ Grade in school _____

☐ Developmental milestones appropriate for age ☐Yes ☐No

☐ Security objects/toys _____

☐ Immunizations current _____ ☐Yes ☐No

Signature: _____

Feeding: ☐ Breast ☐ Bottle/formula ☐ Solids

Type of Formula _____

Primary caregiver _____

Interaction between caregiver and child:

☐ Calming ☐ Agitative

Signature: _____

Head circumference _____

(infants under 1 year of age only)

Further Assessment

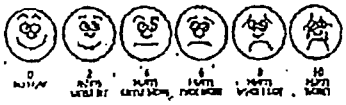
Cardiac Rhythm: _____

Pre-procedure Peripheral Pulses: (Absent, 1+, 2+, 3+, 4+, Doppler)

Rt. DP Lt. DP Rt. PT Lt. PT Rt. Rad. Lt. Rad. Other

Other: _____

Signature: _____



Rating scale is not recommended for persons age 3 years and older. Wong, D. Whaley & Wong's Essentials of Pediatric Nursing, ed. 5, 1997, p. 1218. Copyrighted by Mosby-Year Book, Inc. Reprinted by permission.

Supplemental Nurses Notes: _____

Pre Procedure Preparation

Date Called _____ Time Called _____ Instructions given to: _____

Type of Procedure _____

Date of procedure: _____ Time of procedure: _____ Arrival Time: _____

Via: ☐ Phone ☐ Appointment ☐ Left Phone Message ☐ Unable to reach

☐ No Make-up, Jewelry, Perfume, Nail Polish or Valuables

☐ NPO Status/Time _____

☐ Instructions for: _____

☐ Medications A.M. of Procedure with a sip of water

☐ Bring Medications / Inhalers / List / To Hospital

☐ Pre-Admission Diagnostic Tests Done:

Date _____ Location _____

☐ Date/Location Previous CXR: _____

☐ Date/Location previous EKG: _____

☐ Informed that responsible adult must accompany patient to Hospital, transport home and remain with patient post Procedure

Name of Responsible Person Post Procedure: _____

Signature: _____ RN/LPN

ROPER ST FRANCIS HEALTHCARE

( ) ROPER HOSPITAL (V) BON SECOURS ST. FRANCIS HOSPITAL

NURSING INITIAL ASSESSMENT

MRN: 000609898 OPC
WILSON SARA Y
[redacted] REW E
[redacted]
Name

⊕ ER Only ⊕ Category # **BASELINE INFORMATION**

DATE 1-14-0 TIME 3:50 AGE 64 ARRIVED AMB WC STRETCHER EMS CARRIED OTHER: Primary MD

Initial/Chief Complaint/History of Present Illness

Emesis
R. CVA w/ back pain

T 98.1 (O) R TM | P 119 | R 20 | BP RT 186/69 | ⊕ O_2 Sat 100% | Sex: M F | Ht 4'11" | Wt: Actual 116 Stated:

⊕ Tetanus / Immunizations: | Pneumococcal Vaccine ☑ No ☐ Yes · Most Recent Date:

⊕ Pregnant ☐ No ☐ Yes N/A | Influenza Vaccine? ☐ No ☑ Yes · Most Recent Date: 2011

ALLERGIES: ☐ NONE ☑ MEDICATIONS ☐ LATEX ☐ FOOD ☐ ANESTHESIA ☐ OTHER

List Names & Reactions

Demerol Injection - nausea
vomiting

TB ASSESSMENT Initiate Airborne Isolation if 4 or greater criteria checked Yes

Persistent cough > 2 weeks	☑ No ☐ Yes	Abnormal Chest X-Ray	☑ No ☐ Yes	Respiratory Isolation Ordered	☑ No ☐ Yes
Fever > 100.4 (night sweats)	☑ No ☐ Yes	Physician order for AFB (smear/culture)	☑ No ☐ Yes		
Unexplained weight loss	☑ No ☐ Yes	Recent exposure to person with Suspected TB or + PPD	☑ No ☐ Yes		

RN / LPN Signature: DSHunter RN

☑ See Home Medication Orders – **MEDICATION / OVER THE COUNTER / HERBAL HISTORY** ☐ Investigation drugs/devices:

MEDICATION	DOSE	FREQUENCY	LAST DOSE	MEDICATION	DOSE	FREQUENCY	LAST DOSE
reconciliation sheet							

Hospitalizations / Surgery: hysterectomy cervical fusion (C-5 - C-6) 1970 C-section 1983 partial hysterectomy 1989 right breast removed (cancer) 2000 gallbladder 2010 tumpectomy

MEDICAL HISTORY

Neurological	☐ No ☑ Yes headaches	Sensory Impairment	☐ No ☑ Yes	Vision	
Cardiovascular	☑ No ☐ Yes	Endocrine	☐ No ☑ Yes		
Hypertension	☐ No ☑ Yes	Blood Disorder	☑ No ☐ Yes		
Respiratory	☐ No ☑ Yes	Cancer	☑ No ☐ Yes		
Gastrointestinal	☐ No ☑ Yes IV Table Inj Sinus	Psychosocial	☑ No ☐ Yes		
Renal / Urological	☑ No ☐ Yes	Tobacco Use	☑ No ☐ Yes		
Gynecological	☑ No ☐ Yes	Alcohol / Drug Use	☑ No ☐ Yes		
Musculoskeletal	☐ No ☑ Yes mid to lower back	Infectious Disease	☑ No ☐ Yes		
Integumentary	☑ No ☐ Yes	Cough/Cold Past 2 Wks	☑ No ☐ Yes		
EENT	☐ No ☑ Yes SINUS	Anesthesia	☐ No ☐ Yes	vomiting	

Source of Information ☐ Patient ☐ Family ☐ Unable to obtain ☐ Other ☐ "Home" Medications sent home with

Arrival Date	Arrival Time	T (O) R TM	P	R	BP Rt	Lt	O_2 Sat %

RN Initials DSH RN Signature Deborah Hunter Date 1-14-0 Time 4:17 Unit PMD

RN Initials _____ RN Signature _____ Date _____ Time _____ Unit _____

090918 Nursing Assessment P 1 # 2100441

S. Wilson Brief 25

#4 W 8942 WC

Bon Secours St. Francis
PROCEDURE NOTE
01/14/2008

WILSON, SARA V. [redacted]
Andrew Geer, MD
Page 1

JRA

INDICATION: Ms. Wilson is a 64-year-old African American female with a history of low back pain referred by Dr. James Aymond for evaluation for low back pain. I discussed the above with her at length. She understands the risks, benefits, and complications of facet blocks. We also discussed possible radiofrequency ablation. She understands and agrees to proceed.

ASSESSMENT: Facet arthropathy.

PLAN: Bilateral L5-S1 facet blocks and we will consider radiofrequency ablation if she is successful with this current procedure. Will follow up on a p.r.n. basis with myself or Dr. James Aymond.

PROCEDURE NOTE: Informed consent was obtained. The patient in the prone position. Standard monitors were applied. The area was prepped x3 with Betadine and aseptically draped. Then 1% preservative-free lidocaine was used for local anesthetic. A 3.5 inch 25-gauge spinal needle advanced to the transverse processes associated with the L5-S1 facet. There was negative aspiration, negative paresthesias. At each site 2 cc of 1% preservative-free lidocaine and 20 mg of Depo-Medrol were injected and flushed. The needle removed. The patient to recovery, discharged awake, alert and in stable condition with good relief of pain.
Andrew Geer, MD

TH [redacted]

cc: James K. Aymond, MD
Pain Mgt. Center BSSF
Andrew Geer, MD

COPY FOR James K. Aymond, MD

ROPER ST FRANCIS HEALTHCARE

MRN: 000808896 OPC

[redacted] MD, ANDREW E

Home Medication / Discharge Reconciliation

This is to be used for outpatient departments who are not computerized.

☐ Roper Hospital ☑ Bon Secours St. Francis Hospital ☐ Roper St. Francis Medical Center - Berkeley

Home Medications Reported by the Patient

Drug Name	Dose	Route	Frequency	Comments	Last Dose
Zanaflex	4mg	p.o	as needed		1-18-08
Mepiazine	50mg	p.o	as Needed		1-7-08
Librax	Tab	p.o	HS		1-13-08
Lovazepam	1mg	p.o	daily		1-14-08
Micardis	40mg	p.o	daily		1-14-08
Nexium	40mg	p.o	daily		1-14-08
Promavin	0.5mg	p.o	daily		1-14-08
Toprol XL	50mg	p.o	daily		1-14-08
Zocor	40mg	p.o	HS		1-13-08
Tylenol	100mg	p.o	as Needed		Unsure
Vitamin C	500mg	p.o	as Needed		Unsure

New Medication Orders Post Procedure

Drug Name	Dose	Route	Frequency	Comments	Last Dose

RN Signature Deborah Hunter Date 1-14-08 Time 14:00

Patient's Primary Care Physician: _____ Fax Number _____

This list indicates medications to be taken/given following discharge.
Do not take any additional medications unless you check with your physician.

S. Wilson Brief 27

BON SECOURS
ST FRANCIS HOSPITAL

MRN: 000808888 OPC
WILSON BARRY
DOB: [illegible] SEX: M

The Pain Clinic Intra/Post Procedure Form

Procedure: L/S Facets Date: 1/14/08

Procedure Physician: A Beer

☒ Pre-procedure Plan of Care Continued

Time	Pain Score 0/10	LOC	RR	HR	B/P	SaO_2	Cs	Knowledge Deficit/Potential for Post-Procedure Complications at Home. ☐ Goal Met
1527	6	A	20	91	147/88	100	☒	Written discharge instructions reinforced. Copy given
1535	4	A	20	90	138/77	100	☐	INT d/c no signs of infection or infiltration noted.
1539	—	A	20	92	120/69	100	☒	Procedural injection site(s) clean, dry, and intact.
1544	0	A	20	86	211/98	100	☒	Ambulates self with steady gait.
1548	0	A	20	95	216/97	100	☐	Ambulates with minimal assistance.
1556	0	A	20	79	190/98	100	☐	Prescriptions given to patient/family.
1602	0	A	20	87	198/95	100	☐	Discharge via wheelchair: ☒ Home ☐ Floor
							☐	Other
								Discharge Time: 1610
								Recovery/Discharge Criteria
								Vital signs stable or pre-procedure level
								O_2 sat 93% on room air
								LOC at level 1-2 or pre-procedure level
								Minimal or no pain

Medications	Time	Amount	Initials	Route	Location
☐ Lidocaine 1 % ☐ ____ %	1527	8cc	WB	Local infiltration	Skin
Versed				IV	
Fentanyl				IV	
Normal saline				IV	
1% Xylocaine		7cc	WB		
Depomedrol		80mg	WB	☐ Lumbar level 5-1	☐ Epidural
				☐ Cervical level	☐ Transforaminal
				☐ Thoracic level	☐ Facet
				☐ Level	☐ Sacroiliac
				☐ Right	☐ Stellate
				☐ Sacral Level	☐ Other
				☐ Other	Trigger points

Physician/VO/TO Signature:

Initial: WB Signature: Wilson Barry

Initial: CJ Signature: Dacanay

Initial: WB Signature: Wilson Barry

Initial: CJ Signature: Dacanay

STFPAINPAIH (07/07)

WILSON, SARA Y.
Saint Francis
MD: Gee-Md, Andrew E., MD
Acct:
Discharge Date: 01/16/2008 23:09
Requested Date: 01/16/2008 12:37

Discharge Meds Caregiver (discharge)

Medication	Dose	Route	Freq	Last Taken	Next Dose Due	Start Date	Stop Date
Allegra Generic: Fexofenadine	1 tablet	Oral	Daily	3/30/07			
LIBRAX Generic: Also Known As: Not Available	1 tablet	Oral	Every pm	3/29/07			
Lorazepam Generic: Lorazepam	1 mg	Oral	Every am	3/30/07			
Micardis Generic: Telmisartan	40 mg Tablet	Oral	Every am	3/30/07			
Nexium Generic: Esomeprazole Magnesium	40 mg Capsule, Delayed Release(E.C.)	Oral	Every am	3/30/07			
Percocet Generic: Oxycodone-Acetaminophen Comment: pm pain	1-2 tablet	Oral	Every 4-6 hrs as needed				
Premarin Generic: Conjugated Estrogens	0.9 mg Tablet	Oral	Every am	3/30/07			

Discharge Meds Caregiver (discharge)

Medication	Dose	Route	Freq (Last Taken)	Next Dose Due	Start Date	Stop Date
Toprol XL Generic: Also Known As: Not Available	50 mg	Oral	Every am 3/30/07			
Zocor Generic: Simvastatin	40 mg	Oral	Every pm 3/29/07			
Zoloft Generic: Sertraline	25 mg Tablet	Oral	Every am 3/30/07			

ROPER ST FRANCIS HEALTHCARE

ADMISSION RECORD

MED REC #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM NO	PAY TYPE	F.C.	ACCT #
[redacted]	06/02/08 0001	N/A		MED	OBS	-	OPC	W	08125-00286

PATIENT

LOCATION(S)	REL	PAT. CLA	PUBLIC	LNG	SEX	RACE	NS	DATE OF BIRTH	AGE
PRM	MRT		I N	E	F	H	H	[redacted]	

PATIENT NAME AND ADDRESS	SOC SEC NO	PATIENT EMPLOYER	TELEPHONE NO.
WILSON, SARA Y [redacted] CHARLESTON SC 29403	[redacted] PH TELEPHONE NO. -	RETIRED SHIP STAT SC	

GUARANTOR

GUARANTOR NAME AND ADDRESS	SOC SEC NO	GUARANTOR EMPLOYER	TELEPHONE NO.
WILSON, SARA Y CHARLESTON SC 29403	[redacted]	RETIRED SC	

EMPLOYERS

INSURANCE

INSURANCE 1	INSURANCE 2
THE SCHAFFER COMPANY 171 CHURCH ST SUITE 140 CHARLESTON SC 29401	
WILSON, SARA Y VERBAL	

MISC

IN CASE OF EMERGENCY NOTIFY		SPOUSE	
ROBINSON, CHARLES	OTHER	HOT, STEVEN	OTHER
RH	WK:	RH:	WK:

ADM DX/PRESENTING COMPLAINT	ARRIVAL MODE	ADM TYP/SOURCE
FACET ARTHROPATHY	WALKIN/A	3 / 1

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
GEER--MD, ANDREW E	GEER--MD, ANDREW E	AYKOND-MD, JAMES K	SIMMONS-MD, JACK W JR

ALERTS	OPT OUT	D/A	FND	MKT	PHN MSG	PRIVACY	ALT.		BY
NO NOTE		No		CHN		Yes			[illegible]

FOR EMERGENCY DEPARTMENT USE ONLY

ALLERGIES	LMP#	TEMP #	RESP#	PULSE#	BP#	TME	SIGNATURE

PRINCIPLE DIAGNOSIS — DRG

OTHER DIAGNOSIS(ES) — CODE(S)

PRINCIPAL OPERATION/PROCEDURE:

OTHER OPERATION(S)/PROCEDURE(S):

Outpatient

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED PHYSICIAN SIGNATURE: _____ DATE _____

MRN: 000509886 OPC
WILSON,SARA V

ROPER ST FRANCIS HEALTHCARE

☐Roper Hospital ☒St. Francis Hospital ☐Roper Berkeley

(pt. label)

Outpatient History and Physical Report

Pertinent history (as appropriate to the patient's condition) LBP

Physical Examination	Normal	Abnormal	If Abnormal, Explain Below
1. Mental Status			
2. Heart			
3. Chest/Lungs			

	Normal	Abnormal	Deferred	If Abnormal, Explain Below
4. Abdomen				
5. HEENT				
6. Neurological				
7. Lymph Glands				
8. Neck				
9. Breasts				
10. Genitalia/Vaginal				
11. Rectal				
12. Muscule-Skeletal		✓		
13. Skin				
14. Other				

Anesthesia Assessment and Plan of Care

Assessment	Plan of Care
Previous problems(s) with sedation and/or anesthesia? ☐No ☐If Yes, describe:	☐ Local ☐ Moderate sedation ☐ Moderate sedation with local anesthesia ☐ If General, see Anesthesia Record

Principal/preoperative diagnosis: facet OA

Comorbid conditions:

Course of action planned: L5/S1 Facet Block

Physician Signature: Date:

Origin Date: 6/02, Revised: 7/03, Revised: 7/05

S. Wilson Brief 32

PRINTED BY: greequ DATE 1/2/2009

ROPER ST FRANCIS HEALTHCARE

MRN: 00000000 DOB:

PHYS: GEER MD, ANDREW E



Informed Consent for Operation/ Procedure/Anesthesia EXCLUDING Blood and Blood Products

1. I give my permission to Dr. (include any assistants) Andrew Geer

to perform the following procedure (s) Lumbar Epidural Injection

on Wilson, Sara (patient's name)

2. I understand that during the procedure(s) new findings or conditions may appear and require an additional procedure(s) for proper care.
3. My doctor has discussed with me the items listed below:
   (a) the nature of my condition;
   (b) the nature and purpose of the procedure(s) that I am now authorizing;
   (c) the possible complications and side effects that may result, problems which may be experienced during recuperation, and the likelihood of success;
   (d) the benefits to be reasonably expected from the procedure(s);
   (e) the likely result of no treatment; and
   (f) the available alternatives, including the risks and benefits.
   (g) My physician has also explained that, in addition to the specific risks involved in the procedure(s), there are other possible risks that accompany any surgical and diagnostic procedure.

   (for physician use to add any specific risks if he/she deems necessary)

   I acknowledge that neither my physician nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the procedure(s) that I am now authorizing.
   (h) I know that other clinical staff may help my doctor during the procedure(s) and have been told of any surgical assistants that will assist my doctor.
4. I understand that the procedure(s) may require that I undergo some form of anesthesia, which may have its own risks. My doctor or a representative from the department of anesthesiology has informed me of the course of anesthesia that is recommended (if any) along with its possible risks and alternatives.
5. Any tissue or specimens taken from my body as a result of the procedure(s) may be examined and disposed of, retained, preserved, or used for medical, scientific, or teaching purposes by the hospital.
6. I understand that my procedure(s) may be photographed or videotaped and that observers may be present in the room for the purpose of advancing medical care and education.
7. I do not consent to blood and/or blood products as noted on the Blood Transfusion Release Liability form.
8. I understand what my doctor has explained to me and I have had all my questions fully answered.
9. Additional comments:

Having talked with my doctor and having the opportunity to read this form, my signature below acknowledges my consent to the performance of the procedure(s) described above.

Signature of Patient or Legal Representative Sara Wilson Date 5/2/08 Time 13:14

If Legal Representative, Relationship to Patient

Witness CDaeway

Verbal or Telephone Consent

Name of Legal Representative Relationship to Patient Date Time

Witness Witness

1. I have explained the risk, benefits, potential complications, and alternatives of the treatment to the patient and have answered all questions to the patient's satisfaction, and he/she has granted consent to proceed.
2. I have initialed the site with the patient and/or family for procedures that involve laterality, multiple structures or level.

Physician's Signature



Rev3/08

S. Wilson Brief 33

PRINTED BY: areeau DATE 1/7/2009

MRN: 000000000 OPC

(1) Roper Hospital
(2) St Francis Hospital

PRE-PROCEDURE RECORD

Pre-Procedure Care (Day of Procedure)

Date: 5/2/08 Time: 1305
☐ NPO Since: _____ Voided: ☐ Yes ☐ No

Valuables: (√ if present O if removed)
☑ Clothing ☐ Dentures ☐ Glasses ☐ Contact Lens
☐ Hearing Aid ☐ Hair Piece/Wig ☐ Jewelry
☐ Other _____
☑ Patient informed Hospital not responsible for lost valuables
Signature of Person Responsible for Valuables _____
Disposition if no one present: _____
☑ Responsible adult available to accompany patient at discharge
☐ TED Hose ☐ SCDs/Plexi Pulse
☐ Skin Prep _____ By: _____

Medication given prior to procedure:

Phenergan IVP	Time: _____	Initial _____	
_____	Time: _____	Initial _____	
_____	Time: _____	Initial _____	
Refused IVP	Time: _____	Initial _____	
_____	Time: _____	Initial _____	
_____	Time: _____	Initial _____	
_____	Time: _____	Initial _____	
Douche/Enema _____	Time: _____	Initial _____	
☐ IV gauge # ____ Site ____ Fluid ____ Rate ____		Initial ____	
☐ IV gauge # ____ Site ____ Fluid ____ Rate ____		Initial ____	

Completed by: CD (Initial)

OR Checklist: (Initial when completed)

CD I.D. Bracelet Correct
Informed Consent
H & P
Site / Procedure verified with schedule/MD order; consent and patient/representative
Site Marked by Physician ☐ Yes ☐ No ☐ N/A

Completed by: _____ (Initial)

Diagnostic Studies
(O if ordered √ if on chart)

☐ CBC	☐ Sed Rate	☐ Hemo	☐ Liver Profile
☐ Chemistry	☐ Urine C&S	☐ Potassium	☐ Amylase
☐ PT,PTT	☐ UA	☐ T & S	☐ Lipase
☐ EKG	☐ X-rays	☐ Creatinine	☐ BUN

☐ T & C _____ units available
☐ Pregnancy ☐ _____
☐ Bedside Glucose _____
☐ Abnormal results called to MD

Completed by: _____ (Initial)

Assessment — Nursing Assessment (question) Initiated

Alert and Oriented: ☑ Yes ☐ No (See supplemental Nurses Notes)
Suspected Abuse: ☑ No ☐ Yes (See supplemental Nurses Notes)
Learning Barriers: ☑ No Barriers ☐ Physical ☐ Religious ☐ Cultural ☐ Cognitive ☑ Emotional ☐ Language (See supplemental Nurses Notes)
Pain: ☐ No Pain ☑ Yes Location: back Onset: 2001 Duration: sleep Intensity: 6 (1-10) Quality/Characteristics/Pattern: aches
Alleviating Factors: med Aggravating Factors: activity Effects on ADL: yes Referred by: Dr. Lee
Diabetic/Special Diet? ☑ No ☐ Yes (See supplemental Nurses Notes)
Recent Mobility Limitation? ☐ No ☐ Yes (See supplemental Nurses Notes)
Completed by: _____ RN (Initial)

Plan of Care — Clinical Pathway Initiated

CD Potential for Fear and/or Anxiety Goal: Reduction of fear and anxiety ☐ Goal Met	Potential for Injury Goal: Patient is free from injury. ☐ Goal Met
☑ Procedure explained to patient & family.	Side Rails Up ☐ X2 ☐ X4 Bed Position ☐ Low ☐ High
☑ Patient & family encouraged to verbalize concerns and questions	☐ Instructed patient to call for assistance.
☑ Patient & family's questions answered.	Potential for Alteration in Fluid Volume Goal: Fluid volume is within normal limits. ☐ Goal Met
☑ Age appropriate emotional support provided.	☐ IV access present no infiltration noted.
CD Knowledge Deficit Relating to Procedure Goal: Demonstrates adequate knowledge ☐ Goal Met	Privacy/Confidentiality Goal: Privacy/Confidentiality maintained. ☐ Goal Met
☑ Patients' level of learning assessed and instructions modified to meet needs.	☐ Confidentiality of patient records, diagnosis, procedure maintained.
☑ Reviewed printed discharge instructions with patient and family.	☐ Patient minimally exposed during preparation.
☐ Needs for Progress reviewed with patient	Potential Alteration in Cardiovascular Function Goal: Hemodynamically Stable ☐ Goal Met
☐ Cough, turn, deep breath	☑ Continuous cardiac monitoring ☐ Continuous heart rate monitoring
☑ PRN Pain Medications/Pain Scale	Potential Alteration in Gas Exchange Goal: Adequate Air Exchange ☐ Goal Met
☑ Patient/family verbalize understanding of instructions	☐ Continuous pulse oximetry in use ☐ Oxygen therapy initiated as ordered
☐ Age appropriate approach used in education.	
INITIAL/SIGNATURE: CD INIT CDacanay INIT	INITIAL/SIGNATURE: _____ INIT _____ INIT

ROPER ST FRANCIS HEALTHCARE

( ) ROPER HOSPITAL ( ) BON SECOURS ST. FRANCIS HOSPITAL

MRN: 000800886 OPC

NURSING INITIAL ASSESSMENT

Name

BASELINE INFORMATION

⊕ ER Only ⊕ Category # DATE 5/20/16 TIME 1310 AGE 64 ARRIVED: AMB WC STRETCHER EMS CARRIED OTHER: Primary MD

Initial/Chief Complaint/History of Present Illness

C/O Back & leg pain
N. also B leg

T PO R TM	P 86	R: 20	BP RT 171/79 LT	⊕ O2 Sat 100 %	Sex: M ⊕	Ht: 4' 11"	Wt: Actual: Stated 116

⊕ Tetanus / Immunizations: Pneumococcal Vaccine ☑ No ☐ Yes Most Recent Date:

⊕ Pregnant ☐ No ☐ Yes LMP: Influenza Vaccine? ☐ No ☑ Yes Most Recent Date: 2007

ALLERGIES: ☐ NONE ☑ MEDICATIONS ☐ LATEX ☐ FOOD ☐ ANESTHESIA ☐ OTHER

List Names & Reactions: Demerol Injection - nausea, vomiting

TB ASSESSMENT Initiate Airborne Isolation if 4 or greater criteria checked Yes

Persistent cough >2 weeks	☑ No ☐ Yes	Abnormal Chest X-Ray	☑ No ☐ Yes	Respiratory Isolation Ordered	☑ No ☐ Yes
Fever >100.4 (night sweats)	☑ No ☐ Yes	Physician order for AFB (smear/culture)	☑ No ☐ Yes		
Unexplained weight loss	☑ No ☐ Yes	Recent exposure to person with Suspected TB or + PPD	☑ No ☐ Yes		

RN / LPN Signature: CDaeaney

☑ See Home Medication Orders MEDICATION / OVER THE COUNTER / HERBAL HISTORY ☐ Investigation drugs/devices

MEDICATION	DOSE	FREQUENCY	LAST DOSE	MEDICATION	DOSE	FREQUENCY	LAST DOSE
Reconciliation Sheet							

Hospitalizations / Surgery: Posterior Cervical Fusion (6-1970) C-Section 1987
Partial hysterectomy 2006 gallbladder 2006 D&C unspecified

MEDICAL HISTORY

Neurological	☐ No ☑ Yes	Headaches	Sensory Impairment	☐ No ☑ Yes	Visual
Cardiovascular	☑ No ☐ Yes		Endocrine	☑ No ☐ Yes	
Hypertension	☐ No ☐ Yes		Blood Disorder	☑ No ☐ Yes	
Respiratory	☐ No ☑ Yes		Cancer	☑ No ☐ Yes	
Gastrointestinal	☐ No ☑ Yes	Gastroesophageal reflux	Psychosocial	☑ No ☐ Yes	
Renal / Urological	☑ No ☐ Yes	urinary tract infect.	Tobacco Use	☑ No ☐ Yes	
Gynecological	☑ No ☐ Yes		Alcohol / Drug Use	☑ No ☐ Yes	
Musculoskeletal	☐ No ☑ Yes	Mid to L back pain	Infectious Disease	☑ No ☐ Yes	
Integumentary	☑ No ☐ Yes		Cough/Cold Past 2 Wks	☑ No ☐ Yes	
EENT	☐ No ☐ Yes	Sinus	Anesthesia	☐ No ☑ Yes	Vomiting

Source of Information ☐ Patient ☐ Family ☐ Unable to obtain ☐ Other ☐ "Home" Medications sent home with

Arrival Date	Arrival Time	T PO R TM	P:	R:	BP RT	LT	O2 Sat	%

RN Initials CD RN Signature CDaeaney Date 5/20/16 Time 1315 Unit 3 North

RN Initials ____ RN Signature ____ Date ____ Time ____ Unit ____

090019 Nursing Assessment P 1 #2100441

PRINTED BY: greequ DAT S. Wilson Brief 36



WILSON

Bon Secours St. Francis
PROCEDURE NOTE
05/02/2008

Andrew Geer, MD
Page 1

JKA

Ms. Wilson is a 64-year-old African-American female patient of Dr. James Aymond who arrives for repeat treatment of low back. She had facet block back in January of this year, which provided her with some fairly good relief of pain. She has had some worsening over the last two weeks. We discussed radiofrequency ablation and if she agrees we will proceed with radiofrequency ablation on next visit if that is still her decision.

ASSESSMENT: Facet arthropathy.

PLAN: Bilateral L5-S1 facet blocks. We will consider radiofrequency ablation. Follow up with myself, Dr. Aymond, or Dr. Jack Simmons.

PROCEDURE NOTE: Informed consent was obtained. Patient in prone position. Standard monitors applied. Area was prepped x 2 with Betadine and aseptically draped; 1% preservative-free lidocaine for local anesthetic. A 3½ inch 25-gauge spinal needle advanced to the transverse processes of L5-S1 bilaterally using fluoroscopic guidance and confirmation. At that time, 2 cc of 1% preservative-free lidocaine and 20 mg of Depo-Medrol were injected at each site. Needles flushed and removed. Patient to recovery, discharged awake, alert, in stable condition with no complication.

Andrew Geer, MD

TR: rss DD: 05/02/2008 TO: 05/05/2008 12:15 P JOB#: 002031118 DOC#: 1510285

cc: James K. Aymond, MD
Pain Mgt. Center BSSF
Andrew Geer, MD
J. W. Simmons, Jr., MD

COPY FOR James K. Aymond, MD

ROPER ST FRANCIS HEALTHCARE

[redacted]

Home Medication / Discharge Reconciliation

This is to be used for outpatient departments who are not computerized.

☐ Roper Hospital ☐ Bon Secours St. Francis Hospital ☐ Roper St. Francis Medical Center - Berkeley

Home Medications Reported by the Patient

Drug Name	Dose	Route	Frequency	Comments	Last Dose
Doxycycline	100mg	po	BID	start 4/29/08	5/1/08

New Medication Orders Post Procedure

Drug Name	Dose	Route	Frequency	Comments	Last Dose

RN Signature [signature] Date 5/2/08 Time 1311

Patient's Primary Care Physician: _____ Fax Number _____

This list indicates medications to be taken/given following discharge.
Do not take any additional medications unless you check with your physician

2 of 2

S. Wilson Brief 37

[redacted]

BON SECOURS
ST FRANCIS HOSPITAL

MRN: 00080986 OPC

PATIENT: GEER-MD,ANDREW E

The Pain Clinic Intra/Post Procedure Form

Procedure: Lumbar Facet Block Date: 5/2/00

Procedure Physician: Geer

Pre-procedure Plan of Care Continued

Time	Pain Score O/10	LOC	RR	HR	B/P	SaO_2	Knowledge Deficit/Potential for Post-Procedure Complications at Home. Goal Met
1443	10	A	20	94	179/88	100	☑ Written discharge instructions reinforced. Copy given to patient
1448	7	A	20	94	176/83	100	☐ INT d/c no signs of infection or infiltration noted.
1453	7	A	20	94	175/82	100	☑ Procedural injection site(s) clean, dry, and intact.
1458	6	A	20	86	171/80	100	☑ Ambulates self with steady gait.
1523	6	A	20	92	167/80	99	☑ Ambulates with minimal assistance.
1528	6	A	20	92	164/78	99	☐ Prescriptions given to patient/family
1533	6	A	20	90	164/78	100	☑ Discharge via wheelchair: ☑ Home ☐ Floor
1538	6	A	20	88	170/85	100	☐ Other
1543	6	A	20	83	168/84	100	Discharge Time: 1530
1548	6	A	20	85	141/69	100	Recovery/Discharge Criteria
							Vital signs stable or pre-procedure level
							O_2 sat 03% on room air
							LOC at level 1-2 or pre-procedure level
							Minimal or no pain

Medications	Time	Amount	Initials	Route	Location
☑ Lidocaine 1 % ☐ ___ %	1444	10cc	[illegible]	Local infiltration	Skin
Versed				IV	
Fentanyl				IV	
Normal saline				IV	
				☑ Lumbar level 5 & 1	☐ Epidural
				☐ Cervical level ___	☐ Transforaminal
				☐ Thoracic level ___	☑ Facet
Xylocaine 1%	1457	2cc	[illegible]	☐ Level ___	☐ Sacroiliac
Depo-Medrol	57	80mg	[illegible]	☑ Right	☐ Stellate
				☐ Sacral Level ___	☐ Other
				☐ Other ___	Trigger points

Physician/VO/TO Signature:

Initial: [illegible] Signature: [illegible]

Initial: DB Signature: [illegible]

Initial: Signature:

Initial: Signature:

STFRANPAIN (07/03)

S. Wilson Brief 38

PRINTED BY: [illegible] DATE 1/2/2000

MRN: 00060888 OPC
WILSON BARA

ROPER ST FRANCIS HEALTHCARE

GREENMD, ANDREW E

Pain Management Clinic Discharge Instructions

You may experience the following as indicated under each procedure:

☐ Post Caudal or Lumbar Block
- Increase low back and/or leg pain for several days.
- Improvement in leg pain may be noticed in the first two to three days, but it may be delayed for up to 10 to 14 days

☐ Post Cervical Epidural Block
- Increase neck, upper back and/or arm pain for several days.
- Improvement in arm pain may be noticed in the first two to three days, but it may be delayed for up to 10 to 14 days.

☐ Post Prolotherapy Injection
- You will experience some increased discomfort that may vary in severity. Drink plenty of fluids.
- Do Not use anti-inflammatory medications (Motrin, Advil, ect)
- No ICE should be used because it is anti-inflammatory. You may use heat as tolerated.
- Be sure to do stretching exercises 2-3 times a day as determine by your physician.

☐ Radio Frequency
- You may experience some discomfort at the site of Radio Frequency lesioning.
- The discomfort usually subsides within 24 to 48 hours.

☐ Post Facet Block
- Low back achiness, stiffness and/or increased pain for about two to seven days.
- Improvement in back pain may be noticed in three to five days, but it may be delayed for up to 14 days.

☐ Stellate Ganglion Block
- Your face, neck and arm can be numb for up to 24 hours.
- Your throat may be numb for several hours. Check gag reflex with sips of water before eating meal.
- Avoid carrying or lifting anything more than 15 pounds.

☐ Post Discogram
- Low-back pain and/or leg pain for about a week after a lumbar discogram.

☐ Cryo-Rhizotomy
- Increase pain for 24 hours after the treatment.
- The freezing effect may last from 7 to 10 days, but further improvement may occur this time. Keep your activity to minimum for the next couple of days. Showers only for the next three days (No tub baths); after your shower apply band-aids with antibiotic ointment over each injection site.

☒ Other: Lumbar facet Injection

The steroid (cortisone like medication) used during the block will take one to seven days to begin working to relieve inflammation and settling in your back or neck. The Lidocaine and/or Marcaine used to numb your back or neck will wear off within 30 minutes to six hours.

1. During the first one or two days after the block, you may place an ice pack on the painful area for up to 20 minutes at a time (no ice, if you had Prolotherapy).
2. Keep activity to minimum for the first 24 hours after your block. You may resume your normal activities _____.
3. **DO NOT** drive a car or operate machinery for at least 24 hours after your procedure.
4. Use caution with ice or heat because you may not be able to feel extremes in temperature while your skin is numb.
5. You may shower after the block, but use caution with hot water temperature.
6. If you have any problems or questions, or you need to make an appointment, please call Dr. Green at 423 344 1
7. Additional Instructions: _____
8. I agree to a post procedure discharge telephone call: Yes X No X at this number _____

Physician's Signature: _____ Date: _____

I have received and understand the above instructions.

Patient's Signature: Dana G Wilson Date: 5/2/08

Witness Signature: _____ Date: 5/2/08

Part 1 (White) Chart Copy
05/06

Part 2 (Yellow) Patient Copy

S. Wilson Brief 39

PRINTED BY: [illegible] DATE 1/2/2009

ROPER ST FRANCIS HEALTHCARE

ADMISSION RECORD

PATIENT

MED REC #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM/BD	PAT TYPE	F.C.	SUB/ACCT #
000609890	11/13/08 0230	N/A		MED	OPC		OPC	W	

LOCATION(S)	REL.	PAT. CLA	PUBLIC	LNG	SEX	RACE	HIS	DATE OF BIRTH	AGE
PRN	MRT		N	E	F	B	H	[redacted]	

PATIENT NAME AND ADDRESS: WILSON, BARA Y [redacted] CHARLESTON SC 29403

SOC SEC NO: PRI TELEPHONE NO.

PATIENT EMPLOYER: RETIRED — EMP STAT: SC — TELEPHONE NO.

GUARANTOR

GUARANTOR NAME AND ADDRESS: WILSON, BARA Y [redacted] CHARLESTON SC 29403

SOC SEC NO: [redacted]

GUARANTOR EMPLOYER: RETIRED — SC — TELEPHONE NO.

EMPLOYER

INSURANCE

INSURANCE 1: THE CORVEL COMPANY, 171 CHURCH ST, SUITE 140, [redacted] SC 29401, WILSON, BARA Y

INSURANCE 2:

MISC

IN CASE OF EMERGENCY NOTIFY: [redacted] OTHER WK:

SPOUSE: NOT GIVEN — OTHER WK: HM:

ADM DX/PRESENTING COMPLAINT: FACET ARTHROPATHY — ARRIVAL MODE: WALKIN/A — ADM TYPE/SOURCE: 3 / 1

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
GEER-MD, ANDREW E	GEER-MD, ANDREW E	RAYMOND-MD, JAMES X	DICHONG-MD, JACK W JR

ALERTS	PREVIOUS ADM DATE	OPT OUT	DR	FND	MRT	PHN MSG	PRIMARY	ALT.		BY
NO NOTE	05/02/08		No		CHR		Yes			JH

FOR EMERGENCY DEPARTMENT USE ONLY
ALLERGIES | LNP# | TEMP # | RESP# | PULSE# | BP# | TIME | SIGNATURE

PRINCIPLE DIAGNOSIS | DRG

OTHER DIAGNOSIS(ES) | CODE(S)

PRINCIPAL OPERATION/PROCEDURE:

OTHER OPERATION(S)/PROCEDURE(S):

Outpatient

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED PHYSICIAN SIGNATURES: _____ DATE _____

S. Wilson Brief 40

ROPER ST FRANCIS HEALTHCARE

( ) Roper Hospital
( ) Bon Secours St. Francis Hospital
( ) Roper Berkeley

MRN: 00080[redacted] OPC
WILSON,SABA Y
PHYS: GEER-MD,ANDREW E

PHYSICIAN'S ORDER SHEET

DATE & TIME		USE	DO NOT USE
4/12/08	Permit for Lumbar facet injection Received order Dr Andrew Geer /CJ Downey		
1035	11/13/08 11:05	Daily or Every other day	QD or Daily
		UNITS	IU OR iu
		UNITS	U
		10 mg	10.0 mg
		0.2 mg	.2 mg
		Morphine Sulfate	MS, MSO4
		Magnesium Sulfate	MgSO4
		both ears, left ear, right ear	AU, AS, AD
		both eyes, left eye, right eye	OU, OS, OD
		HS (bedtime)	HT
		Microgram	Ug
		sliding scale	SS or ss,
		3 days or 3 doses	X3d,

Physician Signature/Time/Date

BR06 Revised 02/07

S. Wilson Brief 41

MRN: 000608898 OPC
WILSON S
P [redacted] ANDREW E
[redacted]

ROPER ST FRANCIS HEALTHCARE

(Patient Label)

☐Roper Hospital ☒St. Francis Hospital ☐Roper Berkeley

Outpatient History and Physical Report

Pertinent history (as appropriate to the patient's condition) _____

L BB

Physical Examination	Normal	Abnormal	If Abnormal, Explain Below
1. Mental Status			
2. Heart			
3. Chest/Lungs			

	Normal	Abnormal	Deferred	If Abnormal, Explain Below
4. Head				
5. Ears, Nose, Throat				
6. Neck				
7. Neurological				
8. Lymph Glands				
9. Breasts				
10. Abdomen				
11. Genitalia/Vaginal				
12. Rectal				
13. Musculo-Skeletal				
14. Skin				
15. Other				

Anesthesia Assessment and Plan of Care

Assessment	Plan of Care
Previous problems(s) with sedation and/or anesthesia? ☐No ☐If Yes, describe: _____	☐ Local ☐ Moderate sedation ☐ Moderate sedation with local anesthesia ☐ If General, see Anesthesia Record

Principal/preoperative diagnosis: _____ facet arthropathy

Comorbid conditions: _____

Course of action planned: _____ L5-S1 facet

Physician Signature: _____ Date: _____

Origin Date: 6/02, Revised: 1/05, Revised: 7/05, Revised 01/08

S. Wilson Brief 42

ROPER ST FRANCIS HEALTHCARE

MR#: 000809896 OPC
WILSON,SARA V
[redacted] GEER-MD,ANDREW E

Informed Consent for Operation/ Procedure/Anesthesia EXCLUDING Blood and Blood Products

1. I give my permission to Dr. (include any assistants) Andrew Geer
to perform the following procedure (s) Trumbar Epidural injection
on Sara Wilson (patient's name)
2. I understand that during the procedure(s) new findings or conditions may appear and require an additional procedure(s) for proper care.
3. My doctor has discussed with me the items listed below:
   (a) the nature of my condition;
   (b) the nature and purpose of the procedure(s) that I am now authorizing;
   (c) the possible complications and side effects that may result, problems which may be experienced during recuperation, and the likelihood of success;
   (d) the benefits to be reasonably expected from the procedure(s);
   (e) the likely result of no treatment; and
   (f) the available alternatives, including the risks and benefits.
   (g) My physician has also explained that, in addition to the specific risks involved in the procedure(s), there are other possible risks that accompany any surgical and diagnostic procedure.

   (for physician use to add any specific risks if he/she deems necessary)
   I acknowledge that neither my physician nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the procedure(s) that I am now authorizing.
   (h) I know that other clinical staff may help my doctor during the procedure(s) and have been told of any surgical assistants that will assist my doctor.
4. I understand that the procedure(s) may require that I undergo some form of anesthesia, which may have its own risks. My doctor or a representative from the department of anesthesiology has informed me of the course of anesthesia that is recommended (if any) along with its possible risks and alternatives.
5. Any tissue or specimens taken from my body as a result of the procedure(s) may be examined and disposed of, retained, preserved, or used for medical, scientific, or teaching purposes by the hospital.
6. I understand that my procedure(s) may be photographed or videotaped and that observers may be present in the room for the purpose of advancing medical care and education.
7. I do not consent to blood and/or blood products as noted on the Blood Transfusion Release Liability form.
8. I understand what my doctor has explained to me and I have had all my questions fully answered.
9. Additional comments:

Having talked with my doctor and having the opportunity to read this form, my signature below acknowledges my consent to the performance of the procedure(s) described above.

Signature of Patient or Legal Representative Sara Wilson Date 11/3/08 Time 2:15

If Legal Representative, Relationship to Patient

Witness Dawnay R

Verbal or Telephone Consent
Name of Legal Representative Relationship to Patient Date Time

Witness Witness

1. I have explained the risk, benefits, potential complications, and alternatives of the treatment to the patient and have answered all questions to the patient's satisfaction, and he/she has granted consent to proceed.
2. I have initialed the site with the patient and/or family for procedures that involve laterality, multiple structures or level.

Physician's Signature

Rev3/08

S. Wilson Brief 43

Surgeon: Dr. Andrew Geer.

History of Present Illness: Ms. Wilson is a 65-year-old African-American female patient of Dr. James K. Aymond and Dr. Jack Simmons who arrives for treatment of facet arthropathy. We discussed this at length. She understands the risks and benefits and complications and agrees to proceed.

Assessment: Facet arthropathy.

Plan: Bilateral L5/S1 facet blocks. Consider radiofrequency ablation based on the results of the above. Followup on a p.r.n. basis with myself, Dr. Simmons, or Dr. Aymond.

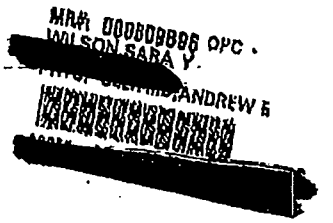
Procedure Note: Informed consent was obtained. The patient was placed in prone position and standard monitors were applied. The area was prepped x 3 with Betadine and aseptically draped. 1% preservative free lidocaine for local anesthetic. At that time a 3.5 25 gauge spinal needle was advanced to the transverse processes bilaterally of aforementioned using fluoroscopic guidance for confirmation and loss of resistance technique. There was negative aspiration, negative paresthesias. At that time 2 cc of 1% plain lidocaine and 20 mg of Depo-Medrol were injected and flushed. The needle was removed. The patient was taken to recovery room discharged awake, alert, in stable condition with no complications.

Andrew Geer, MD
TR: slm DD: 11/14/2008 TD: 11/15/2008 9:44 A JOB#: 002048463 DOC# 1593254

cc: James K. Aymond, MD
Andrew Geer, MD
J. W. Simmons, Jr., MD

Authenticated by ANDREW E GEER MD On 12/03/2008 11:03:55 AM

ROPER ST FRANCIS HEALTHCARE



Pain Management Clinic Discharge Instructions

You may experience the following as indicated under each procedure:

☐ Post Caudal or Lumbar Block
- Increase low back and/or leg pain for several days.
- Improvement in leg pain may be noticed in the first two to three days, but it may be delayed for up to 10 to 14 days

☐ Post Cervical Epidural Block
- Increase neck, upper back and/or arm pain for several days.
- Improvement in arm pain may be noticed in the first two to three days, but it may be delayed for up to 10 to 14 days.

☐ Post Prolotherapy Injection
- You will experience some increased discomfort that may vary in severity. Drink plenty of fluids.
- Do Not use anti-inflammatory medications (Motrin, Advil, ect)
- No ICE should be used because it is anti-inflammatory. You may use heat as tolerated.
- Be sure to do stretching exercises 2-3 times a day as determine by your physician.

☐ Radio Frequency
- You may experience some discomfort at the site of Radio Frequency lesioning.
- The discomfort usually subsides within 24 to 48 hours.

☐ Post Facet Block
- Low back achiness, stiffness and/or increased pain for about two to seven days.
- Improvement in back pain may be noticed in three to five days, but it may be delayed for up to 14 days.

☐ Stellate Ganglion Block
- Your face, neck and arm can be numb for up to 24 hours.
- Your throat may be numb for several hours. Check gag reflex with sips of water before eating meal.
- Avoid carrying or lifting anything more than 15 pounds.

☐ Post Discogram
- Low-back pain and/or leg pain for about a week after a lumbar discogram.

☐ Cryo-Rhizotomy
- Increase pain for 24 hours after the treatment.
- The freezing effect may last from 7 to 10 days, but further improvement may occur this time. Keep your activity to minimum for the next couple of days. Showers only for the next three days (No tub baths); after your shower apply band-aids with antibiotic ointment over each injection site.

☐ Other: _____

The steroid (cortisone like medication) used during the block will take one to seven days to begin working to relieve inflammation and selling in your back or neck. The Lidocaine and/or Marcaine used to numb your back or neck will wear off within 30 minutes to six hours.

1. During the first one or two days after the block, you may place an ice pack on the painful area for up to 20 minutes at a time (no ice, if you had Prolotherapy).
2. Keep activity to minimum for the first 24 hours after your block. You may resume your normal activities _____.
3. DO NOT drive a car or operate machinery for at least 24 hours after your procedure.
4. Use caution with ice or heat because you may not be able to feel extremes in temperature while your skin is numb.
5. You may shower after the block, but use caution with hot water temperature.
6. If you have any problems or questions, or you need to make an appointment, please call Dr. Green at 223 344
7. Additional Instructions: _____
8. I agree to a post procedure discharge telephone call: Yes ____ No ____ at this number _____

Physician's Signature: _____ Date: _____

I have received and understand the above instructions.

Patient's Signature: S. A. Wilson Date: 11/13/08

Witness Signature: _____ Date: 11/13/08

Part 1 (White) Chart Copy
05/05

Part 2 (Yellow) Patient Copy



S. Wilson Brief 45

6756

WILSON, SARAH

02/23/09

CHIEF COMPLAINT: Left shoulder pain. DO: 11/2008.

CONSULTING PHYSICIAN: Robert Oliverio, M.D.

HISTORY: Ms. Wilson is a 65-year-old female who comes in with atraumatic left shoulder pain. She states she has aching and discomfort over the anterior shoulder and deltoid region. At its worst, the pain is 10 out of 10. She can't sleep on the left side. She does have some neck and some numbness and tingling down in the arms. She has not received therapy or injections and she denies previous injuries, fractures, or dislocations to this area.

PAST MEDICAL HISTORY: Her past medical history, past surgical history, medications, family history, social history and review of systems is recorded on the patient information sheet and has been reviewed by me. She had a cervical disc fusion at C4-5 and C6-7. She is on Premarin, Valium, Aciphex, Crestor, metoprolol, and lisinopril. She has nerve problems, heart problems, blood pressure problems, and back trouble. She does not smoke or drink.

ALLERGIES: She is allergic to penicillin, sulfa, and Demerol.

PHYSICAL EXAMINATION: She is an alert, somewhat tearful female with depressed affect but in no apparent distress. The cervical spine and the right and left shoulders were examined for tenderness, range of motion, scapular dyskinesis, rotator cuff strength, biceps injury, impingement signs, SLAP lesions and instability and are recorded in detail on the shoulder assessment sheet. In summary, the pertinent findings reveal decreased extension, left lateral bending, and left axial rotation with pain into the lateral shoulder. Right lateral bending causes pain into the left shoulder. She has AC tenderness 1, ALA 1, bicipital groove 1, coracoid 1, ATE 100, PTE 125 with pain, IR to L3, ER 45, SAR ER 85, SAR IR 55, supraspinatus 5 with pain, infraspinatus 5, Napoleon 5, Hawkins 1, and reverse Hawkins 0. Elbows and wrists show full range of motion without tenderness, effusion, instability, ecchymosis, or edema. She is neurologically and vascularly intact. Skin and lymphatics are normal. DTRs are equal bilaterally. Gait and station are normal. There is no intrinsic atrophy or unilateral atrophy.

IMAGING: X-rays of the left shoulder show normal glenohumeral joint space. There appears to be a subchondral cyst or bony island in the humeral head. Mild greater tuberosity sclerosis is noted and she has moderate narrowing of the AC joint. A type I acromion is noted. There are no acute fractures, avulsions, or dislocations.

PROCEDURE: After discussing with the patient the benefits and risks of a subacromial injection, the patient's left shoulder was sterilely prepped. Then 80 mg of Depo-Medrol, 4 cc of 1% Lidocaine and 4 cc of 0.25% Marcaine were injected without difficulty. The patient tolerated the procedure well.

IMPRESSION:

1. Cervical spine known DDD status post ACDF of C4 through C6.
2. Cervical neuritis.
3. Left shoulder impingement syndrome with loss of internal rotation.

PLAN: We provided a corticosteroid injection. I would like for either Dr. Oliverio or Dr. Samuel Rosen to consider either starting her on Cymbalta or Lyrica to help with some of this neuropathic pain and depression. I suspect that a boost in serotonin will help with her pain, particularly at night. We will get her in physical therapy with Sharon to work on her neck and shoulder modalities, range of motion, and strengthening. I recommended ice treatments in the evening. She is unable to take nonsteroidals, so she will just continue with her Tylenol and Valium for now. I will see her back in about 6 weeks for a recheck.

James R. DeMarco, M.D. /af
CC: Robert Oliverio, M.D.
Samuel Rosen, M.D.

C-Spine PT

PALMETTO ORTHOPAEDICS OF CHARLESTON, P.A.
Waddell H. Gilmore, III, M.D. * R. Marshall Hay, M.D. * James R. DeMarco, M.D. * R. Blake Dennis, M.D.

913 Bowman Road, Suite 2-B
Mt. Pleasant, SC 29464
[redacted]

615 Wesley Drive, Suite 100
Charleston, SC 29407
(843) 763-2857
(843) 763-2868 Fax

PALMETTO ORTHOPAEDICS SHOULDER THERAPY PRESCRIPTION

Name: Sara Wilson Date: 2/23/09

Diagnosis: C-Spine DDD s/p Fusion C4-6, Cervical

Surgery: ANTERIOR (L) SH Date of Surgery: Burning / Impingement

☐ PENDULUMS ☐ TABLE/WALL STRETCHES ☐ PULLEYS ☐ SUPINE STICK

ROM:
☐ PROM ☐ AAROM ☐ AAROM without gravity (supine) ☐ AROM vs. gravity

RESTRICTIONS/GOALS: 1ST GOAL IS ↑ PAIN LESS 120 MOF (L) SH +/- C-Spine
☐ FORWARD FLEXION SUPINE/SITTING @ _____ weeks post-op
☐ EXTERNAL ROTATION @ 0° ABDUCTION @ _____ weeks post-op
☐ EXTERNAL ROTATION @ 90° ABDUCTION @ _____ weeks post-op
☐ INTERNAL ROTATION @ 0° ABDUCITON (behind back) _____ level @ _____ weeks post-op
☐ INTERNAL ROTATION @ 90° ABDUCTION @ _____ weeks post-op
☐ ABDUCTION IN SCAPULAR PLANE @ _____ weeks post-op

STRENGTHENING:	ISOMETRICS	ISOTONICS	ISOKINETICS	GO SLOWEST AND PROTECT
SUPRASPINATUS	☐	☐	☐	☐
INFRASPINATUS	☐	☐	☐	☐
SUBSCAPULARIS	☐	☐	☐	☐
BICEPS	☐	☐	☐	☐
SCAPULAR STABILIZERS	☐	AS TOL	DUE only	AFTER ACHIEVING FULL ROM

SCAPULAR RHYTHM STABILIZATION:
WORK ON SCAPULAR RHYTHM ☐
POSTURE/SCAPULAR RETRACTION AND DEPRESSION ☐
JOINT MOBILIZATIONS ☐
CLOSED/OPEN CHAIN SCAPULAR STABILIZATION EXERCISES ☐
CORE EXERCISES (THIGH, HIP, RECTUS, OBLIQUES, LAT'S, PECS, ETC.) ☐
POSTERIOR CAPSULAR STRETCHING:
(SLEEPER STRETCH, INTERNAL ROTATION EXERCISES, CROSSOVER STRETCHES:) ☐

SPORTS SPECIFIC ACTIVITIES: C-Spine PT / HEAT / MUE / MUSC / PRN

HANDS ON MANUAL STRETCHING FOR ADHESIVE CAPSULITIS/ CONTRACTURES ☐

MODALITIES:
☐ HEAT ☐ CRYOTHERAPY ☐ EDEMA CONTROL
☐ ULTRASOUND ☐ E-STIM ☐ TENS ??
☐ IONTOPHORESIS ☐ TRANSVERSE FRICTION MASSAGE
☐ SOFT TISSUE/SCAR MOBILIZATION ☐ TAPING

FREQUENCY 2 TIMES A WEEK FOR 6-8 WEEKS.
Unless otherwise stated, goals for ROM and motor function should be equal to the uninjured side.

Signature: _____

JRD/lm 08/11/05

S. Wilson Brief 48

PALMETTO ORTHOPAEDICS OF CHARLESTON, P.A.

WADDELL H. GILMORE III, M.D. • R. MARSHALL HAY, M.D. • JAMES R. DEMARCO, M.D. • R. BLAKE DENNIS, M.D.

180 Wingo Way, Suite 301
Mt. Pleasant, SC 29464
(843) 884-0302
(843) 849-9308 Fax

615 Wesley Drive, Suite 100
Charleston, SC 29407
(843) 763-2857
(843) 763-2868 Fax

February 23, 2009

Robert R. Oliverio Jr., M.D.
615 Wesley Drive Suite 300
Charleston, SC 29407

Re: Sara Wilson

Dear Bob:

Enclosed is my office note on Ms. Wilson. I think she may benefit from either a Cymbalta prescription or a Lyrica prescription, but given her medical problems and the medications she is on, I would like for you to manage that if you see fit. My first choice would probably be a trial of Cymbalta, though she failed Effexor because it made her feel funny. I think the lowest possible dose and increasing slowly may be beneficial for her. This would help with her serotonin and pain receptors and allow her to rest more comfortably. If that doesn't work, Lyrica would be a good second choice. Let me know what you end up doing. I am going to see her back in about six weeks in my office. Thank you for your help.

Sincerely,

James R. DeMarco, M.D.

JRD/af

CareAlliance
Health Services

ADMISSION RECORD

MED. REC. #	ADMISSION DATE/TIME	DISCHARGE DATE/TIME		SERVICE	STATION	ROOM NO.	PAY TYPE	F.C.	GUARCT #
[redacted]	[redacted]	8/20/03 1300		MED	CP1	0209-01	LPC	PP	[redacted]

PATIENT

LOCATION(S)	REL	PAT. CLA	PUB/VAL	LNG	SEX	RACE	MS	DATE OF BIRTH	AGE
BED	PVT		/ N	E	F	B	M	[redacted]	59Y

PATIENT NAME AND ADDRESS
WILSON,SARA Y
[redacted]
CHARLESTON, SC 29403

SOC SEC NO [redacted]
TELEPHONE NO. [redacted]

EMPLOYERS
PATIENT EMPLOYER
CHAS CTNY SCH DIST
75 CALHOUN ST
CHARLESTON, SC 29401

TELEPHONE NO. [redacted]

GUARANTOR

GUARANTOR NAME AND ADDRESS
WILSON,SARA Y
[redacted]
CHARLESTON, SC 29403

SOC SEC NO. [redacted]
RELATION
SELF

GUARANTOR EMPLOYER
CHAS CTNY SCH DIST
75 CALHOUN ST
CHARLESTON, SC 29401

TELEPHONE NO. [redacted]

INSURANCE

INSURANCE 1
BCBS STATE
PO BOX 100505
COLUMBIA, SC 29260-0505
CHAS CTNY SC STATESC
ZCS249726758
WILSON,SARA;Y

INSURANCE 2

MISC.

IN CASE OF EMERGENCY NOTIFY
WILSON,MOSE;Y SPOUSE
HM: [redacted] WK:

SPOUSE
NOT,GIVEN OTHER
HM: WK:

ADM DX/PRESENTING COMPLAINT
SYNCOPE

ARRIVAL MODE
WALKIN/A

ADM TYPE/SOURCE
3 / 1

ADMITTING DOCTOR	ATTENDING DOCTOR	REFERRING DOCTOR	PRIMARY CARE DOCTOR
CLARE SR-MD,W PETT	CLARE SR-MD,W PETT	CLARE SR-MD,W PETT	CLARE SR-MD,W PETT/GREW

ALERTS
NO NONE

PREVIOUS ADM DATE
08/28/02

BY
JYF

FOR EMERGENCY DEPARTMENT USE ONLY
ALLERGIES | HR/P | TEMP/ | RESP/ | PULSE/ | BP/ | TIME | SIGNATURE

PRINCIPAL DIAGNOSIS:

DRG

OTHER DIAGNOSIS(ES):

CODE(S)

780.2
401.9
300.4

PRINCIPAL OPERATION/PROCEDURE:

OTHER OPERATION(S)/PROCEDURE(S):

☐ OPERATIVE SUMMARY DICTATED ☐ DISCHARGE SUMMARY DICTATED

PHYSICIAN SIGNATURE: [signature] DATE: 8/20/03

S. Wilson Brief 60

Roper Hospital
316 Calhoun Street
Charleston, SC 29401

Roper St. Francis Hospital
2095 Henry Tecklenburg Drive
Charleston, SC 29414

Roper Rehabilitation Hospital
316 Calhoun Street
Charleston, SC 29401

Roper Berkeley Day Hospital
730 Bishop Gadsden Blvd
Charleston, SC 29412

CHART COPY

CareAlliance

Health Services

Bon Secours – St. Francis Xavier Hospital
2095 Henry Tecklenburg Drive
Charleston, SC 29414

WILSON, SARA Y
[redacted]
W. Pettigrew Clare Sr., MD
Page 1

ADMISSION HISTORY AND PHYSICAL REPORT
02/18/2003

Room: 209.

History of Present Illness: This is a 59-year-old female admitted with syncopal episodes. He has been followed by me with hypertension, arrhythmias and hypercholesterolemia. She has recently lost her husband, has been under a fair amount of stress and anxiety because of this. Today she had two episodes of becoming very lightheaded, falling, being poorly responsive for a period of time. The second one was witnessed by a friend who stated that she did not have any seizures. She never completely lost consciousness; however, for a period of time she was confused and unable to converse. She was seen in my office. Her blood pressure was 154/76. Heart was somewhat rapid and EKG showed nonspecific ST and T-wave changes, previously noted. Because of the severity of her symptoms, she was admitted. Her health has generally been fairly good. She has had no prior history of cardiac disease.

Past Medical History: Her past problems have been gastroesophageal problems and essentially negative workup. In 1999 she was having palpitations for which a Holter monitor demonstrated isolated PVCs and isolated PACs. Her history is otherwise unremarkable.

Physical Examination: Examination on admission showed a blood pressure of 154/76, pulse 108, temperature 98°. She is a well-developed, slightly obtunded female. HEENT is normocephalic. Funduscopic examination – no vessel changes. Neck is supple. No bruits were noted. Lungs were clear. Examination of the heart revealed a regular rhythm without murmur. Abdominal examination showed no enlarged organs or masses. No edema.

Impression:
1. Syncope.
2. Anxiety and depression related to her husband's death.
3. Hypertension.

Plan: She will be admitted and placed on telemetry with CIP and successive EKGs obtained.

W. Pettigrew Clare Sr., MD

TR: cnb DD: 02/18/2003 TD: 02/18/2003 8:09 P JOB#: 000007931 DOC#: 950098

cc: W. Pettigrew Clare Sr., MD

401

C

2-20

CareAlliance

Health Services

Bon Secours – St. Francis Xavier Hospital
2095 Henry Tecklenburg Drive
Charleston, SC 29414

WILSON, SARA Y
[redacted]
Wm. Blount Ellison, Jr., MD
Page 1

ECHOCARDIOGRAPHY REPORT

[redacted]

Tape: GERR 99.

The left ventricular size and systolic function appear normal. Ejection fraction is estimated at 66%. No focal left ventricular wall motion abnormalities are seen. The left ventricular wall thickness appears normal. The other cardiac chambers appear of normal size. The mitral, aortic, and tricuspid valves appear morphologically normal. The aortic valve appears tricuspid in morphology. Doppler studies suggest the presence of mild to moderate aortic regurgitation. A trace of mitral regurgitation is incidentally noted. There is no pericardial effusion. The cardiac aortic root appears normal.

Impression:
1. Mild to moderate aortic insufficiency.
2. Otherwise unremarkable study.

Signature

Wm. Blount Ellison, Jr., MD

TR: drt DD: 02/20/2003 TD: 02/23/2003 7:05 A JOB#: 000000935 DOC#: 951522

cc: W. Pettigrew Clare Sr., MD
Wm. Blount Ellison, Jr., MD
Room 209.

I. A ID: [redacted]

25mm/s Med:
10mm/mV Age: Ht: Wt:
100Hz Sex: Race:
Pgm 010C/v78 Loc: Room:
Cart: 1

Vent. rate 85 BPM
PR inter . 16 ms
QRS dura
QT/QTc
P-R-T ax.

Tech.:

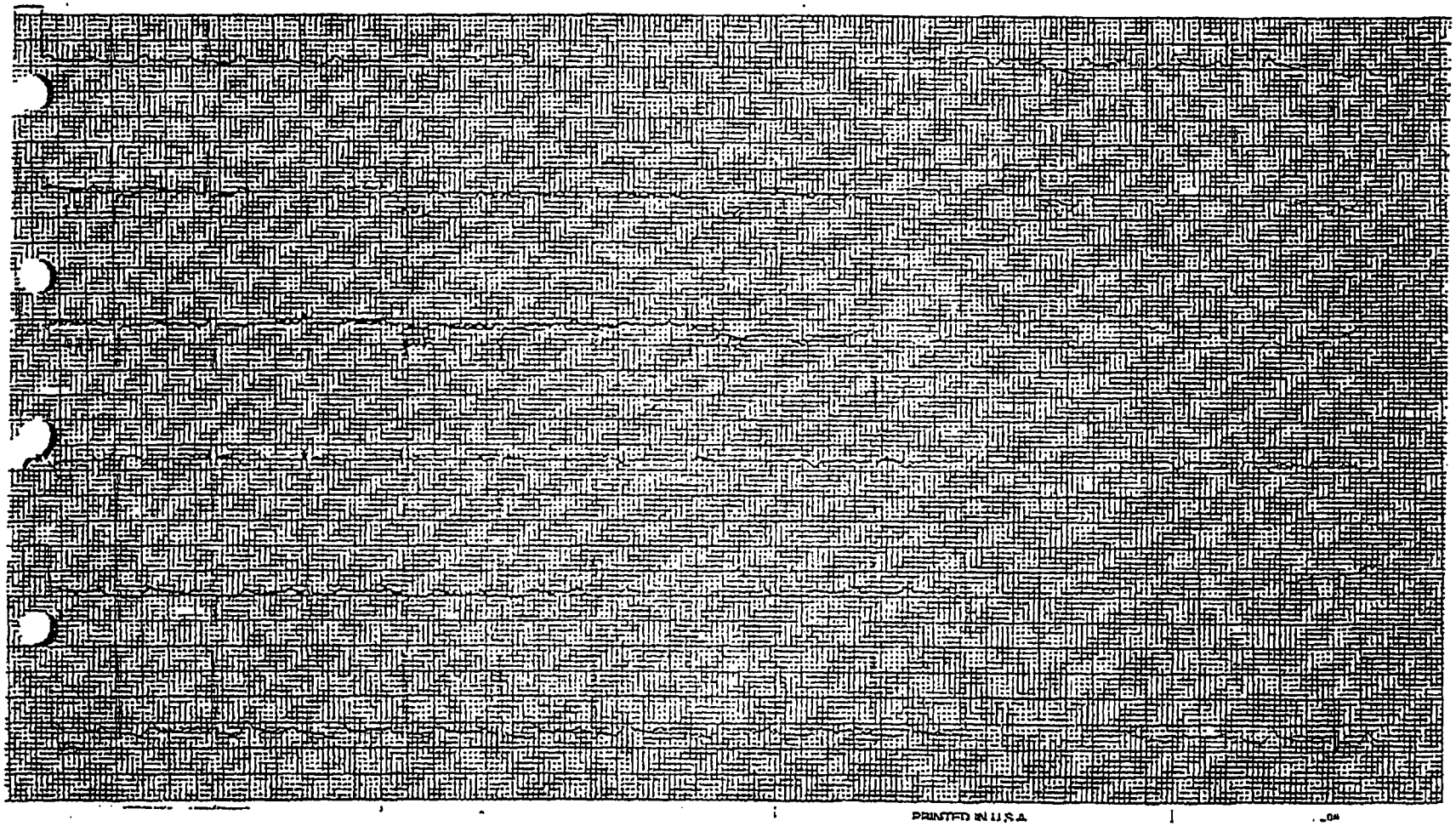
NORMAL SINUS RHYTHM
NONSPECIFIC [illegible] WAVE ABN.
ABNORMAL

MRN: [redacted] IPC [redacted]
WILSON,SARA Y [redacted]

PHYS: CLARE SR-MD,W PETT

ACCT#:03049-00314 FC: PP

S. Wilson Brief



PRINTED IN U.S.A.

WILSON, SARA ID: 000609896 19-Feb-2003 7:08:17 BON SECOURS ST.FRANCIS HOSPITAL 64

Female Black

Room: 209
Loc: 20

Vent. rate 72 bpm
PR interval 152 ms
QRS duration 82 ms
QT/QTc 366/400 ms
P-R-T axes 48 -10 12

Normal sinus rhythm
Normal ECG

Technician:
Test ind:

Referred by: CLARE, SR

Unconfirmed

S, Wilson Brief

Bon Secours - St. Francis
2095 HENRY TECKLENBURG DR CHARLESTON, SC 29414

Date:	Name	Acount #	Financial Class
02/24/03	WILSON,SARA Y	[redacted]	PP - PPO

Sex	Birth Date	Age	Adm Date	Dsch Date	LOS
F	[redacted]	59Y	02/18/03	02/20/03	2

Attending Physician
CLARE SR-MD,W PETT
Coder: NR

Discharge Status
01 - HOME OR SELF CARE

MDC: 05 DISEASES/DISORDERS OF THE CIRCULATORY SYSTEM
DRG: 141 SYNCOPE/COLLAPSE W CC M

OUTLIER STATUS: N/A

	DIAGNOSIS	DESCRIPTION
1.	(P) 780.2	SYNCOPE AND COLLAPSE
2.	o 424.1	AORTIC VALVE DISORDER
3.	401.9	HYPERTENSION NOS
4.	300.4	NEUROTIC DEPRESSION
5.	427.9	CARDIAC DYSRHYTHMIA NOS
6.	530.81	ESOPHAGEAL REFLUX

PROCEDURE	DESCRIPTION	DATE	SURGEON NAME

WILSON,SARA Y [redacted]
02/24/03

Bon Secours St. Francis Hospital

Name: WILSON,SARA Y
Exam Date: 02/18/03 1559
Ord. Phy.: CLARE SR-MD,W PETTIGREW

MR#: [redacted]
DOB: 10/27/43
Pt. Phone#: [redacted]
Ord. Phy.#: (843)723-5705
Phy. Fax #: (843)577-2096

CLARE SR-MD,W PETTIGREW
**114 ASHLEY AVENUE

CHARLESTON SC 29401

Acct_Nbr : [redacted]
Pat_Type : IPC

Chk-in #	Order	Exam	
[redacted]	0006	30144	XR CHEST SINGLE VIEW

Ord Diag: ,SYNCOPE

CHEST, 02/18/03:

CLINICAL HISTORY: Syncope, "chest pain".

Portable AP view of the chest at 1641 hours on 02/18/03 demonstrates the lungs to be clear of active infiltrates. There are no signs of cardiac failure. Thoracolumbar scoliosis is noted.

IMPRESSION:

No evidence of active intrathoracic disease by portable chest exam.

dmc

Read By: JEFFREY K SHORT-MD
Released By: REBECCA T NEWELL-MD

DMC
Approved: 02/19/03 1037

Bon Secours St. Francis Hospital

Name: WILSON,SARA Y
Exam Date: 02/19/03 0941
Ord. Phy.: CLARE SR-MD,W PETTIGREW

MR#: [redacted]
DOB: 10/27/43
Pt. Phone#: [redacted]
Ord. Phy.#: [redacted]
Phy. Fax #: (843)577-2896

CLARE SR-MD,W PETTIGREW
**114 ASHLEY AVENUE

CHARLESTON SC 29401

Acct_Nbr : [redacted]
Pat_Type : IPC

Chk-in #	Order	Exam	
774313	0022	35140	CT HEAD WITHOUT CONTRAST

Ord Diag: ;SYNCOPE

CT SCAN OF THE BRAIN, 02/19/03:

Axial scans were obtained through the brain without intravenous contrast material enhancement. There is no evidence of mass effect, midline shift, or altered areas of attenuation. No bleeding is seen within or around the brain.

IMPRESSION:

Normal CT scan of the brain. Of interest is that there is a prominent pineal type calcification.

dmc

Read By: R WESLEY SMITH-MD
Released By: R WESLEY SMITH-MD

DMC
Approved: 02/19/03 1538

Name: WILSON, SARA Y MR# [redacted] Nurs Stn: PROGRESSIVE CARE PI
Admission Date: 02/18/03 Date of Birth: [redacted] Room# 0209
Doctor: CLARE, W PETTIGREW SR Sex: F Race: B Bed: 01

SPECIMEN DATE	02/19/03	02/18/03	02/18/03		
COLLECTED TIME	0515	2245	1450		
WEEKDAY	WED	TUE			
----CARDIAC INJURY PROFILE----				UNITS	REFERENCE
TROPONIN I	< 0.2 f			NG/ML	0.0-2.2
TROPONIN I		< 0.2 f		ng/ml	0.00-0.22
TROPONIN I			0.03 f	ng/ml	0.00-0.50
CPK	103	119	166	IU/L	55-170
CK INDEX(CALC)			NOTE f		< 4.0
CK INDEX(CALC)	NOTE f	NOTE f			< 4.7
CKMB(MASS)			1.1	NG/ML	0.0-4.0
CKMB(MASS)	1.0	1.2		NG/ML	0.0-9.3

02/19/03 0515 TROPONIN I New Methodology for Troponin & CKMB with New Diagnostic Cut-off Values
FOOTNOTE ADDED ON 02/19/03 AT 0813 BY DISCERN
02/18/03 2245 TROPONIN I New Methodology for Troponin & CKMB with New Diagnostic Cut-off Values
FOOTNOTE ADDED ON 02/19/03 AT 0010 BY DISCERN
02/18/03 1450 TROPONIN I New Methodology for Troponin & CKMB with New Diagnostic Cut-off Values
FOOTNOTE ADDED ON 02/18/03 AT 1613 BY DISCERN

SPECIMEN DATE	02/18/03			
COLLECTED TIME	1450			
WEEKDAY				
----- CARDIAC PROFILE (PARALLEL) -----			UNITS	REFERENCE
CPK	166		IU/L	55-170
AXSYM CKMB	1.6		NG/ML	0.0-9.3
AX CK IND	NOTE f			< 4.7
TROP AXSYM	< 0.2		NG/ML	NONE DET

TROP AXSYM Note: Troponin and CKMB being run in parallel with new methodology see companion report.

Footnotes
f = Footnote
CK INDEX(CALC). 02/18/03 1450 DUE TO LOW CKMB, CK INDEX NOT CALCULATED.
CK INDEX(CALC). 02/19/03 0515 DUE TO LOW CKMB, CK INDEX NOT CALCULATED.
CK INDEX(CALC). 02/18/03 2245 DUE TO LOW CKMB, CK INDEX NOT CALCULATED.
AX CK IND..... 02/18/03 1450 DUE TO LOW CKMB, CK INDEX NOT CALCULATED.

CareAlliance

Health Services

Bon Secours – St. Francis Xavier Hospital
2095 Henry Tecklenburg Drive
Charleston, SC 29414

WILSON, SARA Y
000609896
W. Pettigrew Clare Sr., MD
Page 1

DISCHARGE REPORT
ADMISSION: 02/18/2003
DISCHARGE: 02/20/2003

HISTORY OF PRESENT ILLNESS: The patient is a 59-year-old female who was admitted after a syncopal episode. She has been followed by me with hypertension, arrhythmia and hypercholesterolemia.

She has been under a fair amount of stress and anxiety due to the recent death of her husband.

On the day of admission, she had two episodes of being very lightheaded, falling and poorly responding. The patient presented to the office. Blood pressure was 154/76. EKG revealed nonspecific ST-T changes.

PHYSICAL EXAMINATION: Examination on admission revealed blood pressure 154/76 and pulse 108. Temperature 98. The patient was well developed and well nourished. Fundi were negative. Neck supple. No bruits. Heart regular. Lungs clear.

IMPRESSION:
1. Syncope.
2. Anxiety.
3. Depression.
4. Hypertension.

HOSPITAL COURSE: The patient was admitted. Echocardiogram revealed mild-to-moderate aortic insufficiency and was otherwise unremarkable with a good ejection fraction. EKG revealed nonspecific ST-T changes but no subsequent change. CT of the brain was normal. Chest x-ray was normal.

The patient's rhythm remained normal throughout the hospitalization. Comprehensive metabolic profile was normal. Cardiac injury profile was normal. She had no further syncopal episodes after admission.

A long discussion was held with the patient. She had been feeling very depressed. She was stable enough to be discharged on February 20.

FINAL DIAGNOSES:
1. Panic attack or chronic or acute anxiety attack.
2. Depression.
3. Hypertension.

DISCHARGE DISPOSITION: The patient will be seen in my office in 2 weeks.

CareAlliance

Health Services

Bon Secours – St. Francis Xavier Hospital
2095 Henry Tecklenburg Drive
Charleston, SC 29414

WILSON, SARA Y
[redacted]
W. Pettigrew Clare Sr., MD
Page 2

DISCHARGE REPORT
ADMISSION: 02/18/2003
DISCHARGE: 02/20/2003

DISCHARGE MEDICATIONS:
1. Prilosec.
2. Toprol.
3. Aciphex.
4. Librax.
5. Lanoxin.
6. Prozac (added).

W. Pettigrew Clare Sr., MD

TR: lab DD: 04/05/2003 TD: 04/19/2003 5:17 P JOB#: 000016440 DOC#: 980591

cc: W. Pettigrew Clare Sr., MD

CAROLINA NEUROLOGICAL CLINIC, P.A.

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CAROLINA NEUROLOGICAL CLINIC
NEUROPHYSIOLOGY LABORATORY

PATIENT: SARA WILSON
DATE: MAY 19, 2009
REFERRING PHYSICIAN: JAMES AYMOND, M.D.

BRIEF CLINICAL HISTORY: The patient is a 65 year old referred courtesy of Dr. Aymond for EMG/NCS of the left upper extremity to evaluate for possible peripheral neuropathy vs lower cervical radiculopathy. She has complaints of pain in the left upper extremity which mostly involves the hand. She says it is basically from the elbow to the tips of all the fingers.

NERVE CONDUCTION STUDY

Nerve	Distal Latency-mSec			Amplitude			Conduction Vel-M/Sec		
	R	L	Normal	R	L	Normal	R	L	Normal
Median M		4.0	<4.4		8.3	>4.2Mv		54	>48
S		2.4	<2.2		80	>40uV			
Ulnar M		3.3	<3.5		9.6	>5.6Mv		55	>48
S		2.3	<2.2		22	>11uV			
Radial S		2.7			48				

EMG

MUSCLE	Ins.Activity	Fascicu.	Fibrill.	MUP
L Deltoid	WNL	0	0	WNL
L Biceps	WNL	0	0	WNL
L Triceps	WNL	0	0	WNL
L FDI	WNL	0	0	WNL
L APB	WNL	0	0	WNL
L Cervical paraspinals - upper	WNL	0	1+	WNL
L Cervical paraspinals - mid	I	0	1-2+	WNL
L Cervical paraspinals - lower	I	0	2-3+	WNL

FINDINGS: The left median and ulnar motor nerves both had normal distal latencies, normal amplitudes, and normal conduction velocities.

The left median and ulnar sensory nerves both had prolonged distal latencies with normal amplitudes. The left radial sensory nerve had a normal distal latency and a normal amplitude.

Concentric needle EMG testing was done in at least three to four areas of each listed muscle. The extremity muscles were normal, however, the cervical paraspinal muscles showed denervation potentials in the lower, mid and upper cervical spinal region. This was most pronounced in the lower cervical paraspinal region where she had complex repetitive discharges as well as fibrillation potentials. These were seen to a lesser degree in the mid and upper cervical paraspinal region. Sampling of the lower right cervical paraspinal region showed a few fibrillation potentials.

IMPRESSION: This nerve conduction portion of this study shows evidence of a sensory neuropathy affecting the median and ulnar sensory nerves in the left upper extremity. The EMG portion of this study showed scattered denervation in the left cervical paraspinal region. No denervation potentials were seen in the extremity muscles, therefore, a specific nerve root territory or territories could not be determined. Polyradiculopathy or spinal cord disorders could cause this type of result. Clinical correlation is advised.

Thank you for this referral.

Charles S. Jervey, M.D.

CSJ/sf
cc: James Aymond, M.D. Fax 958-2684 Fax by Sam 5/29/09
Fax by Sam
6-19-09

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

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PATIENT: SARA Y. WILSON
DATE: JUNE 26, 2009
FOR: FOLLOW-UP VISIT

Ms. Wilson came in for a visit today for evaluation of pain in the left upper extremity. It mostly involves the hand, although she also has pain from the elbow to the tips of all the fingers. Sometimes, she will have pain over the shoulder and in the neck as well. She does have a history of surgery on her cervical spine. She had a recent EMG, which showed denervation in her cervical spine but no denervation in the extremity muscles. Given her relatively recent neck surgery, I think the denervation is likely related to her prior surgery. The nerve study also shows mild delaying of the distal latency in both the median sensory as well as the ulnar sensory nerves, which is suggestive of a mild peripheral neuropathy. I am uncertain as to whether that is actually related to her pain, however. She has gone through physical therapy twice and says she just recently completed the second program but it does not seem to provide any lasting help.

At this point, I want to try going up on her Cymbalta (she is currently on 30 mg a day) and see if that will help to give better overall pain control. I am also going to give her some Lortab as well for acute pain relief. I do not think a cervical epidural injection is likely to provide any lasting relief for this type of pain and we did discuss that today. I will see her for reevaluation in the near future.

Charles S. Jervey, M.D.

CSJ/sun
cc: James K. Aymond, M.D.
Fax: 843-958-2680

Fax by Sam 7/7/09

Robert R. Oliverio, M.D.
Fax: 843-577-0455

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FB0304244 • SC MD24898
1861571837

THOMAS E. STOUT, M.D.
BS9210807 • SC 16846
1114996725

Name [illegible] Date 11/26/01

Address

Rx	mg	No.	Signature	Refill
Cymbalta	60	30	1 po qAM	4
Cymbalta	30	30	1 po qAM	4
Lorcet	5	20	1 po q 6 prn	0

M.D. [signature] M.D.

Dispense As Written Substitution Permitted

( ) Number of Medications Label all Medications form #92422

S. Wilson Brief 64

Date: 07-27-09 Time: VM?: ✓ Taken By: DeLuc

Bahadori Bumgartner Dukes (Jervey) Stout

Caller Name Sara Wilson

Relationship Spouse Daughter Son Employer Other

Home # Work # Cell # [redacted]

Patient Name DOB [redacted]

Reason For Call Req. Lidoderm Patch RX
samples working

Assessment

Doctor Response MR CG

Action 07-27-09 1100 Lidoderm patch #1 box RX'd
called to CVS doctor will Dale

Pharmacy Info CVS 723-9981

S. Wilson Brief 65

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

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PATIENT: SARA Y. WILSON
DATE: AUGUST 25, 2009
FOR: FOLLOW-UP VISIT

Ms. Wilson came in for a follow-up visit today. She says that after her encounter with me she went and checked her records and found out that she had taken Lyrica before and did not do well with it so it had been stopped. She was not taking Lyrica currently. She is on Cymbalta and is tolerating that without any difficulties. I also had her called in for Lidoderm patches because she says those are working well. She is pleased with the improvement she has had in her left upper extremity pain.

She reports a separate problem, however. She has been in the hospital since she last saw me. She was diagnosed with diverticulitis and is scheduled to have surgery in mid 09/09. She was told her recovery time would be about a month.

PHYSICAL EXAMINATION: On exam today, she is nontender to palpation of the left upper extremity and has good range of motion with no apparent discomfort.

IMPRESSION AND PLAN: The patient's pain has improved. I want her to continue on the Cymbalta and the Lidoderm patches. I will see her for followup in about three months, but she is to call me in the meantime if needed.

Charles S. Jervey, M.D.

CSJ/sun

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

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PATIENT: SARA Y. WILSON
DATE: NOVEMBER 17, 2009
FOR: FOLLOW-UP VISIT

Ms. Wilson came in for a follow-up visit today. Since she was last here, she had surgery for her diverticulitis. She says she has had a little difficulty with that. She says when she was in the hospital she had no pain in left upper extremity. She says they were very careful not to draw blood from the left upper extremity. She says she was on pain medicine for her abdominal problems and that seemed to keep her from having any problems with pain in the left upper extremity. She says during the last few weeks, however, she started having the pain in the left upper extremity again. She is still on her Cymbalta 60 mg a day and using Lidoderm patches. In addition, she is complaining of neck pain. She says this never really went away even following her surgery in 2007. She says she has had brief occasions where it is better but most of the time it still bothers her. She had cervical epidurals before her C-spine surgery, but none since. She says they might help for a week or two but never worked any better than that.

PHYSICAL EXAMINATION: On exam today, her neck is supple with no palpable muscle spasm. She has mildly reduced range of motion of the neck. She has strong shoulder shrug. She has good strength in her upper extremities. There is a little tightness in the left biceps, but I am able to extend the elbow fully. She does report, however, that she is doing stretching exercises on that extremity on a regular basis. She has good strength. Reflexes were approximately symmetrical.

IMPRESSION AND PLAN: I have given her refills on her Cymbalta and Lidoderm patches. We discussed again consideration of a cervical epidural. Although it is a relatively low probability of providing long-term relief, the patient is interested in trying. I will go ahead and make arrangements for that. She reports she would be going out of town for a month in the near future, and I will see her for followup sometime after that.

Charles S. Jervey, M.D.

CSJ/sun
cc: Robert R. Oliverio, M.D.
Fax: 843-577-0455 Fax by Sam 12-8-09

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1861571887

THOMAS P. STOUT, M.D.
BS3220807 • SC 16846
1114996725

Name Sara Wilson Date 11/17/09

Address

Rx	mg	No.	Signature	Refill
Cyclobenzaprine	10	30	1 PO QD	2
Lidoderm patches		30	1 q Day	2

M.D. Charles S. Jervey M.D.

Dispense As Written Substitution Permitted

( ) Number of Medications Label all Medications form #92422

S. Wilson Brief 68

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

Hamid R. Farhadi, MD
James L. Bumgarner, MD
Thomas H. Dukes, III, MD
125 Doughty Street, Suite 460
Charleston, SC 29403
843-723-0202 Tax ID: 67-0871085 FAX 843-723-1052
Charles S. Jervey, MD
Thomas F. Stout, MD

ACCOUNT 65042	ADVANCE RAYMOND	[redacted]	AGE 66	NEXT CHARGE DATE	DR. 8	APPOINTMENT DATE & TIME 11/17/09 10:30A	NO 1315

PATIENT WILSON, MS. SARA Y. :n (SW)	SUBSCRIBER WILSON, MS. SARA Y. :n (SW)
[redacted]	[redacted]
CHARLESTON, SC 29403	CHARLESTON, SC 29403
(H) [redacted] (W) [redacted]	(H) [redacted] (W) [redacted]

REV/CUR BALANCE	DELQ. AGE/AMOUNT	ADJUSTMENTS	DATE	PREV. TCODE	DESCRIPTION OF PREVIOUS TRANSACTION	AMOUNT
0.00	0.00	MEDICARE | BCBS	09/18/09		BLUE CROSS PAYMENT	6.94
LAST PAYMENT DATE 09/18/09	LAST PAY AMT 6.94	AMT RCD THIS YR 507.22	CNTL 0	INSURANCE FILED 09/11/09	COMMENT: 3 months ha	
REV. ICD-9 CODE 780.4	DESCRIPTION OF PREVIOUS DIAGNOSIS 08/09				APPTTYPE F/U F/U	
999.9	09/09				MEDICARE XMIT. SC) PAIDNSF 249726756A	
					BCBS STATE XMIT 249726756	

INSURANCE

NOTES:

CODE	PROCEDURE	FEE
	OFFICE VISITS	
	New Patient	
99205	High Severity	
99204	Moderate to High Severity	
99203	Moderate Severity	
99202	Low to Moderate Severity	
	Established Patient	
99215	Moderate to High Severity	
99214	Moderate Severity	
99213	Low to Moderate Severity	
99212	Limited Severity	
	Consultations	
99245	Office Consultation - High	
99244	Office Consultation - Moderate	
99243	Office Consultation - Low	
	PROCEDURES	
64613	Botox - Cervical	
64612	Botox - Facial	
64614	Botox - Trunk	
J0585	Botoxin Serum	
J0587	Myobloc B	
95869	EMG selected muscles	
95860	EMG one extremity	
95861	EMG two extremity	
95863	EMG three extremity	

CODE	PROCEDURE	FEE
95900	NCS motor nerve	
95904	NCS sensory nerve	
95903	NCS motor with F wave study	
95934	H Reflex	
90772	Inj. of Med. - B12	
20560	Trigger Point Inj.	
62270	Lumbar Puncture	
62272	Lumbar Puncture Therapeutic	
64405	Occipital Nerve Block	

Accept Assignment? J Y J N

RETURN ____ Days ____ Wks 2 Mos ____ Yrs ____ PRN

CT ( ) ____ XRAY ____

MRI ( ) ____

LAB ( ) ____

OTHER ____

DISABILITY STATEMENT

FROM ____ TO ____

OK to return to work/school on: ____

Diagnosis / Comments / Instructions:

Physician's Signature:

PAYMENT OF OFFICE FEES IS REQUIRED AT TIME OF SERVICE - THANK YOU!

Diagnosis Codes	
Altered Mental Status	780.09
Alzheimer's Disease	331.0
Ataxia/Lack of coordination	781.3
Back Injury	959.1
Back Pain	724.5
Bell's Palsy	351.0
Cerebral Hemorrhage	431
Cerebral Infarct	434.91
Cervical Radiculopathy	723.4
CVA	435
Degenerative Disc Disease	722.6
Dysequilibrium Syndrome	780.4
Encephalopathy	348.30
Extremity Pain	729.5
Gait Disturbance	781.2
Head Injury	854.00
Headache	784.0
Headache, Tension	307.81
Low Back Pain	724.2
Lumbar Radiculopathy	724.4
Memory Disturbance	780.93
Migraine	346.00
Multiple Sclerosis	340
Muscle Weakness	728.87
Myasthenia Gravis	358.00
Narcolepsy/Cataplexy	347
Neuropathy/Nerve Entrapment	355.9
Numbness/Tingling/Paresthesias	782.0
Parkinson's Disease	332.0
Peripheral Neuropathy	356.9
Radiculopathy/Neuralgia/Neuritis	729.2
Seizure Disorder	780.39
Stroke	436
Syncope	780.2
TIA	435.9
Tremor	781.0
Ulnar Nerve Palsy/Neuropathy	354.2

Previous Balance	
Today's Charges	
Adjustments	
Total Charges	
Today's Payment	
Balance Due	
Type of Payment:	

S. Wilson Brief 68

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

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January 25, 2010

Robert R. Oliverio, M.D.
Low Country Medical Associates
615 Wesley Drive, Suite 300
Charleston, SC 29407
Fax: 843-577-0455 Fax by 9am 2/3/10

RE:. SARA Y. WILSON
DOB: [redacted]

Dear Dr. Oliverio:

I had the pleasure of seeing Sara Wilson for a follow-up visit today. Since she was last here, she had a cervical epidural. Overall, she says she is doing a lot better. She says she still has some pain around her left elbow but the rest of the extremity seems to be much better. The neck and upper back are improved as well.

PHYSICAL EXAMINATION: On exam, she has relatively good range of motion in all joints with little discomfort. Good fine motor coordination.

IMPRESSION: Overall, she has made a good improvement. I want to continue her on the Lidoderm patches and the Cymbalta and she was provided refills. I have extended her visit out to four months, although she is to call sooner if needed.

Thank you for the opportunity to participate in this patient's management.

Sincerely,

Charles S. Jervey, M.D.

CSJ/sun

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

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May 24, 2010

Robert R. Oliverio, M.D.
Low Country Medical Associates
615 Wesley Drive, Suite 300
Charleston, SC 29407
Fax: 843-577-0455 fax by Sam

RE: SARA Y. WILSON
DOB: [redacted]

Dear Dr. Oliverio:

I had the pleasure of seeing Sara Wilson for a follow-up visit today. She says that she was still having some difficulty with neck pain. She says the left elbow was not bothering her currently, although she still has some pain around the shoulder area and in the middle and index fingers in the left hand. She is using her Lidoderm patches regularly and those are helping and she is on her Cymbalta. She says sometimes she is little sleepy during the day and she explained that she was taking her Cymbalta in the morning, so I have recommended that she change it and take it at night. She also says she forgot to tell me she was having some dizziness. She says it has probably been going on for a couple of months. She just has it on occasion. She also mentioned that she has just stopped two of her blood pressure medications. She says they are amlodipine and she believes the other one was lisinopril. Those may have contributed to or caused her dizziness, and so for now, I think it reasonable just to hold off and wait and see how she does regarding the dizziness. She also mentioned she was having headaches. She says they are infrequent and they only last a few minutes. She does not take any medication because the headaches are so brief in duration.

PHYSICAL EXAMINATION: On exam, she is alert and oriented. Speech was normal. Cranial nerve exam was unremarkable. She has good strength and good coordination. She has no tremor. She has a normal gait.

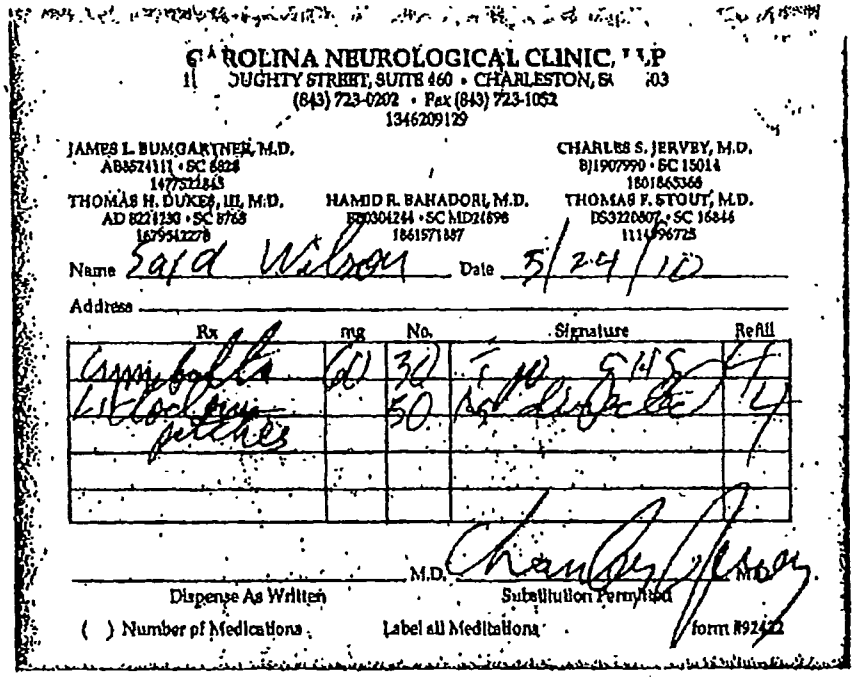
IMPRESSION AND PLAN: The patient's symptoms are such that I think she should stay on her current dose of Cymbalta. I had been hoping to start weaning her at this visit, but I think she needs to stay on the same dose and we will not be able to start weaning just yet. I have given her refills on her Cymbalta as well as her Lidoderm patches, and she is to return for follow-up visit in a few months.

Thank you for the opportunity to participate in this patient's management.

Sincerely,

Charles S. Jervey, M.D.

CSJ/sun



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FB0304244 • SC MD21696
1861571887

THOMAS F. STOUT, M.D.
BS3220807 • SC 16846
1114596725

Name Sara Wilson Date 5/24/10

Address

Rx	mg	No.	Signature	Refill
Cyclobenzaprine	10	30	[illegible]	4
Lidoderm patches		30	[illegible]	4

M.D. [illegible] M.D.

Dispense As Written Substitution Permitted

( ) Number of Medications Label all Medications form #92422

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

JAMES L. BUMGARTNER, M.D.
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PATIENT: SARA Y. WILSON
DATE: OCTOBER 5, 2010
FOR: FOLLOW-UP VISIT

Ms. Wilson came in for a follow-up visit today. She says she had been doing great with her neck and arm pain until about a week ago. She just returned from a trip and she had a flare up in pain. She says prior to that she was doing great and had been for quite a long time. She does not recall any unusual physical activity that might have caused the flare-up. Specifically, she denies lifting any heavy luggage, as she had her daughter do that for her. When she got to the airplane, she had the porters handle her luggage and she just had a small, lightweight carry-on, which she stored underneath the seat and did not have to lift up into an overhead bin. She says the pain is better now but is not back to a level it had been prior to her trip.

She also reports a problem with increase in the headaches. She describes them as a sudden intense pain, which just lasts a few seconds and then goes away. Sometimes, they are in the mid forehead or they can be on the right or the left side of her head. She says they generally come on without any warning at all. She says she may have it three or four times in a week now but each time it is only for a matter of seconds. She reports being under a lot of stress lately and thinks that might have something to do with the increase. She grades her stress as a 9 on a 10-point scale. She says she sleeps well. She is staying active socially. She walks through her neighborhood for exercise and does that on a regular basis. She does not smoke or drink any alcohol. She continues to take her Cymbalta. She occasionally takes Tylenol.

REVIEW OF SYSTEMS: Noted in the chart.

PHYSICAL EXAMINATION: She is alert and oriented, pleasant, cooperative, and in no apparent distress. Speech was normal. Neck is supple and nontender with a good active range of motion and no apparent discomfort. Sensation was intact to pinprick in the upper extremities and lower extremities. Motor exam, symmetrical bulk and tone with 5/5 strength throughout. She has good coordination throughout, normal reflexes, and normal gait. Extremities had normal warmth and moisture without swelling or edema and good peripheral pulses. Nontender to palpation.

IMPRESSION AND PLAN: Chronic pain of the neck and left upper extremity, which was doing much better for many months until this recent flare-up. I am uncertain as to the cause of

the recent flare-up, although it is improving again. I want to continue on the Cymbalta. She is also having brief headaches, which have likely been increased related to her stress. The duration is such that I do not think analgesics would be very helpful but instead she needs prophylactic pain medication for these as well. I think increasing her Cymbalta to 60 mg a day would be reasonable.

Charles S. Jervey, M.D.

CSJ/sun
cc: Robert R. Oliverio, ~~M.D.~~
Fax: 843-577-0455 Fax by Sam 10·7·10

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

JAMES L. BUMGARTNER, M.D.
THOMAS H. DUKES, III, M.D.
CHARLES S. JERVEY, M.D.
HAMID R. BAHADORI, M.D.

125 Doughty Street
Suite 460
Charleston, SC 29403
(843) 723-0202
Fax (843) 723-1052

PATIENT: SARA Y. WILSON
DATE: MARCH 17, 2011
FOR: FOLLOW-UP VISIT

Ms. Wilson came in for an evaluation today. She says she could not wait until her regularly scheduled appointment in 04/11. She has had a flare up in pain in the left upper extremity. It hurts all the way from the neck through the shoulder and down into the wrist. She says it did go into the fingers, primarily the index, middle, and right fingers but not so much anymore. She does not recall any unusual activity recently that might have flared it up. She had no recent injury. She had been taking the Cymbalta and wearing a Lidoderm patch and says usually those help. She takes occasional Tylenol, but that does not seem to help much.

PHYSICAL EXAMINATION: She is alert, pleasant, and cooperative. Neck is nontender to palpation. Neck is nontender to palpation and supple. Left upper back is nontender to palpation. Shoulder, arm, wrist, and hand are nontender to palpation. She has good passive range of motion of the shoulder, although with circumduction, she indicates there is some discomfort with that. No significant discomfort with elbow movement, wrist movement, or finger movement. There are masses or swelling noted in the extremity. She has good distal pulse. Sensation is intact to pinprick in the upper extremities. Motor exam, symmetrical bulk and tone with equal strength. No pronator drift. Coordination is symmetrical to fine motor skills. Reflexes are symmetrical.

IMPRESSION AND PLAN: I am uncertain as to etiology of the pain. She has tried a variety of treatments in the past, including cervical epidurals, prophylactic pain medications, and topicals. In addition to the Lidoderm patch, she has also used over-the-counter topicals such as "Icy Hot." Those have not helped. She has had injections into the arm before and that did not help. She says she cannot take aspirin products as they make her feel "giddy" and dizzy. I have given her Lortab in the past and she did not like the side effects from that. I do not think Ultram would be appropriate given that she is on Cymbalta and they both have some tricyclic affects. After much discussion, she was agreeable to trying Aleve and she will see how that works for her. She is to contact me in a couple of days. I have also suggested moist heat. I will, otherwise, see her for follow-up visit in a few weeks.

Charles Jervey

Charles S. Jervey, M.D.
CSJ/sm

6696482 REF 00 03/29/11
WILSON, SARA Y
KETO/GABA/LIDO 10/10/5% 50GM
NE MEDSC 1460230

[redacted] Poplar

402 E. MAIN ST.
Honoke Corner,SC 29461
761.5255

RX # [redacted] DR.JERVEY 03/29/11
WILSON, SARA Y KETO/GABA/LIDO 10/
COPAY 30.00

[redacted]
CHARLESTON, SC 29403
STATESC 50GM AU# EN3MPH3
DAYS SUPPLY 30
ORG DT-[redacted]

RX'S RETURNED TO STOCK AFTER 8 DAYS
843-577-2447

RX # 6696482 DR.JERVEY [redacted]
WILSON, SARA Y KETO/GABA/LIDO
COPAY 30.00

126 WEST POPLAR ST
CHARLESTON, SC 29403
STATESC 50GM AU# EN3MPH3
L FILL: 30 AUTHBY 10/27/43

SAFETY CAP: Y [redacted]

This Medication Was prepared for me. The combo Was ordered by Dr. Jervey for pain, I am going to try using it on my arm, neck and back.. This is a Cream.

INITIAL APPOINTMENT

SARA Y. WILSON
[redacted]
May 16, 2008

HISTORY: This is the first psychiatric contact for this 64-year old widowed female who was referred among others by her doctor, Dr. Oliverio. She has had persistent problems with chronic pain and associated anxiety and depression. She was doing generally well in all respects until May of 2006. She was working at her job (data technician at James Simmons Elementary School). Two "boys" were horse playing initially although the horse play got a bit out of hand. As they began to come closer to her vicinity, she tried to get out of the way, but "the next thing I know I was screaming"; she was in fact knocked by these boys across a counter. The workup immediately following showed some blood in her urine and eventually hematoma. This resolved itself. Unfortunately, within a few days, she began experiencing increasing pain both in her back and neck. This led to an evaluation including a MRI and x-rays and referral to Dr. Dennis and orthopedic surgeon who did another MRI and found the she'd hernia a cervical disc. Attempts to manage the pain with physical therapy and other pain management technique (Dr. Alexander) were unsuccessful and in March of 2007 under the care of Dr. Aymond, she had a surgical fusion of her neck. Although this helped her neck pain to some degree, her low back pain persisted until today. In fact there is apparently a bulging disc but she had considerable daily pain. It is made worse by most types of activities. Sitting long periods of time, bending, lifting, etc. all create serious problem for her. She, therefore, cannot drive and certainly has been unable to work. Her hopes to go back to work two or three hours a day turned out to be impossible as they could not accommodate these hours and she finally had to go out on disability and workman's compensation. Unfortunately in December for reasons that are somewhat unknown, the checks stopped coming and in addition to her chronic pain and impairment in her lifestyle, she now has serious financial difficulties and stress. She is quite depressed and anxious about what the future (and present for that matter) holds for her. She had hoped that she could retire at age 65 and continue to teach or interact with kids on a part-time and/or volunteer basis. She finds herself very restricted in her social life.

She does have associated endogenous depressive symptoms mostly of decreased energy, concentration, interest in activities and social withdrawal. Her appetite is generally okay.

She's not been suicidal and certainly not a danger to anyone else.

She has had some anxiety problems in recent months and at times can be quite anxious and have palpitations, but no frank panic attacks or anxiety attacks.

Her past psychiatric history includes a depressive episode following the death of her husband in 2003. They had been happily married for 39-years. Her treating physician at the time put her in the hospital for a couple of days and started her on Prozac which either was helpful or time itself was helpful and she was returned to full function. She had an ~~ensinkable~~ episode that may have been anxiety related in 2005. The workup was negative and while in the office of Jervey she was

Type copy

tearful and upset. He placed her on Zoloft 100 mg eventually given. After a few months, this was tapered to 25 mg and as noted above by the time of the incident at the school, she was once again back to her normal self.

There's no history of alcohol or drug abuse. No history of other mood disorders. No history of other psychiatric disorder.

FAMILY AND SOCIAL HISTORY: She was born and raised in Charleston. She has a high school degree plus college courses. She has worked in data technician with the school district for many years retiring because of her disability in September of 2006.

Her father died at age 60 of a stroke, her mother died at age 82 of sepsis. The patient is the second of four children. She does have one brother with an alcohol problem. Otherwise her family history is negative for psychiatric illness or alcoholism.

PAST MEDICAL HISTORY: She is currently under the care of Dr. Oliverio. HER ALLERGIES INCLUDE CILLINS, SULFA. She is intolerant of Demerol unless she gets Phenergan with it or Aspirin. Her current medications include Librax about once a day, Lorazepam 1 mg usually just once a day (although she's approved to take up to three a day), Micardis 40 mg a day, Nexium 40 mg a day, Premarin 0.9 mg daily and Xanaflex 2 mg (usually about once a day). She has hypertension, hypercholesterolemia, irritable bowel and the pain as noted above. Surgeries are limited to hysterectomy, cholecystectomy and C-sections. She does not smoke!

MENTAL STATUS: She is alert, cooperative and pleasant. Sensorium is clear. She's well oriented. Her memory is intact for recent and long-term events. Speech is normal. Her affect is mildly to moderately depressed, perhaps mildly anxious at times. She is not suicidal. There is no psychosis. No thought disorder. Insight and judgment are generally intact.

IMPRESSION: 1. Adjustment disorder with mixed emotion. 2. Anxiety disorder NOS. 3. Depressive disorder NOS.

PLANS: It does not appear that she has a clear endogenous depression. Hopefully we will be able to manage without antidepressants at this point. I have suggested because of her tension and chronic pain that she consider switching to Valium (Rx 5 mg tablets #30 with two refills to one-half to one every four hours if needed for anxiety or pain), this would be in place of the Librax, Ativan and Xanaflex.

Should she have persistent bowel symptoms, perhaps a small dose of Bentyl would suffice. Hopefully Dr. Oliverio will agree with the current plans.

We will discuss counseling options over the next several weeks. I will plan to see her again in two weeks. She will call me if needed in the meantime.

Samuel H. Rosen, M.D.

SHR/ao

Cc: Robert R. Oliverio, Jr, M.D., Lowcountry Medical Associates, 615 Wesley Drive Suite 300 Charleston SC 29407

INSURANCE CONFIRMATION

DATE_____ PATIENT_____
INS NAME_____
INS PHONE_____ FAX_____
ADDRESS_____
_____
POLICY#_____ GROUP_____
EFF. DATE_____ PRE CERT REQ?_____
DED_____ MET?_____ AMOUNT_____
INS PAYS_____ PT PAYS_____ VISIT ALLOWED_____
AUTH#_____ FOR_____ VISITS
DATE RANGE_____ TO_____
BY_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO SAMUEL H. ROSEN,M.D./CHRISTINE LLOYD,M.D./JOSEPH COCKRELL,M.D. FOR SERVICES PROVIDED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT PAID BY MY INSURANCE COMPANY. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOICED BY SIGNEE OR OTHER LEGAL REPRESENTATIVE.

PAYMENT IS DUE AT TIME OF SERVICE. THANK YOU.

SIGN_____ DATE_____

I

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
SARA Y WILSON
MEDICARE CLAIM NUMBER
[redacted] SEX
IS ENTITLED TO FEMALE
EFFECTIVE DATE
HOSPITAL (PART A) 10-01-2008
MEDICAL (PART B) 10-01-2008
SIGN HERE → Sara Y. Wilson

II

APS

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Name Sara Wilson Age ___ Primary Dr ___

Date ___ Time ___ AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	✓		
Appetite/Weight:		✓	
Mood:			
Concentration:			
Interest/Motivation:			
Sociability:			
Energy:			

Notes: ___

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:		
Affect:		
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		
Obsessive/Compulsive:		

Medication (s): side effects risks discussed Rx written

RTC ___ Signature: ___

(Revised 06/15/05)

S. Wilson Brief 81

Name Sara Wilson Age ___ Primary Dr Olivera

Date 5/31/8 Time ___ AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	/		
Appetite/Weight:	/		
Mood:	/		
Concentration:	/		
Interest/Motivation:	/		
Sociability:	/		
Energy:	/		

Notes: Doing well on Valium 5 mg 2 tabs/d. Pt. is glad

Cruise - sea sickness Rx - 6/15 - 22

7 days ativan/Ex Thera

Mental-Status Examination:	Normal	Abnormal
Appearance:	/	
Sensorium/Cognition:	/	
Speech:	/	
Thought Process:	/	
Affect:	/	
Anxiety/phobia:	/	

But a little better

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		N/A
Obsessive/Compulsive:		

Medication (s): side effects risks discussed Rx written

Valium - 5 - 1/2 of pill pm anxiety

RTC 6-8 wk Signature:

(Revised 06/13/05)

6/3/08 Pt called to say she is on Demerol + Phenergan for pain. Wanted to know if it was okay to take with the med Dr Rosen has her on. Dr Rosen said he would rather she not take them, but [illegible]

S. Wilson Brief 82.

Name Sara Wilson Age ____ Primary Dr ____

Date 7/11/18 Time ____ AXIS I ____ AXIS II ____

AXIS III ____ AXIS IV ____ AXIS V ____ Current GAF ____

Last year's GAF ____

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	✓		
Appetite/Weight:			
Mood:			
Concentration:			
Interest/Motivation:			
Sociability:			
Energy:			

Notes:

Doing well – classes, meet with

w/ Victoria P.

Mental-Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		
Speech:		
Thought Process:		
Affect:		
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		
Obsessive/Compulsive:		

Medication (s): side effects risks discussed Rx written

Vistaril 50 1/2 - 1 po BID prn

RTC 7/13 Signature:

(Revised 06/15/05)

S. Wilson Brief 83

Name Sara Urbon Age ___ Primary Dr ___

Date 9/4/8 Time 16 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:			
Appetite/Weight:		↓ 5# 115	
Mood:			
Concentration:			
Interest/Motivation:			
Sociability:		Church	
Energy:		↓	

Notes: * postpartum → Stress test ↑ 20 previously

financial stress /

R back pain → Volin helps.

to early for injection

Mental-Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		
Speech:		
Thought Process:		
Affect:		Anxiety Depression
Anxiety/phobia:		

(B) & BD (has Cord clip)

forms not ready

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		
Obsessive/Compulsive:		

Medication (s): side effects risks discussed Rx written

Volin 5 1/2-1 pm BED

Nexium

Lopressor

RTC 2 months Signature: ___

(Revised 06/15/05)

Name Sara Wilson Age 65 Primary Dr Olivero

Date 1/22/8 Time _____ AXIS I _____ AXIS II _____

AXIS III _____ AXIS IV _____ AXIS V _____ Current GAF _____

Last year's GAF _____

Interim History:	Normal	Abnormal
Sleep:		↓
Appetite/Weight:		↓
Mood:		↓
Concentration:		↓
Interest/Motivation:		↓
Sociability:		↓
Energy:		↓

Substance use/abuse

Notes: Olivero
upn c Dr Olivero
Chronic Back Pn
Cont gpnd
Anxiety, phobia - note up in 0300 c
11 anxiety, SOB

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:	✓	
Affect:		labile
Anxiety/phobia:		Depressed

	Present	Absent
Suicidal/Homicidal:		✓
Delusions/Hallucinations:		✓
Obsessive/Compulsive:		✓

Valium 5 mg po qd 0300

Renewal Cortez for Anxiety in Valium c elderly + Dep. Yolles, Evelyn

Medication (s): side effects risks discussed Rx written

Valium 5 mg po qd
Effexor LR 37.5 c/d x1 TR 2/d #30 Rfs
Missed + eval, discontinue use, TAN
Dr.

RTC Feb Signature: _____

(Revised 06/15/05)

1/12/09 Started the Effexor XR 37.5mg. 12/31/08. Not feeling well & wants to stop it. Dr Rosen said okay & will talk at the appt on 1/20/09. ADR.

S. Wilson Brief 86

Name Sara Wilson Age ____ Primary Dr ____

Date 1/20/09 Time ____ AXIS I ____ AXIS II ____

AXIS III ____ AXIS IV ____ AXIS V ____ Current GAF ____

Last year's GAF ____

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	✓		
Appetite/Weight:		Wt 110	✓
Mood:			
Concentration:	✓		
Interest/Motivation:	✓		
Sociability:		↓ Church	
Energy:		↓	

Notes: Dog OK. enjoyed kids event. / ampulp stay

Returned to family environment. Risks.
benefits explained.

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:	✓	
Affect:	Tearful	
Anxiety/phobia:	✓	

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		NAD
Obsessive/Compulsive:		

Medication (s): side effects risks discussed Rx written

Effexor - stopped - felt awful.

Valium 5 1/2 - 1 tid - for fever

RTC ____ Signature: ____

(Revised 06/15/05)

Name Jane Wilson Age 65 Primary Dr Oliveira

Date 4/19/1 Time _____ AXIS I _____ AXIS II _____

AXIS III _____ AXIS IV _____ AXIS V _____ Current GAF _____

Last year's GAF _____

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:			
Appetite/Weight:		↓ wt ↓ 102#	
Mood:			
Concentration:		↓	
Interest/Motivation:			
Sociability:		↓ Church	
Energy:			

Notes: * ant w/ birth yesterday *

dog ate.

Clinic helpful.

Daughter to retrieve from DF today 3 hrs

Mental Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		— THA — "fun speech"
Speech:		
Thought Process:		—
Affect:		
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		
Obsessive/Compulsive:		NA

Medication (s): side effects risks discussed Rx written

Clinic 5 11-1 TID prn pain

RTC _____ Signature: _____

(Revised 06/15/05)

1411U

Samuel H. Rosen, M.D.

Adult Psychiatry • Geriatric Psychiatry • Addiction Medicine

March 17, 2009

Dr. James R. Demarco
615 Wesley Drive
Suite 100
Charleston, S.C. 29407
FAX: 763-2868

RE: Sara Wilson

Dear Dr. Demarco:

I appreciate the copy of your evaluation and letter concerning our patient Sara Wilson. She and I had discussed the use of anti-depressants both for whatever depressive symptoms she has as well as the chronic pain. The depressive symptoms that are present are so tightly related to her pain that it is difficult to separate. We have decided to give a trial to the Cymbalta. She will start with 30mgs today and after a week increase to 60mg. I will see her in about 2 weeks. She plans to follow up with her primary care physician Dr. Oliverio in April and by then we should at least know whether or not she can tolerate the Cymbalta.

I will keep you posted of any further changes.

Sincerely,

Samuel H. Rosen, M.D.

Cc: Dr. Robert R. Oliverio, M.D. 615 Wesley Drive Suite #300, Charleston, S.C. 29407

SHR/sn

198 Rutledge Avenue, Suite 8 • Charleston, South Carolina 29403
Phone: (843) 577-5012 • Fax: (843) 722-8368

Name Sonya Wilson Age ___ Primary Dr Oliveira

Date 3/12/9 Time 20 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:			
Appetite/Weight:			
Mood:			
Concentration:			
Interest/Motivation:			
Sociability:			
Energy:			

Notes: 2.5 pain

pain in (R) shoulder — see letter re hyperextension injury

Rx P.T.

Valium helps

Mental-Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		
Speech:		
Thought Process:		
Affect:		anxiety, tearful
Anxiety/phobia:		

Depressed "from pain"

"Broke down in his (Dr Moore's) office"

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		
Obsessive/Compulsive:		

Medication (s): side effects risks discussed Rx written

Valium 5 1/2 - 1 TID prn

~ 3/d

Micardis, Premarin, Lopressor → aspirin, creatine

transport

RTC 2wks Signature: ___

(Revised 06/[illegible])

(R) Cymbalta 30 mg x 1wk → 60 mg x 1wk

Patient's Name: Sara Wilson

3/25/09 Pt started on Cymbalta 30mg. She is to ↑ to 60mg tonight. Pt states she feels funny & makes her very sleepy. Also not hungry." Asked if she should continue or what to do. Dr Rosen said to stay on 30mg & come in this week. Appt was made for 3/27.09. ADR.

Name Sara Wilson Age ____ Primary Dr ____

Date 3/29/9 Time 10 AXIS I ____ AXIS II ____

AXIS III ____ AXIS IV ____ AXIS V ____ Current GAF ____

Last year's GAF ____

Interim History:	Normal / Abnormal	Substance use/abuse
Sleep:	/	
Appetite/Weight:	/	
Mood:	Depressed	
Concentration:	↓	
Interest/Motivation:	↓	
Sociability:	↓	
Energy:	↓	

Notes: ____

See note

not tried 1/2 458

Volin [illegible] not myself

if doesn't look at feet like thing in bed

Mental-Status Examination:	Normal / Abnormal
Appearance:	/
Sensorium/Cognition:	/
Speech:	/
Thought Process:	/
Affect:	mild-mod lability
Anxiety/phobia:	mild-mod anxiety

	Present	Absent
Suicidal/Homicidal:		/
Delusions/Hallucinations:		/
Obsessive/Compulsive:		NR

anxiety 3 5 wks

P.T.

Medication (s): side effects risks discussed Rx written

- Gabapentin 300 1/2 0

Valium - myself 1/2 - 1 PO

RTC ____ Signature: ____

(Revised 06/15/05)

Name Sara Wilson Age ___ Primary Dr ___

Date 4/17/16 Time 10 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal
Sleep:	✓	
Appetite/Weight:	✓	
Mood:		✓
Concentration:		✓
Interest/Motivation:		✓
Sociability:		✓
Energy:		✓

Substance use/abuse: ✓

Notes:

half tablet worked

[illegible] — pain @ side → (Nightmare) → [illegible] →

60 dg

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:	✓	
Affect:		✓
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		NA
Obsessive/Compulsive:		

Medication (s):	side effects	risks discussed	Rx written
Geodon 20	1/1	— no side effects —	#90 Rx1
Vdin 5	1/2 — 1 po HS		

RTC NA

Signature: [signature]

(Revised 06/15/05)

Name Sonya Wilson Age ___ Primary Dr ___

Date 6/16/04 Time 15 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:		2.5 hrs	
Appetite/Weight:			
Mood:			
Concentration:			
Interest/Motivation:			
Sociability:			
Energy:			

Notes: ___

Dr Cymbalta — pt is ☹ am. Rx for "neck"

MRI done — T. Wilson

Mental-Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		
Speech:		
Thought Process:		
Affect:		
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		
Obsessive/Compulsive:		

Medication (s):	side effects	risks discussed	Rx written
Cymbalta 60 mg 30			
Diazepam 5			

1 po q 6h prn anxiety

RTC 6-8wk Signature: ___

(Revised 06/15/05)

S. Wilson Brief 93

Name Jose Vilsa Age ____ Primary Dr ____

Date 7/9/6 Time 16 AXIS I ____ AXIS II ____

AXIS III ____ AXIS IV ____ AXIS V ____ Current GAF ____

Last year's GAF ____

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:			
Appetite/Weight:		Wt weight	13
Mood:			
Concentration:			
Interest/Motivation:			
Sociability:			
Energy:			

Notes: Denies — ? 2° chron (Caffeine + interactions — Jan 2010 (probable)

Pain - Neck / Shoulder (+ Side) — more so (R)

Mental-Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		
Speech:		
Thought Process:		
Affect:		
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		CRS
Delusions/Hallucinations:		
Obsessive/Compulsive:		

EMG — nerve damage.

Dr Tariq

Zonked out

Medication (s): side effects risks discussed Rx written

Cyclobenzaprine 10 mg tab 1 po qhs x 1 mo — fwd. 30

Voltaren 5 1/2 — 1 (= 1/24h)

Lortab 5 — 1 po q 4h (Dr Tariq)

RTC ____ Signature: ____

(Revised 06/15/05)

? ∆ Volt → Flexeril

B. Wilson Brief 94

Name: Sara Wilson Age ___ Primary Dr ___

Date 7/8/04 Time 10 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	✓		
Appetite/Weight:	✓		
Mood:	fair		✓
Concentration:		✓	6
Interest/Motivation:		✓	
Sociability:		✓	
Energy:		✓	

Notes:

Cymbalta does well to mood. Tyler not to per

Dr Clewy Rx Lyrica

Still pain

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:	✓	
Affect:	✓	
Anxiety/phobia:	✓	

	Present	Absent
Suicidal/Homicidal:		✓
Delusions/Hallucinations:		✓
Obsessive/Compulsive:		✓

Dr Smith

Wicks down Stitches 12)

Medication (s):	side effects	risks discussed	Rx written
Cymbalta 60			1/d
Vicodin			

Tapes — Counter not written by Dr of Sara

Tapes — Dr Clewy — generally stable

RTC 1 M Signature: ___

(Revised 06/15/05)

? my Lyrica Rx -

Name [illegible] Age ___ Primary Dr ___

Date 8/27/4 Time 15 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal
Sleep:		
Appetite/Weight:		
Mood:		
Concentration:		
Interest/Motivation:		
Sociability:		
Energy:		

Substance use/abuse

10th Gr

Notes: Discontinue RH - antibiotics

↓

• Surgery 9/14/4 Dr Sergeev / Irvine

Mental-Status Examination:	Normal	Abnormal
Appearance:		
Sensorium/Cognition:		
Speech:		
Thought Process:		
Affect:		
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		N/A
Obsessive/Compulsive:		

Medication (s):	side effects	risks discussed	Rx written
Cipro Lotion 60		1/cl	
Vicodin 5	more	½-1	BID prn
more			

RTC ___ Signature: ___

(Revised 06/15/05)

S. Wilson Brief 98

Name Sara Wilson Age ___ Primary Dr Shurin

Date 11/3/09 Time 15 AXIS I ___ AXIS II ___

AXIS III ___ AXIS IV ___ AXIS V ___ Current GAF ___

Last year's GAF ___

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	pretty good		
Appetite/Weight:			
Mood:	fine		8
Concentration:			
Interest/Motivation:			
Sociability:			
Energy:			

Notes:

Surgery went well
Still some CP pain

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:	✓	
Affect:	✓	
Anxiety/phobia:	✓	

reduced

	Present	Absent
Suicidal/Homicidal:		
Delusions/Hallucinations:		N/A
Obsessive/Compulsive:		

Medication (s):	side effects	risks discussed	Rx written
Gabapentin 600 TID			hx mail
Ultram 5 1/2-1 po q6h prn pain			#60 RF Rx called in. Pharm. 703-948 1 11/3/09

RTC ___ Signature: ___

(Revised 06/15/05)

S. Wilson Brief 97

Name Sara Wilson Age 66 Primary Dr Behrens

Date 3/10/10 Time 15 AXIS I _____ AXIS II _____

AXIS III _____ AXIS IV _____ AXIS V _____ Current GAF _____

Last year's GAF _____

Interim History:	Normal	Abnormal	Substance use/abuse
Sleep:	✓		
Appetite/Weight:	✓		
Mood:		dysth	
Concentration:	✓		
Interest/Motivation:	✓		
Sociability:	✓		
Energy:		↓	

Notes: _____

8 Risa

Div. Campus Drive Courts

Rx - leg lacerations - 5 days discharged

Mental-Status Examination:	Normal	Abnormal
Appearance:	✓	
Sensorium/Cognition:	✓	
Speech:	✓	
Thought Process:	✓	
Affect:		mildly
Anxiety/phobia:		

	Present	Absent
Suicidal/Homicidal:		✓
Delusions/Hallucinations:		✓
Obsessive/Compulsive:		✓

energy / expectations.

Wally - started Lunesta

Medication (s):	side effects	risks discussed	Rx written
Geodon 60 1/0		no Norvasc	(? 1 90d)
Valium 5			
use 1-2/week			

RTC _____ Signature: _____

(Revised 06/15/05)

BP - Holeyn Farrell

Cardiac

Ass-Wayne 5 -> 10 -> 5

Cypher

S. Wilson Brief 98

The Spann-Wilder Law Firm, LLC

Tiffany R. Spann-Wilder, Esquire
tiffany@spannwilderlawfirm.com

2131 Dorchester Road (29405)
Post Office Box 70488
North Charleston, SC 29415
(843) 266-7792 • (800) 866-3830
(843) 266-7797 (fax)

April 29, 2011

BY WAY OF FAX 843-402-1961 @ & US MAIL
Dr. Samuel Rosen
2095 Henry Tecklenburg Drive, Suite 303
Charleston, SC 29407

RE: Claimant: Sara Y. Wilson
Employer: Charleston County School District
WCC No.: [redacted] (Date of Injury: May 9, 2006)

Dear Dr. Rosen:

Please be advised that I represent Ms. Sara Wilson as a result of her work related accident on May 9, 2006. On or about November 29, 2007 the S. C. Workers Compensation Commission issued an Order finding that Ms. Wilson suffered a work related injuries to her neck and back. After that time, we filed a petitions (Amended Form 50's) alleging that Ms. Wilson's physical and psychological condition changed for the worse over time. In that regard, it is my understanding that you have been treating Ms. Wilson for psychological issues relating to her chronic pain and depression since 2008. In that regard, I would ask that you respond to the following questions: (Please check "yes" or "no" and provide an explanation if necessary)

1. That I have been providing ~~psychological counseling~~ Psych / Mtrc Care to Ms. Sara Wilson since May 2008.

✓ Yes ____ No

If YES, please list Diagnoses: Adjustment Disorder, Anxiety Disorder, Depressive Disorder (NOS)

2. To my knowledge, Ms. Wilson's past psychological history includes a depressive episode in 2003 following the death of her husband in which she was hospitalized. She was prescribed medication and returned to full function psychologically.

✓ Yes ____ No

Explanation, if necessary: ____

3. That based upon my treatment, ~~psychological testing~~ and review of her records, Ms. Wilson suffers from psychological issues of depression relating to her chronic pain issues stemming from her workers' compensation case.

✓ Yes ____ No

Explanation, if necessary: ____

S. Wilson Brief 99

Sara Wilson • page 2
Questionnaire

4. That in my medical opinion, Ms. Wilson's chronic pain and depression for which I have treated him since 2008 is "most probably and to a reasonable degree of medical certainty" [greater than a 50% probability] related to her workers' compensation injuries (neck, back & arm) at Charleston County School District.

✓ Yes ____ No

Explanation, if necessary:_____

_____

5. That Ms. Wilson's current psychological condition is a change in condition from the anxiety and single episode depression of her husband's death.

✓ Yes ____ No

Explanation, if necessary:_____

6. That Ms. Wilson's condition has plateaued; however, she still requires psychiatric psychological maintenance in the form of periodic counseling sessions and medications in order to effectively treat her condition and maintain her level of functioning at maximum medical improvement.

✓ Yes ____ No

Explanation, if necessary:_____

_____

5/3/11
DATE

Dr. Samuel Rosen
Adult Psychiatry

Should you have any questions or require any further information in these regards, please do not hesitate to contact me. With kindest personal regards, I remain,

Yours very truly,
THE SPANN-WILDER LAW FIRM, LLC

Tiffany R. Spann-Wilder

S. Wilson Brief 100

Initial Evaluation / Examination

Patient: WILSON, SARA
MR #: [redacted]
PT: Marilyn M. Swygert PT, MHS

Date: Tuesday, March 03, 2009
Provider: Charleston Physical Therapy
Provider #: [redacted]

Patient Information

Address: [redacted]
CHARLESTON, SC 29403

Birth Date: [redacted]
Physician: James DeMarco M.D.

Occupation:
Gender: Female
Contact Person:

Physician Num:

Medicare #: [redacted]
Claim #:

Rehabilitation Information / History

Onset Date of Medical Diagnosis with ICD9: 02/23/2009	Degeneration - Disc - Cervical Intervertebral 722.4 Brachial Neuritis 723.4 Disorder - Shoulder - Bursae & Tendons - Specified - Other 726.19
Preferred Practice Pattern:	Musculoskeletal D: Impaired joint mobility, motor function, muscle performance, ROM associated w/ connective tissue dysfunction
Physical Therapy Diagnosis:	Multiple Sites - Stiffness - Joint- Not Else Classified 719.59 Muscular Wasting & Disuse Atrophy - Not Else Classified 728.2
Recent Physical Therapy:	None within the last sixty days
Prior Functional Status:	Independent with no pain or limitation in ambulation, IADL's, work or recreation
Required Equipment:	TENS unit
Weight Bearing Status:	No restrictions
Safety Measures:	Adhere to orthopedic precautions/restrictions
Rehab Prognosis:	Good rehab potential to reach the established goals
Mental Status:	Alert and oriented in all spheres- cooperative and motivated
Concerns that led to PT:	Decreased functional ability secondary to pain or increased pain
Systems Review, History:	PMH: Hypertension; dizziness resulting from headaches; cervical fusion C4-6 in March 2007; degenerative disc disease.

Patient has a history of behavioral health risks: NO

Patient / Caregiver concur with established goals: YES
Emotional response to health status: GOOD
Patient's communication skills: GOOD
Knowledge of Exercise and Fitness: FAIR

Frequency of Exercise sessions per week:
Reported Eating Habits: GOOD
Reported Sleeping Patterns: FAIR
Reported Energy Level: FAIR

Patient is aware of and understands his/her diagnosis and prognosis: YES

Additional Pertinent Information: Patient states, "My arm pain started in November 2008." Patient though it was due to side lying on the left, so she changed her sleeping position. "There was no pain relief." She was injected in her left shoulder on 2-23-09 with no relief of pain.

Functional Measures

Tolerance to IADLs

Current Level: Moderate pain and limitation during and/or after a specific IADL affecting performance

Goal: Mild pain during and/or after a specific IADL affecting performance

S. Wilson Brief 101

Patient: WILSON, SARA — Date: Tuesday, March 03, 2009

Tolerance to Recreation Activities

Current Level: Severe pain and limitation in a specific recreational activity affecting performance

Goal: Mild - Moderate pain and limitation in a specific recreational activity affecting performance

Functional characteristics and analysis: Patient exhibits head forward, rounded shoulders posture with her left shoulder higher than the right.

Impairment Goals; Short Term: Pain is decreased by 25% in 2 weeks
Increase strength
Range of motion is improved by 25% in 2 weeks
Relaxation is increased by 25% in 2 weeks

Functional Goals; Long Term: IADL performance in related activities is improved
Recreational performance in related activities is improved
Improve cervical posture

Physical Findings

Pain

Site #1: Joint Pain - Shoulder - Right; At Rest 9/10; With Activity 9/10; Dull; Radiating
Exacerbating Factors: Inactivity & Reaching
Relieving Factors: Ice to the affected area & Medications

Site #2: Back Pain - Cervical - Lower Segment Syndrome; At Rest 5/10; With Activity 9/10; Sharp; Radiating
Exacerbating Factors: Activity & Flexion
Relieving Factors: Rest

Posture

Current Level: 4/5 Head forward / rounded shoulders

Goal: 5/5 Normal head / shoulder posture

Specific Joints

(Note: Blank indicates Strength / Range of Motion are within functional limits or not tested)

Initial Eval Level

Shoulder	Strength Right	Strength Left	Active ROM Right	Active ROM Left	Passive ROM Right	Passive ROM Left
Flexion		4		168°		
Extension		4-		45°		
Abduction		4		172°		
Adduction						
Horizontal Abduction						
Horizontal Adduction						
Internal Rotation		4		88°		
External Rotation		4		88°		

Goal

Shoulder	Strength Right	Strength Left	Active ROM Right	Active ROM Left	Passive ROM Right	Passive ROM Left
Flexion		5		180°		
Extension		5		55°		
Abduction		5		180°		
Adduction						
Horizontal Abduction						
Horizontal Adduction						
Internal Rotation		5		90°		
External Rotation		5		90°		

Comments on Shoulder: Left shoulder muscle guarding.

Initial Eval Level

Cervical Spine	Strength	ROM
Flexion	4	38°P
Extension	4	32°
Protraction		
Retraction		

	Right	Left	Right	Left
Lateral Flexion	4	4	35°P	30°
Lateral Rotation	4	4	70°	60°P

Goal

Cervical Spine	Strength	ROM
Flexion	4+	50°
Extension	4+	50°
Protraction		
Retraction		

	Right	Left	Right	Left
Lateral Flexion	4+	4+	35°	35°
Lateral Rotation	4+	4+	70°	70°

Patient: WILSON, SARA Date: Tuesday, March 03, 2009

Comments on Spine: Left cervical muscle guarding.

Assessment:

Patient is a 65 year old female who presents to Physical Therapy with complaints of left shoulder/arm pain. Patient status post cervical fusion at C4-6 now with cervical/thoracic immobility. Patient exhibits head forward/rounded shoulders posture, posterior shoulder girdle weakness with scapular dyskinesis, and extreme left shoulder muscle guarding. Physical Therapy would benefit patient to decrease pain, increase range of motion, and restore function of cervical/shoulder region with a program of soft-tissue mobilization, postural correction, and a strengthening/stretching exercise program.. Thank you.

Interventions (CPT Code)

Physical Therapy Initial Evaluation / Examination 97001
Manual therapy techniques - joint mobilization and soft tissue massage 97140
Therapeutic Exercises - Therapeutic Procedure - 1+ Areas 97110

Frequency of PT: Two times weekly

Duration of PT: 4 weeks

3.3.09
Date

Marilyn M. Swygert PT, MHS
State Lic #: 253

Software Reg #: VZ02S-ZWPSX-QOT66-ZGQAM

NAME Sara Y. Wilson PATIENT# _____

NEXT PHYSICIAN APPOINTMENT 8/09 D.O.B [redacted]

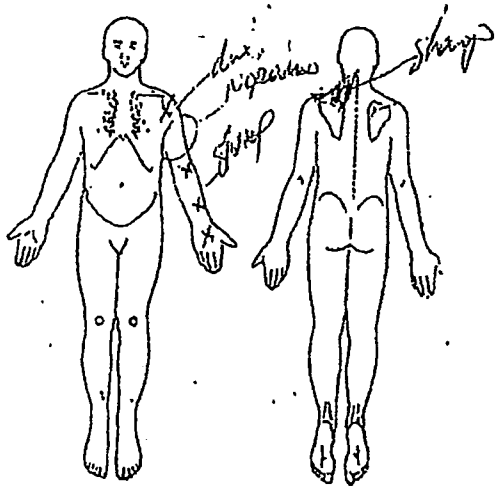
To help us assess the cause of your problem, we ask you to complete this form before being seen by a physical therapist. Please answer as completely as possible.

What are the physical demands of your normal day?

Work _____ Home _____

Complaint

What is your main complaint or problem?
Pain in left shoulder elbow, arm between elbow & wrist & wrist



It is important that we have a measurement of your pain. Please rate the level of your pain on a scale of 1 to 10.

1 2 3 4 5 6 7 8 (9) 10
Mild discomfort — Moderate pain — Extreme agony

History

How did your problem start? ?

Please list any medications you are taking. Diazepam, Lisinipril, Fosrol, premarin? Crestor, Tylenol for pain

What tests or treatments have you had for this problem? Cortisone shots & xrays

Do you have a history of any other medical problems? (diabetes, high BP, shortness of breath, heart problems, polio, dizziness) High BP, Dizziness

Are you allergic to any medications? If yes, please list the medication _____

Are you allergic to:			
	Sulfa based drugs	(Yes)	No
	Latex	Yes	(No)
	Cortisone	Yes	(No)

Additional comments

S. Wilson Brief 104

Printed: 03/02/09 Encounter: 761
Location: 01 WEST ASHLEY
Note:
Off: TIN: Appt: 03/03/09 11:00am With: OTHER WESLEY
NextAppt: With:

Case Id: #82575 Guarantor: PtBal:
SARA WILSON Case Type: InsBal:
Bill Type: Loc: 01 WEST ASHLEY CaseTot:
PtAll: 0.00
DoB: [redacted] Age: 65 Ph: [redacted]

D.C. 11-15-09

Copay:

723.4, ~~728.2~~, 726.19, 719.5

IE: 97001-110 PT Eval ___ 97003-110 OT Eval ___ 97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim ___ *97033-50 Ionto ___
___ 97014-32 Estim TENS ___ *97012-32 Traction Mech. ___
___ *97035-30 Ultrasound ___ *97116-40 Gait Training ___
I *97140-40 Manual Therapy ___ 97016-35 Vas ___
___ 97022-40 Whirlpool ___ 99707 Supply ___
I *97110-40 Therapeutic Exercise [redacted] aini
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy

Sara Wilson

Charges $ 190.00 Payments $ ___ Posted

S: Decr Homolateral immobility
Pt has decr L shld ROM Decr posture Decr strength and
c/o muscle guarding - prior endurance PSG weakness & scap dyskinesis
accident injury → T compression Decr L shld muscle guarding
Worked on relaxation
Unable to get pt. lifted through full accurate Decr L scap mobility
range in shld ROM Postural corrections
Diaphragmatic Breathing

P: CRT Pain Measurement, shld measurements

Therapist Signature: [signature] (PT) Date 3.3.09 License# 253

Time in: 11 Time out: 2:00 Discharge: ___

S. Wilson Brief 105

Charleston Physical Therapy
615 Wesley Drive
Suite 110
CHARLESTON, SC 29407
Off: (843)768-5455 TIN: 57-0735836

Printed: 03/09/09
Note:

Encounter: 1122
Location: 01 WEST ASHLEY

Appt: 03/09/09 8:30am With: SHARON B
NextAppt: 03/11/09 1:00pm With: OTHER WESLEY

Case Id: [redacted]
SARA WILSON
[redacted]
CHARLESTON, SC 29403
DoB: [redacted] Age: 65 Ph: [redacted]

Guarantor: SARA WILSON
Case Type: NC
Bill Type: 2 Loc: 01 WEST ASHLEY

PtBal: 0.00
InsBal: 0.00
CaseTot: 0.00
PtAll: 0.00

Dx1: 723.4 BRACHIAL NEURITIS NOS
Dx2: 726.19 ROTATOR CUFF DIS NEC
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100%

Ins1: MEDICARE 618
Ins2: Blue Cross & Blue S

Id1: [redacted]
Id2: ZCS05519441

IE: __97001-110 PT Eval ___ 97003-110 OT Eval ___97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
_1_ *97140-40 Manual Therapy_____
___ 97022-40 Whirlpool_____
_2_ *97110-40 Therapeutic Exercise
___ *97530-50 Funotional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy

___ *97033-50 Ionto _____
___ *97012-32 Traction Mech._____
___ *97116-40 Gait Training_____
___ 97016-35 Vas_____
___ 99707 Supply_____
___ 97535-45 Self/Care Home Management Traini
[redacted]

Sara U Wilson

Charges $ 120.00 Payments $_____.___ Posted_____

12" lcte.

S: Reports neck pain still radiating into (R) shldr, forearm/wrist pain.

O: Cont to STM to (L) Utrap, L/S, SCalenes & sub-occipitals & (L) Shldr in (R) S/L, F/B decr of fedin w/ pad, sub-occipital stretch in supine, passive stretch of (L) Utrap, (L) wrist flex grip (R) 22lbs (L) 22 lbs decr retract x10, Chin tuck x 10. Rom (L) Shldr: flex 168* Abd 172* ER 88 IR 88*

A: Tol fair. difficult to relax. grip was symmetrical but pt C/o pain to (L) testing. no C/o pain to retraction. pt was emotional & some tears during Rx

P: Measure CROM & decr grip. PSG H&P.

Therapist Signature: Shawn M. Burdo PTA Date 3/09/09 License# 1748

Time in: 8:45 Time out: 9:25 Discharge:

S. Wilson Brief 108

420

Printed: 03/10/09 Encounter: 1223
Location: 01 WEST ASHLEY
Note:
Off: TIN:
Appt: 03/11/09 1:00pm With: OTHER NESLEY
NextAppt: 03/16/09 2:00pm With: SHARON B

Case Id: 82515-01 Guarantor: SARA WILSON PtBal: 0.00
SARA WILSON Case Type: MC InsBal: 0.00
[redacted] Bill Type: 2 Loc: 01 WEST ASHLEY CaseTot: 0.00
CHARLESTON, SC 29403 PtAll: 0.00
DoB: [redacted] Age: 65 Ph: [redacted]

Dx1: 723.4 BRACHIAL NEURITIS NOS Ins1: MEDICARE 618 Id1: [redacted]
Dx2: 726.19 ROTATOR CUFF DIS NEC Ins2: Blue Cross & Blue S Id2: ZCS05519401
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100%

IE: __97001-110 PT Eval ___ 97003-110 OT Eval ___97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
2 *97140-40 Manual Therapy_____
___ 97022-40 Whirlpool_____
1 *97110-40 Therapeutic Exercise
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy
___ *97033-50 Ionto _____
___ *97012-32 Traction Mech._____
___ *97116-40 Gait Training_____
___ 97016-35 Vas_____
___ 99707 Supply_____
___ 97535-45 Self/Care Home Management Traini
___ *97112 Neuromuscular Re-Education
___ Splint _____

Charges $120.00 Payments $_____ Posted

S: Pt reports the breathing tx have helped.

O: SLouR - STM to (L) rom/upper shld/scap (L)scap depress
Supine: Cervical rotation/SB (L) stretch/pain - Manual cerv traction (L) post fint mobs - PROM is WNL's -
Review HEP - tried to progress to resisted ER with (R) tubing Supine

A: Pt responded well to manual techniques to decrease pain as she was able to rotate head to the left more "no pain". Therapist was able to progress to resisted ER with (R) tubing Supine

P: Try STM c suggested self care - recommended pt see in 4 wks for re-eval.

Therapist Signature: Marilyn Dyson PT Date 3/11/09 License 253
Time in: 1 Time out: 1:45 Dis
S. Wilson Brief 107

421

Charleston Physical Therapy
615 Wesley Drive
Suite 110
CHARLESTON, SC 29407
Off: (843)768-5455 TIN: 57-0735836

Printed: 03/13/09
Note:

Encounter: 1452
Location: 01 WEST ASHLEY

Appt: 03/16/09 2:00pm With: SHARON B
NextAppt: 03/19/09 2:00pm With: SHARON B

Case Id: 02515-01
SARA WILSON
[redacted]
CHARLESTON, SC 29403
DoB: [redacted] Age: [redacted] Ph: [redacted]

Guarantor: SARA WILSON
Case Type: MC
Bill Type: 2 Loc: 01 WEST ASHLEY

PtBal: 0.00
InsBal: 0.00
CaseTot: 0.00
PtAll: 0.00

Dx1: 723.4 BRACHIAL NEURITIS NOS
Dx2: 726.19 ROTATOR CUFF DIS NEC
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100%

Ins1: MEDICARE 618
Ins2: Blue Cross & Blue S

Id1: [redacted]
Id2: ZCS05519441

IE: __97001-110 PT Eval ___ 97003-110 OT Eval ___97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
1 *97140-40 Manual Therapy_____
___ 97022-40 Whirlpool_____
1 *97110-40 Therapeutic Exercise
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy

___ *97033-50 Ionto _____
___ *97012-32 Traction Mech._____
___ *97116-40 Gait Training_____
___ 97016-35 Vas_____
___ 99707 Supply_____
___ [redacted] Traini

Sara H Wilson

Charges $120.00 Payments $_____ Posted_____

S: Pt reports she's feeling better. Intensity of pain & irritat otherwise unchanged.

O: Continue c STM in sitting to (B) UTrap, LS, & suboccipitals (R) UTrap & levator scapulae. Chin tucks in supine x10, deep neck flexor x10 x 3 sec. Pectoral position stretch in supine c towel roll x1 min c clasped hand flexion x10, postural ed re: head position, carrying purse & role of postural stab. had pt perform

A: low row isometric / Back rubber X 10 each
A: tol fair but very focused on subjective complaint suggested pt focus on postural support to side leaning as compared to "all exercise will hurt"

P: Cont to Care

Therapist Signature: Sharon M Burds PTA Date 3/16/09 License# 1748

Time in: 2:00 Time out: 2:45 Discharge: _____

S. Wilson Brief 108

422

Charleston Physical Therapy
615 Wesley Drive
Suite 110
CHARLESTON, SC 29407
Off: (043)768-5455 TIN: 57-0735836

Printed: 03/18/09 Encounter: 1654
Note: Location: 01 WEST ASHLEY
Appt: 03/19/09 2:00pm With: SHARON B
NextAppt: 03/26/09 12:15pm With: SHARON B

Case Id: 82515-01
SARA WILSON
[redacted]
CHARLESTON, SC 29403
DoB: [redacted] Age: 65 Ph: [redacted]

Guarantor: SARA WILSON
Case Type: MC
Bill Type: 2 Loc: 01 WEST ASHLEY

PtBal: 0.00
InsBal: 0.00
CaseTot: 0.00
PtAll: 0.00

Dx1: 723.4 BRACHIAL NEURITIS NOS
Dx2: 726.19 ROTATOR CUFF DIS NEC
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100$

Ins1: MEDICARE 610
Ins2: Blue Cross & Blue S

Id1: [redacted]
Id2: ZCS05519441

IE: 97001-110 PT Eval ___ 97003-110 OT Eval ___ 97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
2 *97140-40 Manual Therapy _____
___ 97022-40 Whirlpool _____
2 *97110-40 Therapeutic Exercise
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy

___ *97033-50 Ionto _____
___ *97012-32 Traction Mech. _____
___ *97116-40 Gait Training _____
___ 97016-35 Vas _____
___ 99707 Supply _____
___ [redacted]
___ ✓ Silvia G. Wilson

Charges $120.00 Payments $_____ Posted ✓

S: Pt reports she has been put on Cymbalta per Dr DeMaco request to Dr Rosen-her psych Dr- d/n no better

O: 5PM vc (L) addct (B) CKS, UTrap (L) LS, post/lat scalene & some (L) Rhomboids, deep friction vc (L) scap inf/med c post Hilt, sub occipital stretch in supine, passive stretch of UTrap, Levator scap, Chin tucks x 10, deep neck flexor x 10, scap ex's per chart adding WTB 2x10 scap row; had pt perform AA addct ROM c pulleys) flex/scap/ Hor Abd/Add.

A: Hil very well.

P: Continue c Care - Monitor response to new ex's

Therapist Signature: Shawn M. Burdo PTA Date 3/19/09 License# 1748
S. Wilson Brief 109

Time in: 2:00 Time out: 2:55 Discharge: _____

Charleston Physical Therapy
615 Wesley Drive
Suite 110
CHARLESTON, SC 29407
Off: (843)768-5455 TIN: 57-0735836

Printed: 03/25/09
Note:

Encounter: 2044
Location: 01 WEST ASHLEY

Appt: 03/26/09 12:15pm With: SHARON B
NextAppt: 03/30/09 12:15pm With: SHARON B

Case Id: 82515-01
SARA WILSON
[redacted]
CHARLESTON, SC 29403
DoB: [redacted] Age: 65 Ph: [redacted]

Guarantor: SARA WILSON
Case Type: MC
Bill Type: 2 Loc: 01 WEST ASHLEY

PtBal: 0.00
InsBal: 0.00
CaseTot: 0.00
PtAll: 0.00

Dx1: 723.4 BRACHIAL NEURITIS NOS
Dx2: 726.19 ROTATOR CUFF DIS NEC
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100%

Ins1: MEDICARE 618
Ins2: Blue Cross & Blue S

Id1: [redacted]
Id2: ZCS05519441

IE: __97001-110 PT Eval ___ 97003-110 OT Eval ___97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit
___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
__I__ *97140-40 Manual Therapy_____
___ 97022-40 Whirlpool_____
__I__ *97110-40 Therapeutic Exercise
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy
___ *97033-50 Ionto _____
___ *97012-32 Traction Mech._____
___ *97116-40 Gait Training_____
___ 97016-35 Vas_____
___ 99707 Supply_____
___ 97535-15 Home Management Traini

X [redacted]

Charges $120.00 Payments $____.__ Posted

S: Pt reports some slight ↓ in (L) sided pain. Pt had increase in wrist/hand pain - neck very tight
O: Cont c STM to (B) UPS, upper trap (L) LS post/lat scalene, (L) Rhomboids, stop cycles to (L) scapula ER need c post tilt, sub-occipital stretch in supine, passive stretch of Utrap. U/S chin tucks X 10 stop ex's - per chart c WTB, discussed that perhaps
A: pt might want to return to Dr treating her neck as added ex's indicate her radicular ex's coming from cervical
A: Tol very well but has not had a chance to
P: Complaint
P: Continues c postural stabilization

Therapist Signature: Sharon M. Burdo P.TA Date 3/26/09 License# 1748
S. Wilson Brief 110

Time in: 12:15 Time out: 1:00 Discharge: _____

Charleston Physical Therapy Printed: 04/01/09 Encounter: 2568
615 Wesley Drive Location: 01 WEST ASHLEY
Suite 110 Note:
CHARLESTON, SC 29407
Off: (843)768-5455 TIN: 57-0735836 Appt: 04/02/09 12:15pm With: SHARON B
NextAppt: 04/06/09 12:15pm With: SHARON B

Case Id: 82515-01	Guarantor: SARA WILSON	PtBal:	0.00
SARA WILSON [redacted]	Case Type: MC	InsBal:	0.00
CHARLESTON, SC 29403	Bill Type: 2 Loc: 01 WEST ASHLEY	CaseTot:	0.00
DoB: [redacted] Age: 65 Ph: [redacted]		PtAll:	0.00

Dx1: 723.4 BRACHIAL NEURITIS NOS Ins1: MEDICARE 618 I[redacted]
Dx2: 726.19 ROTATOR CUFF DIS NEC Ins2: Blue Cross & Blue S Id2: [redacted]
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100%

IE: __97001-110 PT Eval ___ 97003-110 OT Eval ___97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
___ *97140-40 Manual Therapy_____
___ 97022-40 Whirlpool_____
___ *97110-40 Therapeutic Exercise
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy
___ *97033-50 Ionto _____
___ *97012-32 Traction Mech._____
___ *97116-40 Gait Training_____
___ 97016-35 Vas_____
___ 99707 Supply_____
___ 97535-45 Self/Care Home Management Train:
___ *97112 Neuromuscular Re-Education
___ Splint _____

Charges $_____.___ Payments $_____.___ Posted_____

S: CANC

O:

A:

P:

S. Wilson Brief 111

Therapist Signature:_____ Date___/___/___ License#_____

Time in: _____ Time out: _____ Discharge: _____ AYL

425

Charleston Physical Therapy Printed: 04/03/09 Encounter: 2635
615 Wesley Drive Location: 01 WEST ASHLEY
Suite 110 Note:
CHARLESTON, SC 29407
Off: (843)768-5455 TIN: 57-0735836 Appt: 04/06/09 12:15pm With: SHARON B
NextAppt: 04/09/09 12:15pm With: OTHER WESLEY

Case Id: 82515-01 Guarantor: SARA WILSON PtBal: 0.00
SARA WILSON [redacted] Case Type: MC InsBal: 0.00
Bill Type: 2 Loc: 01 WEST ASHLEY CaseTot: 0.00
CHARLESTON, SC 29403 PtAll: 0.00
DoB: [redacted] Age: 65 Ph: [redacted]

Dx1: 723.4 BRACHIAL NEURITIS NOS Ins1: MEDICARE 618 Id1: [redacted]
Dx2: 726.19 ROTATOR CUFF DIS NEC Ins2: Blue Cross & Blue S Id2: ZCS05519441
Dx3: 719.59 JT STIFFNESS NEC-MULT JT
Copay: 100%

IE: __97001-110 PT Eval ___97003-110 OT Eval ___97002-56 PT Re-Eval ___ 97004-56 OT Re-E
*15 Minute Unit

___ *97032-32 Estim _____
___ 97014-32 Estim TENS _____
___ *97035-30 Ultrasound _____
1 *97140-40 Manual Therapy _____
___ 97022-40 Whirlpool _____
2 *97110-40 Therapeutic Exercise
___ *97530-50 Functional Activity
___ 97150 Group Therapeutic Procedure
___ 97113-40 Aquatic Therapy
___ *97033-50 Ionto _____
___ *97012-32 Traction Mech. _____
___ *97116-40 Gait Training _____
___ 97016-35 Vas _____
___ 99707 Supply _____
___ 97535-45 Self/Care Home Management Traini
___ *97112 Neuromuscular Re-Education
___ Splint _____

Charges $120.00 Payments $____.__ Posted

S: Pt that (L) forearm contis to be painful "sticking pain in neck. Sometimes pain radiates to (L) elbow rated as an 8 to 10 finger cramping. Stretching helps a little. some pain meds. cymbalta some tylenol. nothing is helping.

Shldr strength: V+ Abd 4 ER 4 IR 4 ext 4

Shldr ROM: (R) V/172 Abd 170. ER WNL IR WNL (L) P

Crom Lat flex 35. (R) 35 (L) 35P. Ext (R) 17. (L) 60

Agrip strength (R) 24 (L) 18. pain felt in (L) elbow

(L) mm guarding in upper trap. pt very reactive & sensitive. Cont estim to upper shldr/neck. L/S mm trap & CPS. cut. accepted and reviewed. ex's & postural awareness. pt asked if we could refer to her neck surgeon. suggested she return to Dr Oliveira formally MD who sent her to Dr Dymalco. discussed findings & POT. pt placed on ice

Therapist Signature: Sharon M. Burdo P.T. Date 4/06/09 License# 1748.112
Marilyn Seay P.C.X.R
S. Wilson Brief

Time in: 12:15 Time out: 1:00 Discharge: _____

426

CHARLESTON PHYSICAL THERAPY

Date: 4/06/09

Referring Physician: Dr DeMarco/Dr Olivevio.

Patient Name: Sara Wilson

Visit(s) Attended: 9 Visit(s) Scheduled: 9

Current Physical Therapy Treatments: STM, U.S/Modalities PRN, Cerv Rom, a gentle stretching, isometrics, shldr Rom, postural stabilization targetong post shldr girdle ms.

Progress: made good progress in (L) shldr Rom & some improved cervical Rom but min progress ē neck pain shldr strength 4/5 excluding IR 4+/5

Flex 170
Abd 170
ER WNL
IR WNL

Problems: c/o (L) forearm painful ē "sticking" pain in neck, sometimes radiates to (L) shldr rated as an 8 on 1-10. (L) upper trap ms guarding, pt very sensitive/reactive, difficult to assess.

Recommendations: Given patients History, she may benefit from TENS/more chronic pain management approach. though her shldr Rom improved, her complaint did not change.

Thank you for the referral of your patient. If you have any questions regarding this patient's care, please contact me at (843) 763-4115

grip strength (R) 24 (L) 18 *
cervical Rom (L) LF 35 (R) LF 35
(L) Rot 66' (R) Rot 72'

Sharon M. Bundo PTA
Therapist Signature

S. Wilson Brief 113

* painful in elbow

427

Discharge Summary

Patient: WILSON, SARA
MR #: 82515
PT: Marilyn M. Swygert PT, MHS

Date: Wednesday, May 06, 2009
Provider: Charleston Physical Therapy
Provider #: [redacted]

Patient Information

Address: [redacted]
CHARLESTON, SC 29403

Birth Date: [redacted]
Physician: James DeMarco M.D.

Occupation:
Gender: Female
Contact Person:

Physician Num:
Medicare #: [redacted]
Claim #:

Onset Date of Medical Diagnosis with ICD-9: 02/23/2009
Degeneration - Disc - Cervical Intervertebral 722.4
Brachial Neuritis 723.4
Disorder - Shoulder - Bursae & Tendons - Specified - Other 726.19

Preferred Practice Pattern: Musculoskeletal D: Impaired joint mobility, motor function, muscle performance, ROM associated w/ connective tissue dysfunction

Physical Therapy Diagnosis: Multiple Sites - Stiffness - Joint- Not Else Classified 719.59
Muscular Wasting & Disuse Atrophy - Not Else Classified 728.2

Reasons for Discharge

Goals met: ☑
Maximum Level Reached: ☑
Hospitalization: ☐
Patient refuses further treatment: ☐
Patient expired: ☐

Patient/Care Giver was given proper and timely notification of Discharge: ◉ Yes ○ No

No further physical therapy intervention is indicated at this time in this setting. Patient's physician has been notified that this patient has been discharged from physical therapist's care. ○ Yes ◉ No

Additional Discharge Information:

Functional Measures

Tolerance to IADLs

Initial Level: Moderate pain and limitation during and/or after a specific IADL affecting performance

Goal: Mild pain during and/or after a specific IADL affecting performance

Final Level: Mild - Moderate pain and limitation during and/or after a specific IADL affecting performance

Tolerance to Recreation Activities

Initial Level: Severe pain and limitation in a specific recreational activity affecting performance

Goal: Mild - Moderate pain and limitation in a specific recreational activity affecting performance

Final Level: Severe pain and limitation in a specific recreational activity affecting performance

Functional characteristics and analysis: Patient continues to present with forward head, rounded shoulder posture and is gaurded throughout all movements.

Impairment Goals; Short Term:
Pain is decreased by 25% in 2 weeks - partially met
Increase strength
Range of motion is improved by 25% in 2 weeks - Met
Relaxation is increased by 25% in 2 weeks

Functional Goals; Long Term:
IADL performance in related activities is improved
Recreational performance in related activities is improved
Improve cervical posture

S. Wilson Brief 114

Patient: WILSON, SARA Date: Wednesday, May 06, 2009

Physical Findings

Pain

Site #1: Joint Pain - Shoulder - Right; At Rest 5/10; With Activity 8/10; Dull; Radiating
Exacerbating Factors: Inactivity & Reaching
Relieving Factors: Ice to the affected area & Medications

Site #2: Back Pain - Cervical - Lower Segment Syndrome; At Rest 5/10; With Activity 8/10; Sharp; Radiating
Exacerbating Factors: Activity & Flexion
Relieving Factors: Rest

Comments: Patient very difficult to assess secondary to sensitivity and reactivity to any type of movement of her left shoulder and neck.

Posture

Initial Level: 4/5 Head forward / rounded shoulders

Goal: 5/5 Normal head / shoulder posture

Final Level: 4/5 Head forward / rounded shoulders

Specific Joints

(Note: Blank indicates Strength / Range of Motion are within functional limits or not tested)

Initial Eval Level

Shoulder	Strength Right	Strength Left	Active ROM Right	Active ROM Left	Passive ROM Right	Passive ROM Left
Flexion		4		168°		
Extension		4-		46°		
Abduction		4		172°		
Adduction						
Horizontal Abduction						
Horizontal Adduction						
Internal Rotation		4		88°		
External Rotation		4		88°		

Final Level

Shoulder	Strength Right	Strength Left	Active ROM Right	Active ROM Left	Passive ROM Right	Passive ROM Left
Flexion		4		172°		
Extension		4-		45°		
Abduction		4		170°		
Adduction						
Horizontal Abduction						
Horizontal Adduction						
Internal Rotation		4+		WNL		
External Rotation		4		WNL		

Comments on Shoulder: Grip strength: Right 24lbs. Left 18lbs.

Initial Eval Level

Cervical Spine	Strength	ROM
Flexion	4	38°P
Extension	4	32°
Protraction		
Retraction		

	Right	Left	Right	Left
Lateral Flexion	4	4	35°P	30°
Lateral Rotation	4	4	70°	60°P

Final Level

Cervical Spine	Strength	ROM
Flexion	4	38°P
Extension	4	32°
Protraction		
Retraction		

	Right	Left	Right	Left
Lateral Flexion	4	4	35°P	30°
Lateral Rotation	4	4	70°	60°P

Comments on Spine: Left cervical muscle guarding.

Assessment:

Assessment: The patient was seen for a total of 7 visits and demonstrated her greatest improvement in her left shoulder range of motion and strength. Her subjective complaint od neck pain radiating into her left shoulder was minimally changed and for this reason she was referred back to her physician. It is her desire and may be in her best interest to seek further diagnostics and may benefit from a TENS unit to assit he in controlling her pain. She is dischraged from physical therapy at this time secondary to her plateau in her progress. She could benefit from postural strengthening when she is better able to tolerate exercise. Thank you.

Patient: WILSON, SARA Date: Wednesday, May 06, 2009

Interventions (CPT Code)

Final Instructions to
Patient / Caregiver: Patient and family were given a written 2 times daily program to maintain current level of function

Shawn R. Burdo PTA #1746

5-6-09 Marilyn Swygert PT

Date Marilyn M Swygert PT, MHS
State Lic #: 253

Software Reg #: VZ02S-ZWPSX-QOT66-ZGQAM

W Pettigrew Clare
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARA Y | Encounter | 05-12-2006

Patient: WILSON, SARA Y | Sex: F | Physician: W Pettigrew Clare
Birth Date: [redacted] | Referring:
Birth Place: | SSN [redacted]
Patient_ID: 3616 | Chart No.:

Description: routine | Type: Office or Outpatient; Established
Seen By: W Pettigrew Clare | Date: 05-12-2006
Signed By: | Signed: Not Signed
Billing Note:

Medications	Started	Stopped	Sig	Sub
lanoxin 0.25mg	11-01-2005		1 PO QD	Y
librax	11-01-2005		1 PO QD	Y
Lorazepam 1mg	11-01-2005		1 po q TID prn	Y
meclizine 25mg	11-17-2005	05-12-2006	1 po QID prn	Y
micardis 40 mg	11-01-2005		1 PO QD	Y
nexium 40mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
nexium 40mg	05-12-2006		1 PO QDay	Y
premarin .9mg	05-12-2006		1 PO QDay	Y
premarin .9mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	05-12-2006		1 PO QDay	Y
vitamin e 400 iu	11-17-2005		1 PO QD	Y

Completed Labs	Ordered	Completed	Facility
Urinalysis	05-18-2006	05-18-2006	

Test Name	Data Value	Abnormal Flags	Lo Norm	Hi Norm	Units	Test Stat
leukocytes ,urine	neg					
nitrite ,urine	neg					
urobilirubin, urine	neg					
protein, urine	neg					
ph, urine	6		5.	8.5		
blood, urine	trace					
specific gravity	1.010		1.	1.03		
ketone, urine	neg					
bilirubin, urine	neg					
Glucose, urine	neg					

CPT	CPT Description	ICD	ICD Description
99213	office visit, established	959.8	INJURY MLT SITE/SITE NEC

Physician: W Pettigrew Clare · Note: 05-18-2006
Note Description: Progress Note /18/06

wt 114 bp 142/68 p 72 temp 97.0
urinalysis trace blood

The patient presents for painful injuries .

S. Wilson Brief 117

Printed by VersaForm 3.125 For W. Pettigrew Clare Sr. MD

W Pettigrew Clare
114 Ashley Avenue
Charleston SC 29401
843 723 8705

WILSON, SARAY | Encounter | 05-12-2006

HPI:She comes in stating that when she was at work in a room two students were fighting and came into the room with one of them being shoved into her knocking her down. Her shoulder and rib cage hit the corner of the desk on her way down,injuring her riboage shoulder and leg. She went to the emergency room where X Rays of her ribs , femur, and chest the did not reveal any bony fractures. She was given an analgesics. she has continued to have considerable pain in her shoulder and reads. The pains are sufficiently bad that they interfere with her normal activities.

ROS
Respiratory: denies cough, dyspnea.
Cardiovascular: denies chest pains, palpitations, dyspnea
GI: denies abdominal pain, heartburn,nausia and vomiting or bowel problems
GENT/Genitourinary: denies urgency dysuria incontinence, nocturia
BJE/Musculoskeletal: As in present illness she is having neck pain , shoulder pain, pains in her right rib cage, and pains in her femur,

General Exam: she appears uncomfortable
Neck/Thyroid: She is tender in the posterior neck and shoulder muscles. There is no limitation of motion although motion causes the pain to be worse .

Respiratory Effort- Lungs sound clear. She has marked tenderness in the right rib cage.

Heart findings: Her heart is a regular without significant murmur .

Gastrointestinal: There are no enlarged organs or masses . She does have some mild diffuse tenderness

Problems: Multiple trauma secondary to a fall. Initiated by being hit by two students

Plan:
She is to continue analgesics .

She is to avoid any
activity and call me if no improvement

S. Wilson Brief 118

Printed by VersaForm 3.126 For W. Pettigrew Clare Sr., MD On 05/12/2006

Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARA Y	Encounter	09-12-2006

Patient: WILSON, SARA Y Sex: F Physician: W Pettigrew Clare Sr., MD
Birth Date: [redacted] Referring:
Birth Place: SSN: [redacted]
Patient_ID: 3616 Chart No.:

Description: routine office visit Type: Office or Outpatient; Established
Seen By: W Pettigrew Clare Sr., MD Date: 08-17-2006
Signed By: W. Pettigrew Clare Sr., MD Signed: 09-12-2006
Billing Note:

Medications	Started	Stopped	Sig	Sub
CLIDINIUM/CDP	08-17-2006		1 po q TID	Y
DICLOFENAC SOD 75 MG	08-17-2006		1 po BID	Y
lanoxin 0.26mg	11-01-2005		1 PO QD	Y
librax	11-01-2005		1 PO QD	Y
Lorazepam 1mg	11-01-2005		1 po q TID pm	Y
meclizine 25mg	11-17-2006	05-12-2006	1 po QID pm	Y
micardis 40 mg	11-01-2005		1 PO QD	Y
nexium 40mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
nexium 40mg	05-12-2006		1 PO QDay	Y
premarin .9mg	05-12-2006		1 PO QDay	Y
premarin .9mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	05-12-2006		1 PO QDay	Y
TRAMADOL 50 MG	08-17-2006		1 PO Q 6HRS PRN	Y
vitamin e 400 iu	11-17-2005		1 PO QD	Y
ZOLOFT 100 MG	08-17-2006		1 PO QD	Y

Ordered Labs	Ordered On	Date Due	Facility
Basic Metabolic Panel	08-17-2006		
Cholesterol Panel	08-17-2006		
SGOT	08-17-2006		
SGPT	08-17-2006		

Completed Labs	Ordered	Completed	Facility
Urinalysis	08-17-2006	08-17-2006	

Test Name	Data Value	Abnormal Flags	Lo Norm	Hi Norm	Units	Test Stat
leukocytes ,urine	neg					
nitrite ,urine	neg					
urobilirubin, urine	neg					
protein, urine	+2					
ph, urine	6		5.	8.5		
blood, urine	moderate					
specific gravity	1.015		1.	1.03		
ketone, urine	neg					
bilirubin, urine	neg					
Glucose, urine	neg					

S. Wilson Brief 119

Printed by VersaForm 3.128 For W. Pettigrew Clare Sr. MD On [illegible]

Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARA Y	Encounter	09-26-2006

Patient: WILSON, SARA Y Sex: F Physician: W Pettigrew Clare Sr., MD
Birth Date: [redacted] Referring:
Birth Place: SS[redacted]
Patient_ID: 3616 Chart No.:

Description: headache, diarrhea Type: Office or Outpatient; Established
Seen By: W Pettigrew Clare Sr., MD Date: 09-26-2006
Signed By: W. Pettigrew Clare Sr., MD Signed: 09-26-2006
Billing Note:

Medications	Started	Stopped	Sig	Sub
CLIDINIUM/CDP	08-17-2006		1 po q TID	Y
DICLOFENAC SOD 75 MG	08-17-2006		1 po BID	Y
lanoxin 0.25mg	11-01-2005		1 PO QD	Y
librax	11-01-2005		1 PO QD	Y
Lorazepam 1mg	11-01-2005		1 po q TID prn	Y
meclizine 25mg	11-17-2005	05-12-2006	1 po QID prn	Y
micardis 40 mg	11-01-2005		1 PO QD	Y
nexium 40mg	11-01-2006	05-12-2006	1 po q8hr, PRN	Y
nexium 40mg	05-12-2006		1 PO QDay	Y
premarin .9mg	05-12-2006		1 PO QDay	Y
premarin .9mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	05-12-2006		1 PO QDay	Y
TRAMADOL 50 MG	08-17-2006		1 PO Q 6HRS PRN	Y
vitamin e 400 iu	11-17-2005		1 PO QD	Y
ZOLOFT 100 MG	08-17-2006		1 PO QD	Y

CPT	CPT Description	ICD	ICD Description
99212	office visit, established	558.9	COLITIS

Physician: W Pettigrew Clare Sr., MD Note: 09-26-2006
Note Description: Progress Note

wt 118 bp 138/60 p 72 temp 98.2

The patient presents for Several problems

HPI:, over the last several days she has developed a fair amount of diarrhea. She is not having pains, or any blood. She has had no nausia to speak of. However she has had a headache and generalized malaise success of the main Maryland faction. She has been doing about the same otherwise. She continues to have pain in her neck related to the bad disk, and if they did by the trauma. She OM has to talk to a neurosurgeon about possible surgical intervention, but would like a second opinion she is given the names of doctor Stephen Rawe or a doctor Pacault.

ROS
Respiratory: denies cough, dyspnea.
Cardiovascular: denies chest pains, palpitations, dyspnea
GI: only as in present illness
GENT/Genitourinary: denies urgency dysuria incontinence, nocturia
BJE/Musculoskeletal:Only as in present illness

S. Wilson Brief 120

General Exam: she appears healthy .

Printed by VersaForm 3.128 For W. Pettigrew Clare Sr., MD On 09/26/2006

Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843 723 8705 .

Neck/Thyroid: no thyromegaly no bruits
Respiratory Effort- clear to ausoultation
Heart findings: regular rhythmwithout significant murmur .
Gastrointestinal: abdominal examination reveals some mild defuse tenderness. This is primarily in the lower quadrants. Al sounds are present and sound normal. There are no enlarged organs or masses.

Problems:
generalized viral infection
persistent diarrhea functional versus viral

Plan:
she will to symptomatic treatment with a modern and penalties its
if the diary of persists are gets worse she will call
otherwise she will be checked again in three months

Appendix 438

Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARA Y — Encounter — 11-20-2008

Patient: WILSON, SARA Y | Sex: F | Physician: W Pettigrew Clare Sr., MD
Birth Date: [redacted] | Referring:
Birth Place: | SS[redacted]
Patient ID[redacted] | Chart No.:

Description: ROUTINE FOLLOW UP | Type: Office or Outpatient; Established
Seen By: W Pettigrew Clare Sr., MD | Date: 11-20-2008
Signed By: W. Pettigrew Clare Sr., MD | Signed: 11-20-2008
Billing Note:

Medications	Started	Stopped	Sig	Sub
CLIDINIUM/CDP	08-17-2006		1 po q TID	Y
DICLOFENAC SOD 75 MG	08-17-2006		1 po BID	Y
lanoxin 0.25mg	11-01-2005		1 PO QD	Y
librax	11-01-2005		1 PO QD	Y
LIPITOR 10MG	11-20-2006		1 PO QD	Y
Lorezepam 1mg	11-01-2005		1 po q TID prn	Y
meclizine 25mg	11-17-2005	05-12-2006	1 po QID prn	Y
micardis 40 mg	11-01-2005		1 PO QD	Y
nexium 40mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
nexium 40mg	05-12-2006		1 PO QDay	Y
premarin .9mg	05-12-2006		1 PO QDay	Y
premarin .9mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	11-01-2005	05-12-2006	1 po q8hr, PRN	Y
Toprol xl 50mg	05-12-2006		1 PO QDay	Y
TRAMADOL 50 MG	08-17-2006		1 PO Q 6HRS PRN	Y
vitamin e 400 iu	11-17-2005		1 PO QD	Y
ZOLOFT 100 MG	08-17-2006		1 PO QD	Y

CPT	CPT Description	ICD	ICD Description
99213	office visit, established	722.4	CERVICAL DISC DEGEN
99213	office visit, established	401.1	BENIGN HYPERTENSION

Physician: W Pettigrew Clare Sr., MD Note: 11-20-2008
Note Description: Progress Note

wt 118 b/p 116/62 pulse 78 97.

The patient presents for Follow up

HPI:she comes in generally doing fairly well. She has been taken and medications without problems. She continues to have some pains in fact has more. otherwise doing fairly well.

ROS
Respiratory: denies cough, dyspnea.
Cardiovascular: denies chest pains, palpitations, dyspnea
GI: denies abdominal pain, heartburn,nausia and vomiting or bowel problems
GENT/Genitourinary: denies urgency dysuria incontinence, nocturia
BJE/Musculoskeletal: denies arthritis, back pain, jOr muscle problems

General Exam: she appears healthy .
Respiratory Effort- clear to auscultation

S. Wilson Brief 122

Printed by VersaForm 3.128 For W. Pettigrew Clare Sr., MD On 11/20/2008

W Pettigrew Clare Sr., MD
114 Ashley Avenue
Charleston SC 29401
843 723 5705

WILSON, SARAY	Encounter	11-20-2008

Heart findings: regular rhythmwithout significant murmur .
Gastrointestinal: no tenderness or or enlarged organs or masses

Problems:
Hypertension
hypercholesteralemia

Plan:
She will continue the same medication
she will obtain a of lipid profile
she needs follow up in about three to four months

Patient name: Sara Wilson Chart Number: [redacted]

DOB: [redacted] Date of Visit: 04/22/2009

Reason for visit: Follow up

Current Concerns: pleasant 63-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she comes in for a couple of problems today including continued, left shoulder discomfort pain in the deltoid region particularly on palpation or pressure in the deltoid region. she also has some radicular type symptoms in the left arm. She is status post steroid injection in the shoulder which relieves some of the shoulder discomfort but she continues to have left arm pain. She also had persistent diarrhea, reflux disease, but has improved with AcipHex with decreased loose stools. She's also been on an increased dose of Crestor without significant worsening of her myalgias. She did blood work this morning.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006

Pneumovax: flu vaccine: 2007 Colonoscopy: 2006

Medications ☐ None

Meprozine 50/25	4-6 prn	Valium 5 1/2 prn	daily
Cymbalta 30	daily		daily
lisinopril 20	daily.	Crestor 10	daily
Aciphex 20 mg	b.i.d.	diazepam 5, 1/2-1	b.i.d.
Premarin 0.9 mg	Q3D		
Toprol-XL 50 mg	daily		

Social History

☒ No ☒ current tobacco pack-years: 5
☒ prior tobacco
☒ No ☒ Alcohol drinks per day:
☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies: Intolerant to Darvon Lortab sulfa aspirin percocet allergic to penicillin/Keflex, omeprazole

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

Patient name Sarah Wilson **Chart Number** [redacted] **Date of Visit** 4/22/09.

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath currently.

Physical Exam

Pulse 70 BP 130/70 RR 14 Temp [ ] Weight 112.5

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☒ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other	
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged.	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☒ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☐ Other	

Results

Impression:

1. Hypertension-well controlled on current regimen of Micardis and Toprol-XL. her palpitations have decreased considerably. Will merely observe.
2. Hyperlipidemia-Crestor to 10 mg p.o. dailyRecheck lipid profile and liver function tests and CK
3. GERD-samples of AcipHex given to be taken daily. Diarrhea is improved
4. status post spinal surgery, left shoulder, arm pain-Dr. DeMarco relieved pain is somewhat in the shoulder with local steroid injection. He feels, and I concur, that in all probability she has an element of cervical radiculitis. We'll have her see Dr. Jervey for evaluation of radicular nerve pain. She does have Cymbalta on board, but she can tolerate no more than 30 mg daily.

Follow-Up: three months Signed By B. Wilson Brief 125

Patient name Sara Wilson **Chart Number** [redacted]

DOB [redacted] Date of Visit [redacted]

Reason for visit: Follow up

Current Concerns: pleasant 63-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she comes in for a couple of problems today including continued, left shoulder discomfort pain in the deltoid region particularly on palpation or pressure in the deltoid region. she also has some radicular type symptoms in the left arm. She is status post steroid injection in the shoulder which relieves some of the shoulder discomfort but she continues to have left arm pain.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
uilateral R oopherectomy
lap chole
L breast lumpectomy 2006

Pneumovax flu vaccine 2007 Colonoscopy 2006

Medications ☐ None

Meprozine 50/25	4-6 pm	Soma 250 qid	p.r.n.
Cymbalta 90	daily		daily
lisinopril 20	daily	Crestor 10	daily
Aciphex 20 mg	b.i.d.	diazepam 5, 1/2-1	b.i.d.
Premarin 0.9 mg	Q3D		
Toprol-XL 50 mg	daily		
Vallum 5 1/2 prn	daily		

Social History

☒ No ☒ current tobacco pack-years 5
☒ prior tobacco
☒ No ☒ Alcohol drinks per day
☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies: intolerant to Darvon Lortab sulfa aspirin percocet allergic to penicillin/Keflex, omeprazole

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

S. Wilson Brief 128

Patient name: Sarah Wilson Chart Number: [redacted] Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath currently.

Physical Exam

Pulse 70 BP 130/70 RR 14 Temp Weight 115.5

- ☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly ☐ Other
- ☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops ☐ Other
- ☒ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally ☐ Other
- ☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits ☐ Other
- ☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities. ☐ Other
- ☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge. ☐ Other
- ☐ Pap done ☐ Breast Exam Normal ☐ Other
- ☐ Prostate: Non-nodular not enlarged. ☐ Other
- ☐ Rectal: Heme-negative brown stool in vault, normal tone, ☐ Other
- ☒ Neuro: Alert and oriented times three, grossly nonfocal
- ☒ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes ☐ Other

Results:

Impression:

1. Hypertension-well controlled on current regimen of lisinopril and Toprol-XL. her palpitations have decreased considerably. Will merely observe.
2. Hyperlipidemia-Crestor to 10 mg p.o. dailydoing well
3. GERD-samples of AcipHex given to be taken daily. Diarrhea is improved
4. status post spinal surgery, left shoulder, arm pain-Dr. DeMarco relieved pain is somewhat in the shoulder with local steroid injection. He feels, and I concur, that in all probability she has an element of cervical radiculitis. She has seen Dr. Jervey for evaluation of radicular nerve pain. She does have Cymbalta on board, and is now on 90 mg daily. Samples of Soma given for torticollis.

Follow-Up: three months Signed By

S. Wilson Brief 127

Patient name Sara Wilson Chart Number [redacted]

DOB [redacted] Date of Visit [redacted]

Reason for visit evaluation of multiple medical problems

Current Concerns pleasant 66-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
unilateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax flu vaccine 2007 Colonoscopy 2006

Medications ☐ None

Meprozine 50/25	4-6 prn	Lidocaine patch	
Diazepam 2.5-5	b.i.d.		
Amlodipine 10	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 10 mg	daily		

Social History

☒ No ☒ current tobacco pack-years 5
☒ prior tobacco
☒ No ☒ Alcohol drinks per day
☐ Drug Use ☐ detox

Occupation disabled data tech

☐ No Known Drug Allergies

Allergies: Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

Patient name: Sarah Wilson Chart Number: [redacted] Date of Visit: [redacted]

Review of Systems

( ) Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

(•) Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath currently,but has had problems with chest discomfort earlier today

Physical Exam Pulse 70 BP 130/70 RR 14 Temp [ ] Weight 123

- [X] HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly [ ] Other
- [X] CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops [ ] Other
- [X] Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally [ ] Other
- [X] Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits [ ] Other
- [X] Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities. [ ] Other
- [ ] GU: [ ] normal male external genitalia, no testicular masses, no penile lesions, no hernias noted [ ] normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge. [ ] Other
- [ ] Pap done [X] Breast Exam Normal [ ] Other
- [ ] Prostate: Non-nodular not enlarged. [ ] Other
- [ ] Rectal: Heme-negative brown stool in vault, normal tone, [ ] Other
- [X] Neuro: Alert and oriented times three, grossly nonfocal
- [X] Derm: No abnormal rashes, malignant appearing lesions or significant skin changes [ ] Other

Results: EKG read by me-normal sinus rhythm, normal axis, normal intervals, no evidence of acute or chronic ischemia.

Impression:

1. Hypertension-Amlodipine controls well
2. Hyperlipidemia-Crestor 10 Her recent lipid profile was less than desirable. The patient should insure that she takes her medication regularly. Will recheck lipid profile in 3 months.
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy.
5. Screening-patient is up to date with colonoscopy, bone mineral density testing scheduled , mammogram March 2011. stool for occult blood negativex 3. pneumovax

Follow-Up: three months Signed By: Robert Oliverio, MD

Digitally signed by Robert Oliverio,MD
DN: cn=Robert Oliverio,MD, o, ou, email=robert.oliverio@rehmail.com, c=US
Date: 2010.01.18 12:22:58 -05'00'

S. Wilson Brief 129

Patient name Sara Wilson **Chart Number** [redacted]

DOB [redacted] **Date of Visit** [redacted]

Reason for visit evaluation of multiple medical problems

Current Concerns pleasant 66-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. Her blood pressure is excellent today.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD — Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax [ ] flu vaccine 2007 Colonoscopy 2006

Medications ☐ None

Meprozine 50/25	4-6 prn	Boniva 150	mo
Diazepam 2.5-5	b.i.d.		
Amlodipine 5	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 10 mg	daily		
Lidocaine patch			

Social History

☒ No ☒ current tobacco — pack-years 5

☒ prior tobacco

☒ No ☒ Alcohol — drinks per day

☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies: Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

S. Wilson Brief 130

Patient name: Sarah Wilson Chart Number: [redacted] Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing; abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats.

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 BP 110/60 RR 14 Temp Weight 126

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☒ Lungs: Clear to auscultation; percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other	
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged.	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☒ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☐ Other	

Results:

Impression:

1. Hypertension-Amlodipine causes edema. Will decrease amlodipine to 5 mg p.o. daily. Recheck blood pressure one month and reevaluate edema. If the edema does not significantly decreased, we may have to consider alternative antihypertensives
2. Hyperlipidemia-Crestor 10 Her recent lipid profile was less than desirable. The patient should insure that she takes her medication regularly. Will recheck lipid profile in 3 months.
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy.
5. Screening-patient is up to date with colonoscopy, bone mineral density testingRevealed bone loss particularly in the hip. She is now on Boniva. She has had problems with esophagitis and I'll try to give her a couple of months samples. If she does not tolerate this, will consider Reclast, mammogram March 2010. stool for occult blood negativex 3. pneumovax done

Follow-Up: one month Signed By: Robert Oliverio, MD

Digitally signed by Robert Oliverio,MD
DN: cn=Robert Oliverio,MD, o, ou, email=robert.oliverio@rehmail.com, c=US
Date: 2010.03.02 09:40:05 -05'00'

S. Wilson Brief 131

Patient name Sara Wilson | Chart Number [redacted]

DOB [redacted] | Date of Visit [redacted]

Reason for visit: evaluation of multiple medical problems

Current Concerns: pleasant 66-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. We decreased her amlodipine to 5 mg p.o. daily. Her edema has resolved and Her blood pressure is excellent today.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD — Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax | flu vaccine 2007 | Colonoscopy 2006

Medications ☐ None

Meprozine 50/25	4-6 prn	Boniva 150	mo
Diazepam 2.5-5	b.i.d.	Cymbalta 60	daily
Amlodipine 5	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 10 mg	daily		
		Lidocaine patch	

Social History

☒ No ☒ current tobacco — pack-years 5
☒ prior tobacco
☒ No ☒ Alcohol — drinks per day
☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies: Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

S. Wilson Brief 132

Patient name: Sarah Wilson Chart Number: [redacted] Date of Visit: [redacted]

Review of Systems

C Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

E Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 · BP 110/60 · RR 14 · Temp [ ] · Weight 122

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid brult or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☒ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other	
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged,	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☒ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☐ Other	

Results:

Impression:

1. Hypertension-at this point, with the maintenance of excellent blood pressure control despite decreased amlodipine, we'll allow her to go off amlodipine and recheck her blood pressure on May 18.
2. Hyperlipidemia-Crestor 10 Her recent lipid profile was less than desirable. The patient should insure that she takes her medication regularly. Will recheck lipid profile in 3 months.
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy.
5. Screening-patient is up to date with colonoscopy, bone mineral density testingRevealed bone loss particularly in the hip. did not tolerate Boniva. We'll discuss Reclast at our next visit

Follow-Up: one month Signed By: Robert Oliverio, MD

Digitally signed by Robert Oliverio,MD
DN: cn=Robert Oliverio,MD, o, ou, email=robert.oliverio@rcfmail.com, c=US
Date: 2010.03.30 12:27:23 -05'00'

Patient name Sara Wilson Chart Number [redacted]

DOB [redacted] Date of Visit [redacted]

Reason for visit evaluation of multiple medical problems

Current Concerns

pleasant 66-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007,. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. We decreased her amlodipine to 5 mg p.o. daily then to off,. Her edema has resolved and Her blood pressure is excellent today. she had some night sweats and then subsequently some hematuria. She was found to have a urinary tract infection and treated with Macrobid.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax [ ] flu vaccine 2007 Colonoscopy 2006

Medications ☐ None

Meprozine 50/25	4-6 prn	Lidocaine patch	
Diazepam 2.5-5	b.i.d.	Cymbalta 60	daily
	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 100 mg	daily		

Social History

☒ No ☒ current tobacco pack-years 5
☒ prior tobacco
☒ No ☒ Alcohol drinks per day
☐ Drug Use ☐ detox

Occupation disabled data tech

☐ No Known Drug Allergies

Allergies: Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

Patient name: Sarah Wilson | Chart Number: [redacted] | Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 | BP 127/68 | RR 14 | Temp | Weight 122

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☒ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other	
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged.	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☐ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☒ Other	exophytic lesion lateral aspect right leg.

Results:

Impression:

1. Hypertension-at this point, with the maintenance of excellent blood pressure control despite cessation of amlodipine,
2. Hyperlipidemia-Crestor 10 Her recent lipid profile was less than desirable. The patient should insure that she takes her medication regularly.
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy.
5. hematuria-the patient will no longer be seeing Dr. Britton. Low her to Dr. Bradley steal.
6. Exophytic lesion right lower extremity-will refer to dermatology down town

Screening-patient is up to date with colonoscopy, bone mineral density testing. Revealed bone loss particularly in the hip. did not tolerate Boniva. Start Reclast.

Follow-Up: three months | Signed By: Robert Oliverio, M.D.

Digitally signed by Robert Oliverio, M.D.
DN: cn=Robert Oliverio, M.D., o, ou, email=Robert.Oliverio@RSFH.com, c=US
Date: 2010.05.18 11:23:19 -04'00'

S. Wilson Brief 135

Patient name Sara Wilson **Chart Number** [redacted]

DOB [redacted] **Date of Visit** [redacted]

Reason for visit evaluation of multiple medical problems

Current Concerns pleasant 66-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. We decreased her amlodipine to 5 mg p.o. daily then to off.. Her edema has resolved her blood pressure increased subsequently. We resumed 5 mg of amlodipine and her pressure has remained stable and she has had no further significant edema.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax | flu vaccine 2007 | Colonoscopy 2006

Medications ☐ None

Meprozine 50/25	4-6 prn	Lidocaine patch	
Diazepam 2.5-5	b.i.d.	Cymbalta 60	daily
amlodipine 5 mg	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 100 mg	daily		

Social History

☒ No ☒ current tobacco pack-years 5
☒ prior tobacco
☒ No ☒ Alcohol drinks per day
☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History
M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

S. Wilson Brief 136

Patient name: Sarah Wilson Chart Number: [redacted] Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 BP 127/68 RR 14 Temp [redacted] Weight 122

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☒ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other	
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged.	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☐ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☒ Other	exophytic lesion lateral aspect right leg.

Results:

Impression:

1. Hypertension-resume amlodipine,
2. Hyperlipidemia-Crestor 10 Her recent lipid profile was less than desirable. The patient should insure that she takes her medication regularly.
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy,
5. hematuria-workup was negative with the exception of urethral stenosis status post dilatation
6. Exophytic lesion right lower extremity-seborrheic keratosis

Screening-patient is up to date with colonoscopy, bone mineral density testing. Revealed bone loss particularly in the hip, did not tolerate Boniva. she is currently on Reclast.

Follow-Up: three months Signed By: Robert Oliverio, M.D.

Digitally signed by Robert Oliverio, M.D.
DN: cn=Robert Oliverio, M.D., o, ou, email=Robert.Oliverio@RSFH.com, c=US

S. Wilson Brief 137

Patient name: Sara Wilson Chart Number: [redacted]

DOB: [redacted] Date of Visit: [redacted]

Reason for visit: evaluation of multiple medical problems

Current Concerns: pleasant 67-year-old African-American female with unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. We decreased her amlodipine to 5 mg p.o. daily then to off.. Her edema has resolved her blood pressure increased subsequently. We resumed 5 mg of amlodipine and her pressure has remained stable and she has had no further significant edema. he had recent blood work done which showed improvement in her total cholesterol 194 from 220 or so in May. She also had a hemoglobin A1c done which was slightly elevated at 7.8.

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax: flu vaccine: 2010 Colonoscopy: 2010

Medications ☐ None

Meprozine 50/25	4-6 prn	Lidocaine patch	
Diazepam 2.5-5	b.i.d.	Cymbalta 60	mo
amlodipine 5 mg	daily	Crestor 10	daily
Aciphex 20	b.i.d.		daily
Premarin 0.9 mg	daily		q.h.s.
Toprol-XL 100 mg	daily		

Social History

☒ No ☒ current tobacco pack-years: 5
☒ prior tobacco
☒ No ☒ Alcohol drinks per day:
☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies: Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History:
M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

S. Wilson Brief 138

Patient name: Sarah Wilson Chart Numbe: [redacted] Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 · BP 127/68 RR 14 Temp [ ] Weight 125

☒	HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid brult or thyromegaly	☐ Other
☒	CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other
☒	Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other
☒	Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or brults	☐ Other
☒	Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other
☐	GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other
☐	Pap done ☐ Breast Exam Normal	☐ Other
☐	Prostate: Non-nodular not enlarged.	☐ Other
☐	Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other
☒	Neuro: Alert and oriented times three, grossly nonfocal	
☐	Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☐ Other

Results

Impression:

1. Hypertension- amlodipine 5 keeping bp under control,
2. Hyperlipidemia-Crestor 10 repeat FLP
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy.
5. hematuria-workup was negative with the exception of urethral stenosis status post dilatation
6. hemoglobin A1c. We will check hemoglobin A1c today with blood sugar.

Screening-patient is up to date with colonoscopy, bone mineral density testing. Revealed bone loss particularly in the hip, did not tolerate Boniva, she is currently on Reclast.

Follow-Up: three months Signed By: Robert Oliverio, MD

Digitally signed by Robert Oliverio, MD
DN: cn=Robert Oliverio, MD, o, ou, email=Robert.oliverio@RSPH.com, c=US
Date: 2010.11.08 11:25:52 -0500'

S. Wilson Brief 139

Patient name Sara Wilson Chart Number [redacted]

DOB [redacted] Date of Visit [redacted]

Reason for visit evaluation of multiple medical problems

Current Concerns

pleasant 67-year-old African-American female with bronchitis, treated both times with the azithromycin. She is now approximately one week after institution of treatment. she continues to have intermittent cough, and some chest tightness and mild fevers. She has an unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. We decreased her amlodipine to 5 mg p.o. daily then to off.. Her edema has resolved her blood pressure increased subsequently. We resumed 5 mg of amlodipine and her pressure has remained stable and she has had no further significant edema. he had recent blood work done which showed improvement in her total cholesterol 194 from 220 or so in May. She also had a hemoglobin A1c done which was slightly elevated at 7.8. she has been taking metformin only intermittently. She is status post partial colectomy for diverticular disease. Repeat colonoscopy was largely unrevealing, however, abdominal CT scan showed evidence of possible stricture. She is to have a repeat colonoscopy in the future

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax flu vaccine 2010 Colonoscopy 2010

Medications ☐ None

Meprozine 50/25	4-6 prn	metformin 500	daily
Diazepam 2.5-5.	b.i.d.	Cymbalta 60	daily
amlodipine 5 mg	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 100 mg	daily		

Lidocaine patch

Social History

☒ No ☒ current tobacco pack-years 5

☒ prior tobacco

☒ No ☒ Alcohol drinks per day

☐ Drug Use ☐ detox

Occupation disabled data tech

☐ No Known Drug Allergies

Allergies: into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History:
M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

Patient name: Sarah Wilson | Chart Number: [redacted] | Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 | BP 127/68 | RR 14 | Temp | Weight 125

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid bruit or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☐ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☒ Other	slight rhonchi left base
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or bruits	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged.	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☐ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☐ Other	

Results:

Impression:

recurrent bronchitis-still with some mild rhonchus breath sounds left base. A chest x-ray. Start Mucinex. If any evidence of infiltrate or bronchial thickening, will try Avelox1. Hypertension- amlodipine 5 keeping bp under control,
2. Hyperlipidemia-Crestor 10 repeat FLP
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy.
5. hematuria-workup was negative with the exception of urethral stenosis status post dilatation
6. DM - he is taking the metformin intermittently. I would recommend taking daily. She is concerned about relative hypoglycemia but the good thing about metformin is the doesn't cause hypoglycemia
possible colonic stricture-repeat colonoscopy to be rescheduled after her current illness resolves

Follow-Up: as scheduled | Signed By: Robert Oliverio, MD

Digitally signed by Robert Oliverio, MD
DN: cn=Robert Oliverio, MD, o, ou, email=Robert.oliverio@RSFH.com, c=US
Date: 2011.01.28 10:31:45 -05'00'

S. Wilson Brief 141

Patient name Sara Wilson | **Chart Number** [redacted]

DOB [redacted] | **Date of Visit** [redacted]

Reason for visit Follow up

Current Concerns

pleasant 67-year-old African-American female with recent pneumonia s/p clarithromycin and doing much better., She has an unfortunate history of traumatic injury to the cervical spine 5/2006 with subsequent radiculitis in the bilateral upper extremities and pain now status post anterior approach cervical fusionApril 2007.. She also has a history of hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) and fibrocystic breast disease. she's had problems with lower extremity edema on amlodipine 10. We decreased her amlodipine to 5 mg p.o. daily then to off.. Her edema has resolved her blood pressure increased subsequently. We resumed 5 mg of amlodipine and her pressure has remained stable and she has had no further significant edema. he had recent blood work done which showed setting of her cholesterol with an LOL of 174. She has been taking her cholesterol medication intermittently do to proceed headache. Now she takes it with meals and feels better is taking it daily. She also had a hemoglobin A1c done which was slightly elevated at 7.4. She is status post partial colectomy for diverticular disease. Repeat colonoscopy was largely unrevealing, however, abdominal CT scan showed evidence of possible stricture. She is to have a repeat colonoscopy in the future

Past Medical History ☐ None

- ☐ HTN
- ☐ CAD — Prior MI
- ☐ Diabetes
- ☐ COPD/Asthma
- ☐ HLP

other: hyperlipidemia, hypertension, arrhythmia (unclear as to etiology) fibrocystic breast disease IBS Diverticulitis

Past Surgical History ☐ None

c-section
anterior approach cervical spine procedure 4/28/07
hysterectomy
ullateral R oopherectomy
lap chole
L breast lumpectomy 2006
Lumbar block
partial colectomy diverticulitis

Pneumovax | flu vaccine 2010 | Colonoscopy 2010

Medications ☐ None

Meprozine 50/25	4-6 prn	metformin 500	daily
Diazepam 2.5-5	b.i.d.	Cymbalta 60	daily
amlodipine 5 mg	daily	Crestor 10	daily
Aciphex 20	b.i.d.		q.h.s.
Premarin 0.9 mg	daily		
Toprol-XL 100 mg	daily		

Lidocaine patch

Social History

- ☒ No ☒ current tobacco — pack-years 5
- ☒ prior tobacco
- ☒ No ☒ Alcohol — drinks per day
- ☐ Drug Use ☐ detox

Occupation: disabled data tech

☐ No Known Drug Allergies

Allergies: Into. to Darvon Lortab sulfa aspirin percocet allerg to penicillin/Keflex, omeprazole, lyrica ACEI

Family History: M- deceased sepsis, cancer unknown primary
F- unknown
1 bro, dm
1 bro colon cancer

Patient name: Sarah Wilson Chart Number: [redacted] Date of Visit: [redacted]

Review of Systems

○ Denies headaches, visual changes, double vision, neck swelling, sore throat, chest pain, palpitations, dizziness or loss of consciousness, shortness of breath, cough or wheezing, abdominal pain, nausea, vomiting, bright red blood per rectum or dark tarry stool, heartburn, difficulty swallowing, urinary frequency, burning, pain, incontinence or hesitancy. Denies focal weakness, seizures, numbness or tingling. Denies significant weight gain, weight loss, fatigue, fevers or sweats

◉ Negative As above with the Exception of the Following: denies chest pain palpitations significant shortness of breath

Physical Exam

Pulse 70 BP 127/68 RR 14 Temp [redacted] Weight 125

☒ HEENT: Normocephalic, atraumatic PERRLA/EOMI EAC clear, TM intact, pharynx clear,neck supple, no JVD carotid brult or thyromegaly	☐ Other	
☒ CV: Regular rate and rhythm, normal S1, normal S2, PMI nondisplaced, no murmurs, rubs or gallops	☐ Other	
☒ Lungs: Clear to auscultation, percussion, no wheezes, rales or rhonchi, good air movement bilaterally	☐ Other	
☒ Abdomen: Soft, non tender, bowel sounds positive, no hepatosplenomegaly, no abdominal masses or brults	☐ Other	
☒ Extremities: No cyanosis, clubbing or edema. Peripheral pulses are two plus bilaterally in the upper and lower extremities.	☐ Other	
☐ GU: ☐ normal male external genitalia, no testicular masses, no penile lesions, no hernias noted ☐ normal female external genitalia, no vaginal lesions, no cervical lesions, no discharge.	☐ Other	
☐ Pap done ☐ Breast Exam Normal	☐ Other	
☐ Prostate: Non-nodular not enlarged.	☐ Other	
☐ Rectal: Heme-negative brown stool in vault, normal tone,	☐ Other	
☒ Neuro: Alert and oriented times three, grossly nonfocal		
☐ Derm: No abnormal rashes, malignant appearing lesions or significant skin changes	☐ Other	

Results:

Impression:

recent pneumonia-clinically resolved. Check x-ray for cure
-1. Hypertension- amlodipine 5 keeping bp under control,
2. Hyperlipidemia-Crestor 10 repeat FLP 3 months, taking Crestor daily
3. GERD-stable on Aciphex
4. status post spinal surgery-continue physical therapy,
5. hematuria-workup was negative with the exception of urethral stenosis status post dilatation
6. DM - he is taking the metformin intermittently. I would recommend taking daily. She is concerned about relative hypoglycemia but the good thing about metformin is the doesn't cause hypoglycemia. Recheck hemoglobin A1c in 3 months
possible colonic stricture-repeat colonoscopy March 1

Follow-Up: three months Signed By: Robert Oliverio, MD

Digitally signed by Robert Oliverio, MD
DN: cn=Robert Oliverio, MD, o, ou, email=Robert.oliverio@RSFH.com, c=US
Date: 2011.02.18 12:43:44 -05'00'

S. Wilson Brief 143

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

SARA T. WILSON, Employee/Claimant,	H.C.C. File No. [redacted]
vs.	DEPOSITION OF:
CHARLESTON COUNTY SCHOOL DISTRICT, Employer, and CHARLESTON COUNTY SCHOOL DISTRICT, Carrier, Defendants.	JAMES K. AYMOND, M.D.

DATE: Tuesday, September 11, 2007
TIME: 5:35 p.m.
LOCATION: Orthopaedic Specialists of Charleston, PA
2093 Henry Tecklenburg Drive
Suite 200 East
Charleston, South Carolina 29414
REPORTER: Deborah Horsley

DEBORAH HORSLEY
Independent Contractor working in association with
Millligan Court Reporting
Telephone: 843.971.5557 Fax: 843.971.6599
Email: hilligans@comcast.net

COPY

APPEARANCES

For the Employee/Claimant: The Spann-Wilder Law Firm, LLC
By: Tiffany H. Spann-Wilder, Esquire
1831 Dorchester Road
N. Charleston, South Carolina 29405

For the Employer/Carrier: Young Clement Rivers, LLP
By: Leslie M. Whitten, Esquire
25 Broad Street
Charleston, South Carolina 29401
29402

Also Present: Ms. Wilson

INDEX TO EXAMINATIONS:

	Page
Direct Examination by Ms. Whitten	3
Cross-Examination by Ms. Spann-Wilder	14

INDEX TO EXHIBITS:

Plaintiff's Exhibits:

1.	Physical Therapy Records	17

It was stipulated by and between counsel for the parties that this deposition is taken for the purpose of discovery; that all objections, save as to the form of the question, are reserved until the time of trial; that the deponent was explained his right to read and sign the deposition and waived that right.

(JAMES K. AYMOND, M.D., being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MS. WHITTEN:

Q. Dr. Aymond, we just met. My name is Leslie Whitten. I'm the attorney for the Charleston County School District in the workers' compensation claim of Ms. Sara Wilson. I really don't think this is going to take very long. I just have a few questions. Then we should be done.

A. Okay.

Q. And just the normal run of the mill stuff. Can you give me your background information?

A. I completed my medical degree at LSU School of Medicine in Shreveport, Louisiana in 1986. I did an orthopaedic surgery rotation -- or residency at Duke University '86 to '92 and did a spine fellowship at Vanderbilt Hospital in Nashville, Tennessee to 1993 and began practice here in 1993 with pretty much the same

group of physicians, and I've been here for 14 years and board certified in orthopaedic surgery with a -- I devote most of my practice to problems with neck and back problems.

Q. Okay. Have you had an opportunity to meet and treat Sara Wilson?

A. Yes, I have.

Q. When is the first time you saw her?

A. I saw Ms. Wilson the first time in mid-January of '07.

Q. Okay. And have you had an opportunity to review medical records from her May 9, 2006, accident that were prior to her visit with you? Do you have those?

A. I mostly have MRI scan reports. That was the main thing I believe that came with her. One was an MRI scan that was performed in May of '06.

Q. Okay. Well, then just for the purpose of this deposition, if we can assume that there is not any documentation or any complaints of low back pain prior to November 3rd, 2006, when she had a visit with Dr. Stovall, would that have any -- would that be significant to you in considering whether her low back pain is related to her work injury of May of 2006?

A. I'm sorry, when was the date of the Dr. Stovall visit?

Page 6

Q. It was November 3rd, 2006, and I have a copy of that if you want to look at it.

A. November of 2006?

Q. Correct. Actually -- yeah, that's right. I'm just looking at the wrong record right now.

A. Well, I have in my notes that she had an independent medical evaluation by Stovall some time in '06. That must have been that visit.

Q. Okay. And I have a copy if you want to review it, but assuming that that is the first real mention of low back pain, would that have any affect on your opinion as to whether it might be related to her workers' comp injury?

A. If it was the first complaint at that time, I would assume that -- I would say that within a reasonable degree of medical certainty complaints of low back pain may have been related to her incident in May of '06.

Q. Okay. Let's go on to the rest of your records. January 16th, 2007, what problems did she present to you with?

A. Her main complaint was of back of the neck pain as well as pain into her right arm and shoulder and as well as complaints of lower back pain and posterior buttock pain or bilateral hip pain.

Page 7

of '07, January 25th.

Subsequent to that, I talked to Ms. Wilson about options for her neck as this was a treatable problem, whereas her lower back, there really wasn't much in the way of any kind of injection intervention or surgical intervention that would help her. And we had recommended that she consider surgery for her cervical disc problem between the 6th and 7th vertebrae, and we were able to get that arranged and performed this in late March, so the next time I saw her was immediately after surgery, April 6th of '07.

Q. Okay. And I, for some reason, do not have that note with me. Is there any mention in that note of her complaints about her low back at that point or any recommendations for it?

A. At that time, again, she was nine days out from surgery. She was doing well and not having any further pain in her right arm. She was having some pain between her shoulder blades, and that was not unusual, and she was also complaining of -- continued complaints of lower back pain as well as pain into her hips.

Q. Okay. And did you have any recommendations as far as her low back on that day?

A. No, ma'am.

Q. Okay. And is the next time you saw her April

Page 8

A. And at that point what did you think was the cause of her lower back pain and buttock pain?

A. Well, after her exam, she -- Ms. Wilson did have some -- some plain X-rays of her lumbar spine and thoracic spine from May 20 of 2006, and these revealed a curvature of her back both in the mid part and as well as the lower back, and that's the only films or studies that we had of her lower back at that time. She did have an MRI scan in June -- or July of '06, that revealed a disc problem between the 6th and 7th vertebrae of her cervical spine.

Q. Okay. So did you order an MRI of her lumbar spine at that point?

A. Yes, we did.

Q. Okay. And was the lumbar spine MRI consistent with the complaints that she had to her hips and with scoliosis?

A. Yes. I mean, the MRI scan showed some facet changes, or some of the small joints of the lower back had some arthritic changes in them. There was no evidence of narrowness of the spinal canal to any specific degree that we felt that any form of surgery would be greatly helpful for that.

Q. And when is the next time that you saw her?

A. We saw her for the MRI scan results in January

Page 9

27th?

A. Yes.

Q. Okay. And what were your recommendations for her as far as her low back was concerned on that day?

A. Low back, she was having complaints of lower back pain. Again, the previous MRI scan had revealed facet arthritis but no evidence of a disc herniation or narrowness of the spinal canal. We recommended that we would have her undergo a trial of physical therapy for both her neck at one month out from surgery as well as her lower back.

Q. Do you know if she got physical therapy to her lower back?

A. I don't have any of the therapy notes in the chart.

Q. All right. And when was your next visit with her?

A. The next visit was about six weeks later. This was June 8th of 2007, at which time Ms. Wilson was about two and a half months out from her neck surgery.

Q. Okay. And I, for some reason, don't have that note either. Can you just let me know if there was any reference to her low back on that day?

A. My notes say that overall she was doing quite well. She was having less of the pain in the back of

Page 9

the neck and had some improvement to her lower back as well. She was also given exercises to be done at home, and through the therapist's notes was recommended to be released to perform her exercises at home. She had X-rays done of her neck at that time and was showing good healing at two and a half months out from her fusion, and she was to remain on sedentary activities and was to follow-up with me approximately five or six weeks later.

Q. Okay. Now, is your understanding that the improvement in her low back was due to the physical therapy?

A. It could be that. It could be time or could have just had a good week. I mean, some people have good improvement of symptoms for awhile, and then they come back and say well, not long after I saw you, I started having my usual pain.

Q. Okay.

A. So that can wax and wane.

Q. And is the next time that you saw her July 20th?

A. Yes, July 20th was the next time I saw Ms. Wilson, and at that time she was four months out from surgery.

Q. Okay.

A. And she was not having any particular neck

Page 10

discomfort. She was having some degree of lower back discomfort secondary to the moderate arthrosis of the facet joints of the lower lumbar spine. And we performed some X-rays of her cervical spine, and this revealed a complete -- a complete fusion of the level where we had done her surgery.

Q. Okay. And what was your recommendation at that point as far as for her lumbar?

A. Mostly -- I didn't particularly address that at the time of her last visit, but mostly it was what we had recommended before was to do the exercises at home.

Q. Okay. There is some mention in your report about facet injections. Are you recommending those at this time?

A. I'm sorry, you know, one option that we did talk about as far as a little bit more of an invasive option other than physical therapy would be if she had either pain that worsened or pain that she wished to try to handle in a different way other than therapy, facet injections would be an option. That's an injection procedure performed by the anesthesia physician that inject these small arthritic joints with a combination of a local anesthetic and a steroid medicine in an attempt to decrease inflammation and help pain.

Q. Okay. Now, you stated earlier that you didn't

Page 11

feel that it would warrant injections. Is there something that changed between the first time that you saw her and then in July, or are you just talking down the road if her back gets worse, that may be something that you recommend?

A. Right. My note said that I will plan to have her notify us if she desires to proceed with these injections. So if her symptoms were to worsen or if she decided to have them, we could do it at any time.

Q. Okay. Are you aware of whether she's contacted your office since July 20th?

A. I'm not -- I'm not aware of it.

Q. All right. And is it fair to say that her underlying condition is arthritis?

A. Yes, from the MRI scan report performed January of '07, the patient had evidence of facet arthropathy, which is degeneration of the facet joints at the L4-L5 and L5-S1 level. Also, some thickening of the ligaments that run between the vertebrae, and that's also a sign of degeneration. That's not usually an acute sort of finding after an injury to a disc, so I think Ms. Wilson had some pre-existing arthritis of her back, and this was aggravated with her work-related injury as best I can tell.

Q. Okay. Are you able to determine to a reasonable

Page 12

degree of medical certainty of whether she would have needed the same treatment like the physical therapy and things like that without the work-related injury?

A. I would say barring any other incident or so, I would say that yes, the physical therapy and the treatment that she had would be necessary because of this incident.

Q. Okay. Now, you stated earlier that even if November 3rd, 2006, was her first mention of low back, you would still say that it was work related. What's the basis for that opinion, or maybe I misunderstood what you said earlier?

A. I'm not sure of your question.

Q. Sure. Let me back up. If November 3rd, 2006, is the first time that there's any real mention of low back pain, do you still feel that there was -- that there's an aggravation of her work injury that caused -- I mean, that her work injury aggravated the arthritis in her low back?

A. Well, all I can truly say is that her complaints were after the accident. I don't know if notes from other physicians at Doctor's Care, Dr. Clare, I don't -- I never had those to look at, and I don't know if they mentioned any degrees of back problems at that point. So using the fact that she hurt her back in May,

Page 13

and then, you know, some time later, four or five -- five or six months later she has documentation by Dr. Stovall that she began having back pain some time in the interim, that's fairly good information and the fact that she has never had -- never had any back problems prior.

Q. Okay. Can someone develop low back pain with arthritis without a precipitating event?

A. Yes.

Q. Do you have an opinion to a reasonable degree of medical certainty as to whether she's at maximum medical improvement regarding her lumbar spine?

A. With the exception of what we had talked about before regarding the injections, I would say yes.

Q. Okay. And that would be only if she were to get worse?

A. That's correct.

Q. Okay. And are you able to provide an impairment rating regarding her lumbar spine at this point?

A. I would probably say on the order of say 8 percent is what the Fifth Edition Guide to the Evaluation of Permanent Impairment may say. Along there.

Q. Okay. And would that be to the whole person?

A. Yes.

Page 14

Q. And does she have any permanent restrictions that you would give her regarding her lumbar spine?

A. Usually the things that aggravate these facet joints and lower back problems are repetitive bending and twisting. Those are the main things.

Q. Okay. Do you have her on any continuing medication for either her neck or her back, low back?

A. I don't think so.

Q. All right. I think that's all I've got.

CROSS-EXAMINATION BY MS. SPANN-WILDER:

Q. I think I have -- I won't say I just have one question. I've been warned about that.

MS. SPANN-WILDER: And we can make a copy for the record.

BY MS. SPANN-WILDER:

Q. Dr. Aymond, I'm going to pass that to you, notes from June 13th, '05, and June 15th, '05, from it looks like Private Therapy Services and give you a chance to look at those.

(Whereupon there was a pause in the proceedings.)

A. Okay.

Q. Okay. And, Dr. Aymond, based on those notes, who was the referring physician for that therapy?

A. Let's see, on one page it says Physicians Dr, Dennis.

Page 15

Q. Okay. And from those records, those notes, is there any mention about low back?

A. On the -- let's see. On the Physical Therapy Assessment not really anything regarding lower back, but the next page dated the same date, there's a treatment note. Subjective complaints is of neck, shoulder, and lower back and arm pain and leg pain after being it says here crunched by students that were fighting, so this was of the time of her injury in May of '05. So that's the first reference or mention to lower back and leg symptoms on the June 13th note.

And the note two days following that, 6/15/05, the subjective portion of the note, meaning what the patient states at the time of her visit, is complaining of neck and back or complaining of pain in neck and back. The plan was to continue with -- I think that means plan of care, which is the physical therapy on the second visit I assume.

And then the third note of 6/27/05, which I'm not too sure if that's the third visit or maybe one in between was not given, patient states that she was getting worse. Patient had been seen for three visits with almost two weeks between the last two sessions. The complaints there were mostly of I think more in the form of neck pain. No real mention of lower back on that last note of 6/27/05.

Page 16

Q. Okay. Thank you. Now, Ms. Whitten asked you about November, a mention of it, and your testimony was that you could link it to the accident; is that correct, this injury?

A. Yes.

Q. Okay. And so with these notes one month out from the injury, I'm assuming your opinion would still be the same?

A. That's correct.

Q. Okay. Now, there was a -- there was mention of low back, and then a focus to cervical. Is it normal to see patients kind of shift to areas that are more troublesome at times than other body parts?

A. Yes, I would say that, as well as there can be another shift of priorities also based on what can be done for a certain problem.

Q. Now, I think in the records of your treatment of Ms. Wilson, it was noted that she had -- or some treatment of scoliosis?

A. Yes.

Q. Okay. Does that at all factor into the issue she's experiencing with the lumbar spine?

A. I think to a small degree it is because of the

curvature of the mid-back and also of the lower back. It is another pre-existing thing that probably may be the culprit of the arthritis of the small joints in the back. So scoliosis can at a later age cause degeneration of these joints, and even though the curvature may not be of a severe degree, it can still lend itself to having more arthritis of the lower back.

Q. And to your knowledge has she had any treatment for the scoliosis, or have you provided that?

A. No.

Q. And is the scoliosis of the nature that she is in need of treatment for that?

A. I would not recommend any formal treatment of the scoliosis. Most likely it's a stable curvature, and any treatment would involve fusing basically the entire mid and lower back.

Q. I have no other questions.

MR. WHITTEN: I'm done.

(PHYSICAL THERAPY RECORDS MARKED FOR IDENTIFICATION AS PLAINTIFF'S EXHIBIT NO. 1.)

(Deposition concluded at 5:57 p.m.)

STATE OF SOUTH CAROLINA)
) C-E-R-T-I-F-I-C-A-T-E
COUNTY OF CHARLESTON)

I, Deborah Horsley, Court Reporter and Notary Public, certify that I did have James K. Aymond, M.D. to appear before me at 5:35 p.m. on Tuesday, September 11, 2007, at the Medical Offices of Orthopaedic Specialists of Charleston, PA, 2093 Henry Tecklenburg Drive, Suite 200 East, Charleston, South Carolina; that the witness was sworn and cautioned to tell the truth, the pages constitute a true and accurate transcript of the testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 18th day of September, 2007.

Deborah Horsley
Notary Public for South Carolina
My Commission Expires 12/29/2009

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION CO[redacted]

SARA Y. WILSON, Employee/Claimant,	H.C.C. File No. [redacted]
vs.	DEPOSITION OF:
CHARLESTON COUNTY SCHOOL DISTRICT, Employer, and CHARLESTON COUNTY SCHOOL DISTRICT, Carrier, Defendants.	SARA Y. WILSON

DATE: Tuesday, January 23, 2007
TIME: 10:11 a.m.
LOCATION: The Spann-Hilder Law Firm, LLC
2131 Dorchester Road
N. Charleston, South Carolina 29405
REPORTER: Deborah Horsley

DEBORAH HORSLEY
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COPY

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INDEX TO EXAMINATIONS:

	Page
Direct Examination by Ms. Whitten	3
Cross-Examination by Ms. Spann-Hilder	36

INDEX TO EXHIBITS:

No exhibits were proffered during this deposition.

It was stipulated by and between counsel for the parties that this deposition is taken for the purpose of discovery; that all objections, save as to the form of the question, are reserved until the time of trial; that the deponent was explained her right to read and sign the deposition and reserved that right.

(SARA Y. WILSON, being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MS. WHITTEN:

Q. Ms. Wilson, my name is Leslie Whitten. I'm an attorney downtown at Young Clement Rivers. I represent the school district in your claim, and I'm just here to find out about your injury and how you've been doing since then. Have you ever had your deposition taken before?

A. No, ma'am.

Q. Okay. Just a couple of things you want to keep in mind. One is that this court reporter here is taking down everything that we say, and she can't take down if you shake your head or nod your head. It's also hard when this gets in written form to tell the difference between uh-huh and huh-uh, so if you can just keep that in mind and try to say yes or no, that would be helpful.

A. Okay.

Q. Also, if I ever ask you something, and you don't understand, just ask me to repeat it or rephrase it, and I'll be happy to do that. And I'll assume that if you've answered my question, that you've understood it; is that fair?

A. Yes.

Q. Please state your full name for the record?

A. Sara Y. Wilson.

Q. What does the "Y" stand for?

A. Young, Y-O-U-N-G.

Q. Where do you live?

A. 126 West Poplar Street, Charleston, South Carolina 29403.

Q. And how long have you lived at that address?

A. I've been there since 1996, so 11 years.

Q. Okay. How old are you today?

A. Pardon?

Q. How old are you?

A. I am 63 years old.

Q. And what's your date of birth?

A. 10/27/43.

Q. Are you married?

A. I'm a widow.

Q. Okay. Do you have any kids?

A. One daughter.

Page 5

Q. What's her name?
A. Her name is LaToya. It's capital L-A, capital T-O-Y-A.
Q. And how old is LaToya?
A. LaToya is 36.
Q. Does anyone live with you?
A. No.
Q. Does anyone depend on you for income?
A. No, ma'am.
Q. Okay. How far did you go in school?
A. I graduated from high school, and I've had two years of college.
Q. Okay. What high school did you go to?
A. Burke High School.
Q. Okay. And what year did you graduate?
A. 1961.
Q. And when you went to college, you went right after high school?
A. No.
Q. When was that that you went to college?
A. I went to the College of Charleston in 1990, but prior to that, I went to Palmer Business -- Palmer Business School, Business College.
Q. Okay. Do you have a certificate or a degree or anything like that?

Page 6

A. No, I don't.
Q. What kind of classes did you take at those two places?
A. At Palmer I took just basic office, typing, bookkeeping. At the College of Charleston I took computer courses, and there was another course, but I can't remember exactly what the name of it was, but I took two courses.
Q. Okay. Any other education that we haven't talked about?
A. No. Huh-uh.
Q. Were you ever in the military?
A. No, I wasn't.
Q. Ever convicted of a crime?
A. No.
Q. Prior to working at the school district, what kind of jobs did you have?
A. I worked for the Department of Commerce under a -- it was sort of like getting you prepared for a job. I worked there for a year. It was like a training program. That's what it was, a training program --
Q. Okay.
A. -- for a year at the Federal Building on Meeting Street. When I left there, they did not have any openings, so I went to Southern Bell, and I worked as a

Page 7

telephone operator.
Q. Okay.
A. And from there, I went to Sears Roebuck, and I worked there as a -- I started off in customer service. By the time I left, I was a trainer. I worked in customer service, a cashier, gift wrapping, which was the parts -- the parts department, and credit department.
Q. Okay. Is that pretty much all your jobs?
A. Yes, until I went to work for Charleston County.
Q. Okay. And other than the accident we're talking about today, have you ever had any other workers' compensation claims?
A. Back in the '80's, and this date I want to say it had to be the '89's because I started working for Charleston County in '85, '86 as a substitute teacher.
Q. Okay.
A. I was working in kindergarten. And at the end of the day we had the students in the center, and two of the little boys pushed a shelf while I was cleaning the desk, and they pushed a shelf on my back.
Q. Okay. What kind of treatment did you get for that?
A. They took me to the hospital, and I was treated and released.

Page 8

Q. Okay. What part of your back was it?
A. The shelf just came down.
Q. Okay.
A. I was leaning over the table.
Q. Okay.
A. So the shelf came down.
Q. Like in the middle of your back, or do you remember?
A. I don't remember.
Q. Okay. So other than that one visit, you didn't get any treatment for that?
A. I can't remember. I really -- I can't remember.
Q. Did you have any problems with your back after that happened?
A. No.
Q. Okay. Is that the only other workers' comp claim?
A. Yes.
Q. Have you ever been in a car accident where you were hurt?
A. Yes.
Q. Okay. When was that?
A. I can't -- I can't tell you. I don't remember.
Q. Okay. Was it before or after this accident in the '80's?

A. It was a long time ago.
Q. Okay. Do you know what parts of your body were hurt?
A. No, I don't.
Q. Okay.
A. It was in a taxicab, my husband, my daughter, and myself.
Q. Okay. Do you know if you had any long-term problems after that?
A. No, I didn't.
Q. Okay. Have you ever been involved in a lawsuit?
A. No, I haven't.
Q. Have you ever filed for short-term or long-term disability benefits?
A. Short-term or long-term disability?
Q. Like if you had to go out of work for something that wasn't a work injury? Like some other health problem that you needed to be out of work for that you'd get paid while you were out?
A. I have a short-term insurance --
Q. Okay.
A. -- that if I'm ill, and I'm out like seven days, then I can file a claim if that's what you're pertaining to.
Q. Right. Have you ever used that?

A. I've used that. Yes, I have.
Q. When did you use that?
A. I don't remember.
Q. Okay. In the past several years, have you used it?
A. I really don't remember.
Q. Okay. Let me ask it this way. Have you ever had problems with your neck or your shoulder before?
A. My neck, no. My shoulder, as far as the type of pain that I'm having now, no.
Q. Okay. What kind of pain have you had in your shoulder before?
A. Like sometimes, you know, if you lie on your arm or something like that, I might feel a little bit of a discomfort.
Q. Okay.
A. But not like it's now.
Q. Okay. Did you ever see a doctor for your neck or your shoulder before this happened?
A. My medical doctor had given me a shot in my shoulder before when I was -- I went in there, and I told him that I had had some pain in my shoulder, and he gave me a shot.
Q. And who is that doctor?
A. Dr. Clare, H. Pettigrew Clare, Sr.

Q. Okay. Did he ever take any X-rays or MRIs of your shoulder?
A. No.
Q. Did he or any other doctor ever tell you that you had arthritis or bursitis or anything like that?
A. I was told that recently --
Q. Okay.
A. -- that I had arthritis.
Q. Okay. Was that before or after this accident?
A. That was after the accident.
Q. Okay. Have you ever filed for unemployment benefits?
A. Yes.
Q. Okay. Have you done that since this accident?
A. No.
Q. Okay. Have you filed for Social Security or Medicare benefits?
A. Social Security.
Q. Okay. Are you on Social Security?
A. Just the regular State Social Security.
Q. Okay. And what about --
A. I'm sorry, regular -- it's regular Social Security, state retirement.
Q. Okay. Now, if you have to go to the doctor for the flu or something like that, would Social Security or

Medicare pick that up?
A. I don't have Medicare. I have health insurance.
Q. Okay. And who is your health insurance with?
A. Blue Cross-Blue Shield State.
Q. Okay. And is that from working with the school district?
A. Yes.
Q. All right. When did you first start working at the school district?
A. I started working with the school district in '05, '06 as a substitute teacher.
Q. And what job were you doing when you got hurt?
A. Data technician, data -- student data clerk. There are three names. It's a data tech, student data clerk, or a data entry clerk, either one of them.
Q. Okay. And what does a data entry clerk do?
A. Basically I keep all data on students as well as teachers. I do reports. I take the attendance. My job did not only consist of that. I went to work at 7:00 in the morning, and I worked in the main office until about 9:00 or 9:30 answering the phone, registering students, or whatever the principal needed me to do. Then sometimes I was able to get to my office by 10:00. I was supposed to be there at 8:30, but about 10:00 I would sometimes get to my office, which was across --

Page 13

excuse me, across the hall.
Q. Okay.
A. I had to do quarterly reports. Every day I had to check to see whether there were any errors, whether there was anything on the e-mail that needed to be put into the computer. I relieved for lunch. I did secretarial duties. I did bulletin boards.
Q. Okay. How much of your day would be spent standing up?
A. I would say maybe -- let me estimate this. About three hours a day.
Q. Okay.
A. The rest of the time would be up and down, sitting, getting up to get something because if I have to get something from the printer, I would have to go across the room and get it.
Q. Okay. And was your supervisor the principal?
A. Yes.
Q. And who was the principal?
A. William Dixon.
Q. What school was this at?
A. James Simons Elementary.
Q. And how long did you work for William Dixon?
A. He came there in October of 2005.
Q. Okay.

Page 14

A. Yes, 2005.
Q. And how much money were you making when you were working there right before your accident; do you remember?
A. I'm going to estimate. Maybe 26 to 27,000.
Q. Okay. How, did you get paid year round or just when school was in?
A. No, I got paid year round, and I was a ten month employee.
Q. Okay. I'm going to show you something that's called a Form 20. It's something that the school district filled out where you can see that they said in the year before your injury, you made a total of a little over $26,000, which averaged out to per week before taxes $502.87 a week. Does that sound like it's right?
A. Yes, it's pretty close. Yeah, I would say yes.
Q. Okay. How, did you work anywhere at the same time that you worked at the school district?
A. Did I work anyplace else?
Q. Right.
A. No, ma'am, I didn't.
Q. And when is the last date that you worked there?
A. May the 9th of 2006.
Q. And is that the day you got hurt?

Page 15

A. Yes.
Q. Okay. Tell me about that. What happened?
A. I was working in my office, and it was about 12:50. We were doing PACT. I came into the main office to look at the attendance cards because there was some children that had been marked absent that were present that day. When I got the cards, I was standing in the office behind the counter. I was towards the end of the counter.
There was another teacher in there with some students and the secretary. There were two boys in there. One was on the outside of the gate, and one was on the inside of the gate. They were tagging back and forth. I moved a little bit further towards the middle of the counter, and I continued to do what I was doing.
The young man on the outside of the gate pushed the young man on the inside of the gate against the wall. He just reached over and pushed him, and he hit the wall. At that time -- let me back up. The young fellow on the inside was trying to keep the one on the outside out, so he pushed him, and he fell against the wall.
At that time the one from the outside came in. When he came in, they started shoving back and forth. I turned around, and I said you all need to stop that. I

Page 16

asked the secretary, I said does Mr. Dixon know that they're out here? She said that he was in there with his mentor.
I turned back around to gather my things because I was trying to get out of the way. By this time, I was facing a teacher. We were talking during this time. She was telling me why she had the other boys in there. The next thing I knew, I heard myself scream. I was pinned against the counter on my right side. I was twisted, and I didn't know whether I had hit my head or not. I hit my arm, my right arm, my chest, my side, and my thigh.
Q. Did you fall onto the ground?
A. I didn't know whether I did or not. I found out later on that I didn't.
Q. Okay.
A. They said some boxes kept me from falling. That is what was told to me --
Q. Okay.
A. -- because I inquired as to whether I had hit my head or not because I had this terrific headache, and I wanted to know if I hit my head. And I inquired about it, and they said that some boxes kept me from hitting the floor.
Q. And who is this?

Page 17

A. The secretary.
Q. And what is the secretary's name?
A. Tolaina Jefferson, and I also asked another lady, which her name is Glenda Brown, whether I hit my head, and she said she didn't think so.
Q. Okay. And immediately after this happened, you had a headache. What else was bothering you?
A. The part --
Q. Other than the headache you had.
A. Yeah, the part that I just told you, which is my arm. I had spasms in my chest, my side, and my thigh. I had just had surgery on my side to have a mole removed, and it was deeper than they thought it was, and I was -- I was fearful of that because I didn't know whether I had reinjured that or not.
Q. Okay. And your side and your thigh, this is on the right side?
A. On the right side, yes.
Q. All right. What happened? Did somebody take you to the doctor?
A. Yes, the nurse took me to the emergency room.
Q. Okay. And what did they do for you in the emergency room?
A. They took X-rays of the parts that I told them that was bothering me. They gave me some pain medicine,

Page 18

and they told me to follow-up with my doctor in a couple of days. I was pretty bruised. I was very painful, and like I said before, I had spasms in the chest. After they released me, I went home.
Q. And when did you go to a doctor next?
A. On the 12th.
Q. Who did you go to then?
A. I went to my personal doctor.
Q. And that was Dr. Clare that you were talking about before?
A. Yes.
Q. And what did Dr. Clare do for you?
A. Dr. Clare called Roper to get the report. He took a urinalysis. He ordered an ultrasound, and there was blood, and I had a hematoma.
Q. Where was the hematoma?
A. I believe it was on my kidneys.
Q. Okay. Did Dr. Clare recommend doing anything for that?
A. No, he didn't.
Q. Did he recommend anything else at that point?
A. Not at that point, no.
Q. Okay. When is the next time you went to a doctor?
A. I went to Dr. Clare again on the 18th.

Page 19

Q. Okay. And what then?
A. On the 16th I started having real bad pains in my neck.
Q. Okay.
A. And when I went to him on the 16th, I told him about it. I told him my neck was hurting real bad, my lower back and upper back was hurting, and my leg was hurting me. He then told me that he would order some X-rays. I told him that I would like to talk to somebody at workman's comp before he ordered the X-rays because nobody had called me to tell me what to do or where to go.
Q. Okay.
A. He said that was okay. He kept me on the pain medicine. They did give me some Ultram.
Q. Okay.
A. And that was the pain medicine. He kept me on the Ultram. Dr. Clare said that was fine. He said that if you don't hear anything by Monday, then I want you to come back in, and I want you to have -- go and have some X-rays made. Well, in the meantime, I spoke to Joe House, and I spoke to Glen Martin, Ana Dietra (ph), and Glen and Dietra, one of them -- one or the other told me that I needed to go to workman's -- that I needed to go to Doctor's Care.

Page 20

Q. Okay.
A. On the 20th I went to -- this was the 19th. On the 20th I went to Doctor's Care.
Q. Okay. And what did they do for you at Doctor's Care?
A. Doctor's Care X-rayed my neck, X-rayed my back. It was then that I found out that there was some abnormality in my neck.
Q. Okay. What did they say the abnormality was?
A. She explained that there was something there, but she couldn't tell what it was, so she needed an MRI.
Q. Okay.
A. She said that she could see on the X-rays the spasms in my back.
Q. Okay.
A. When I went there, I could barely get on the table. The doctor had to help me get up on the table just in order for her to examine me.
Q. Okay.
A. The MRIs were scheduled after they took all the X-rays, and I went to a radiologist on Fernfield, and I can't remember the name of that radiologist. They took the MRIs. The first set of MRIs evidently did not come out really good. I was referred to Dr. Dennis, which is an orthopaedic surgeon.

Page 21

Q. Okay.
A. He was not satisfied with the MRIs, so he ordered another set of MRIs.
Q. Okay.
A. And those MRIs were -- I was sent to Roper for those.
Q. Okay.
A. After taking those MRIs, I went back to Dr. Dennis, and that's when he told me that I had a herniated disc.
Q. Did he say where?
A. In my neck.
Q. And what did he recommend doing about that?
A. He talked about surgery. He said that he would not -- he would recommend that I consider it, but he did not think that it would do me any good because it would take away some of the pain but would not take away all of the pain.
Q. Okay.
A. He then told me that he was going to refer me to a pain management doctor.
Q. Okay. And who did he refer you to?
A. Dr. Alexander.
Q. And what did Dr. Alexander do for you?
A. He took a -- I had cortisone shots. He examined

Page 22

me. I got cortisone shots. I had an epidural in my neck. He did a nerve test, and he put me on -- kept me on Ultram, and then put me on another type of medication, which I can't remember the name of it, but it was for inflammation around my spine.
Q. Okay. Did the injections help?
A. Only briefly.
Q. All right. And is that everything that Dr. Alexander did for you?
A. Yes. As far as I can remember, that's everything.
Q. Okay. Have you seen any other doctors for your work accident?
A. Yes, I saw Dr. Aymond.
Q. Okay. And what did Dr. Aymond say?
A. Dr. Aymond examined me last week, and he examined my neck and my back. He said that I had a bulge on my neck. He touched my back, and it was very tender. And I was having leg pain when I went to him, so he had me to walk. He said that he was going to order an MRI of my back to see if there was anything there, and then he also said that there was -- he would not recommend surgery on my back.
Q. Okay.
A. But he would recommend surgery on my neck

Page 23

because of the herniated disc.
Q. Okay. And you just saw him last week?
A. I just saw him last week.
Q. Okay. Did you go to him on your own? I mean, did workers' comp pay for that, or did you go on your own?
A. No, this was on my own.
Q. Okay. Do you have an appointment to see him again?
A. Yes.
Q. When are you supposed to see him again?
A. On Thursday.
Q. Have you decided whether you're going to -- whether you want the surgery on your neck?
A. I have not decided yet.
Q. Okay.
A. Every doctor has said that the surgery will not take away the pain out of my neck. It may relieve the pain in my arm, but it will not take away the pain in my neck.
Q. Okay. Which is worse, your neck or your arm, or are they the same?
A. There is nothing -- no part of my pain -- when it comes to saying worse, the only thing I can say is I'm in pain every day.

Page 24

Q. Okay.
A. Every day somewhere on my body. If it's not my head, it's my neck. It's my arm, my upper back, my lower back, my leg. This is every day, and this has been every day since May the 9th.
Q. Okay. Is there any part that's constantly in pain?
A. My neck is constantly in pain, and my lower back is constantly in pain.
Q. And have you told all your doctors that?
A. Yes, I have talked about my back from the beginning --
Q. Okay.
A. -- with Dr. Alexander -- I'm sorry, with Dr. Dennis.
Q. And all these injections and all that treatment that you've gotten, has it been just for your neck?
A. Just for my neck. Nobody has done anything about my back until Dr. Aymond the other day.
Q. Okay. Did Alexander or Dennis, did either of them give you any reason why they weren't treating you for your lower back?
A. No. The only thing they said to me was workman's comp only approved your neck.
Q. Okay. Now, is the pain in your shoulder a

Page 25

separate pain from the pain in your neck, or is it --
A. It radiates down.
Q. Okay.
A. And when you say shoulder, it's not only the shoulder. It's the upper part of my back, so it's not only -- it's not only the right shoulder. It's the whole upper part of my back.
Q. Okay. What makes it worse?
A. Right now, I'm getting ready to standup.
Q. Okay.
A. Sitting down for a long period of time.
Q. Okay.
A. Standing for a long period of time. Holding my head up. Holding my head down. Turning my neck going to the left and turning my neck going to the right.
Q. Okay. And how long sitting down and standing is too long? You can standup if you need to.
A. Okay. I can sit down maybe about a half an hour to 45 minutes --
Q. Okay.
A. -- in pain, but I still need to get up. The pain is there whether I'm sitting or standing, but it's just sometimes I sit down for awhile, and I get up. The other thing is lying down.
Q. Okay. And when you're talking about all this

Page 26

bothering you, what part of your body is it bothering?
A. It's bothering my neck, my upper back, and my lower back. I keep my legs on a pillow.
Q. Okay. How do you sleep?
A. I sleep with a towel or a headrest, the little balls that you use when you go on an airplane.
Q. Okay.
A. I sleep with that --
Q. Okay.
A. -- lying in an upward position or a towel folded and under my neck.
Q. Okay. Are you able to sleep through the night?
A. Most of the time.
Q. Okay. And we'll come back to all of that. Now, have you seen any other doctors besides the ones that we've talked about?
A. We've talked about -- I've been to private therapy for physical therapy.
Q. And we talked about Aymond, Alexander, Dennis, Doctor's Care, Dr. Clara, and the emergency room.
A. Yes, and physical therapy.
Q. Okay. Any accidents or injuries since this happened?
A. No.
Q. Okay. Any other health problems like high blood

Page 27

pressure, diabetes, anything like that?
A. I do have high blood pressure.
Q. Okay.
A. It's under control.
Q. Okay.
A. Let me rephrase that. I'm on medication for high blood pressure.
Q. Okay. So the medication keeps it at a normal level?
A. Yes.
Q. Okay. Any other health problems that we haven't talked about?
A. I have high cholesterol, which just occurred recently.
Q. Okay. Are you on medication for that?
A. Yes.
Q. Any other medication that you're on? Are you still on the Vitrax?
A. Yes. I take Nexium. I take Librax for irritable bowel. I'm on Premarin for estrogen because I've had a complete hysterectomy. I am on Vitamin E. I am on Zoloft for depression.
Q. How long have you been on that?
A. Since October of 2005.
Q. Okay. Has the amount that you're taking changed

Page 28

at all since this accident?
A. The amount changed before the accident.
Q. Okay. Go ahead.
A. Lanoxin for palpitations, like irregular heartbeat.
Q. Okay.
A. Toprol and Micardis for high blood pressure.
Q. Is that it?
A. Yes.
Q. Okay. Have you worked at all since this accident?
A. No, I haven't.
Q. Have you looked for a job at all?
A. No, I haven't.
Q. Okay. Are you just considering yourself retired at this point?
A. I would not be retired if it wasn't for this accident.
Q. Okay.
A. I had no intention of retiring right now.
Q. Okay.
A. I was still able to do my job. I was still -- my health was good. I was doing fine, so I had no reason to stop working.
Q. Okay. What is it about your job that you can't

Page 29

do now?
A. I cannot give 100 percent on my job.
Q. Okay.
A. I can't sit at the computer to do what I need to do. I am on a TENS unit that I will probably be on indefinitely. I have to use that three times a day. I am on a home track that I have to use three times a day. My job requires me to get up and down and move my neck and move my arms, and it requires me to be eye level. The doctor says I have to be eye level. My job requires me to not be eye level. My job requires me to look around.
Q. What do you mean by eye level?
A. The doctor said that everything that I do must be -- when I'm looking at the computer, I should be -- I shouldn't have to raise my head just looking.
Q. I see.
A. It has to be eye level.
Q. Okay.
A. I can't do that because of my job. I have to move. I work in a school. There are situations that come up that I have to be ready to move.
Q. Okay.
A. And I'm not able to give 100 percent.
Q. Do you feel able to do one of those other jobs

Page 30

that you did before, customer service at Sears; anything like that? Do you think you could go back and do anything like that?
A. I cannot work.
Q. Okay.
A. I cannot. There is very little that I can do. This accident has really turned my life around, and I just can't. I can't.
Q. Okay. Has anybody contacted you from the school and offered you a job?
A. No. No.
Q. All right. So I just want to get all this together. Your neck and your shoulder hurt every day?
A. My neck, my shoulder, my -- when I said shoulder, we need to -- we need to get away from the shoulder, upper back, which includes the shoulder.
Q. Okay.
A. My neck, my upper back, my lower back, and my leg, and my arm hurts every day. Headaches occasionally, but the rest of them every day. As I said before, every day I'm in some type of pain.
Q. Okay. Does the Ultran help?
A. It puts me to sleep, and when I wake up, the pain is right back again.
Q. Okay. What do you do during the day?

Page 31

A. On a good day I may be sitting in the recliner in my living room reading a book, looking at television, listening to the radio. I can't talk on the phone for a long length of time, so if somebody calls, I have to put them on the speaker because it hurts to hold the phone. When the pain gets to be real, real bad, the only thing I can do that will give me some relief is lie down and put something under my neck and prop my legs up and just basically just go to sleep. My food is brought in.
Q. Do you do the housecleaning yourself?
A. No, I don't.
Q. Are you able to dress yourself, and all that stuff?
A. Yes, I can, but I have problems putting on jackets or anything that has to go over my head or put my arms in it. It takes me awhile.
Q. Okay. Hobbies, anything like that that you can't do anymore that you used to do?
A. Oh, yes.
Q. Tell me about that.
A. I always loved to dance. I can't do that. I can't go to the movies because I can't sit there for the whole movie. I don't go out to eat a lot. I try sometimes, and I end up bringing the food back home with me because I'm so uncomfortable. I am a very good

Page 32

worker as far as my church is concerned, and I've missed quite a few things because I could not go. I could not attend. I miss meetings. Even at church, I'm squirming and squirming back and forth. Walking, I love to walk. I tried. I was told to try to walk, and I did it on two occasions, and when I -- the next day after, I was in bed all day with pain, I mean, really bad pain.
Q. Do you do any of that physical therapy on your own still?
A. Yes, I try. I really try hard to do the exercises, but the one that he wants me to do with the neck turn, I can't do that one.
Q. Okay. Were you satisfied with Dr. Dennis and Dr. Alexander?
A. I was not very pleased with Dr. Dennis.
Q. Okay. Why is that?
A. Because he seemed -- his bedside manner was not very good. He almost seemed like he didn't believe that I was in the amount of pain that I'm in. He told me that I should have been better by the time that I went to him, and that kind of -- that upset me because at the time of this accident -- I've gained some weight. I was about between 110 and 114, and the boys that hit me were over 300 pounds, the two of them together, but the brunt force came from the one that weighed like 200 some

Page 33

pounds.
Q. Okay.
A. So I was not very -- that kind of turned me off a little bit with him.
Q. What about Dr. Alexander?
A. The first visit wasn't very good, but after he read my file and found out what happened, then he became very, very concerned, and he did -- I think he did a good job. I think he did as much as he possibly could do.
Q. Okay. Have you told the doctors all the complaints that you have?
A. Yes.
Q. Any income coming in right now at all?
A. Workmen's comp, my regular Social Security.
Q. And how much is your Social Security?
A. It's $575. Everything is reduced. I'm taking reduced. And I get 2 something from retirement, and that's --
Q. And, I'm sorry, are you talking about per month?
A. This is per month, yes.
Q. Okay. I'm sorry, go ahead.
A. 272 from retirement. That's after the insurance is taken out.
Q. Okay. Is that it?

Page 34

A. Oh, I have a small annuity I get from my husband.
Q. Okay. Do you have any appointments with any doctors other than that one coming up with Aymond?
A. No, I don't.
Q. Have you met with anybody about possible jobs that you could do, any vocational people?
A. No, I haven't. I haven't been able to do anything like that because I'm always in pain.
Q. Okay. Well, have you interviewed with anybody like --
A. No, I haven't.
Q. All right. That's all I've got.
CROSS-EXAMINATION BY MS. SPANN-WILDER:
Q. Ms. Wilson.
A. Yes.
Q. I have some questions. You don't have to turn around and look at me.
A. Okay.
Q. I know it's not comfortable.
A. Okay.
Q. I just want to go back over some of the things that you talked about with Ms. Whitten. I'd like for you to talk a little bit more about what transpired on the day that you were injured. If you could give, I

Page 35

guess, a more descriptive overview of the area where you were, the surfaces, the counters, and all of that, what kind of surfaces they were that you were thrown against?
A. Okay. The area was very confined. There was a desk there, and I was between the desk and the counter. The counter is a marble top, and that was the counter that I was knocked against. I am 4 -- I was about 4'11", but I think I'm still 4'11", but 4'11" and the counter is -- I don't know how high it is, but I know, you know, it was marble, a marble top counter.
Q. Was the counter taller than you?
A. No, I was taller than the counter, about a head taller.
Q. Okay. Whereabout on your body would the counter stop?
A. The counter would be here, and it hit like here.
Q. So you're pointing to your chest?
A. Right. Right.
Q. So it came up to about your chest?
A. Yes.
Q. Okay. Now, when you were -- when these boys were fighting, where were you standing initially?
A. I started off standing at the beginning of the counter. The more -- when they came behind the counter, I started to move, so I ended up in the middle of the

Page 36

counter. By the time I was hit, I was standing almost to the end of the counter against the wall, and that's where the teacher was, and I was facing her.
Q. Okay. At the point of impact, were you facing these young men, or was your back turned?
A. No, my back -- I was like -- my right side was like this. I was headed out, trying to get out, turning to go to get out of their way.
Q. Okay. So did you even -- were you able to brace and see the impact coming?
A. I did not see the impact. I didn't even know it was coming. The only thing I heard was my voice screaming. I was like blindsided.
Q. And what exactly -- what surfaces did your body go against?
A. They went against the marble counter. It was like I was thrown and bounced. That's the way it seemed to me.
Q. But when you hit the counter, where else did your body go after the countertop, or did you just hit there and rest there?
A. I hit the countertop and was like out. I hit it, and when I realized anything, my head was on the counter. I was just leaning on the counter.
Q. Okay. And that's all that you can recall?

Page 37

A. That's all I can recall.
Q. Okay. So is it fair to say when you came to your senses, you were just kind of lying on the counter?
A. My head was on the counter. That was the reason I asked if I had hit my head.
Q. What, if anything, is going on with these young men right now? Any criminal charges?
A. I pressed charges, but nothing was ever done.
Q. Let me go back to your job duties. You talked about doing the bulletin board and, I guess, relieving the secretary at lunch.
A. Uh-huh.
Q. Were there any other duties that you had in terms of dealing with the children, monitoring classrooms, and things like that?
A. Yes, I worked as a proctor doing PACT. Even these two boys, they were not in a classroom because of behavior problems, but they would come in my room sometimes, and I would help them with their work, their school -- their classwork. If there was a teacher late, I would go and hold her class. I was on several committees.
Q. Now, how was the school laid out? One level, two levels, three levels?
A. Three levels.

Page 38

Q. And so if you had to maintain a classroom, if it were on the third floor, you'd have to take the stairs to do that?
A. Right. Well, we have an elevator, but by the time you walk to the elevator, you could be upstairs. That's how far the elevator is.
Q. Okay. Was the elevator something that was free to use for everyone or if you had a special key?
A. No, it was free to use.
Q. Now, the two students, you said that they would come to your room sometimes. Would there be other students that would end up in your room as well?
A. Only if the parent educator or the guidance counselor brought them in there. These two students, the principal would bring them, or sometimes the parent educator would bring them. If she wasn't there, the principal would ask me, you know, would you keep an eye on them for a minute, you know, and give them -- if they have some work to do, and things like that. My room was basically used as well as my office was used as a conference room. I would talk to parents in there and everything.
Q. About attendance?
A. About attendance, truancy, anything like that.
Q. Okay. And so would these kids coming in the

Page 39

room -- so did you -- why were you monitoring them?
A. Because I was asked to do so. They could not stay in the classroom. One boy had just come to us in January. He had not spent one full day in school. He left school every day at 11:00, and even sometimes before that because they have to call his grandmother to come and get him. The other young man was a healthy self-contained student who we could not accommodate, so they mainstreamed him, and he couldn't stay in the classroom. He had to go to the parent educator or go to the resource teacher, and she would help him with his work, but then on most occasions, they would get -- something would happen up there. The police were called very often for these two boys.
Q. Were they called that day when you were injured?
A. No.
Q. So is it fair to say that you just -- a part of your job was monitoring these two students as well?
A. Yes.
Q. And there were discipline issues?
A. Yes.
Q. Now, you told Ms. Whitten that May 9th was the last day you worked.
A. Right.
Q. Okay. Now, I want to go back over it. Now,

Page 40

that was the last day you worked in the 2005/06 school year, correct?
A. Right.
Q. Did there come any other point in time where you actually returned to the school and attempted to work?
A. Yes.
Q. Okay. And when was that?
A. August the 3rd.
Q. Of 2006?
A. Right.
Q. Okay. And what brought that about?
A. Dr. Alexander said that he would send me to work on sedentary duty, part-time, three to four hours per day.
Q. How many days did you work?
A. I went that day, and I stayed until about -- at first I had an appointment with Dr. Alexander that morning. That's the morning I had the nerve test.
Q. On August 3rd?
A. On August 3rd.
Q. Okay.
A. Upon leaving his office, I went to work.
Q. And what time did you get to work?
A. I got to work about 9:15, 9:30.
Q. Okay.

A. I had a conference with Mr. Dixon. I had spoken to him earlier about whether he could accommodate me working part-time. He said that he could. And so we had a conference on that day, and I sat down and took some things off the computer, and I left James Simons about 12:00.

Q. Okay.

A. There was no school that Friday.

Q. And Friday was August 4th?

A. Right.

Q. Okay.

A. Because they were on -- during the summer, they're on a four day week.

Q. Okay. So August 4th no work?

A. Right. On Monday, which was the 7th, I went to an in-service, which had to do with my job. I got there at 8:30.

Q. And where was that?

A. At 75 Calhoun.

Q. And what happened with that?

A. I stayed there until 11:30. I tried my best to retain what they were saying, but I was in so much pain, but I stayed for the three hours.

Q. Has that the extent of the in-service?

A. No, the in-service was all day.

Q. Okay.

A. But I stayed for three hours. At 11:30 I left, and I was waiting for my friend to come and pick me up. And I called to find out what the status was as far as the next day, what was I supposed to do.

Q. You called to who?

A. I called Dr. -- I'm sorry, I called Mr. Dixon. Mr. Dixon told me that he was told that they could not accommodate my working part-time. That Joe House said that they would put me on TTD.

Q. Okay. So if I understand you correctly, Mr. Dixon the week before was willing to try and accommodate --

A. Yes.

Q. -- the schedule Dr. Alexander suggested?

A. Yes.

Q. Okay. But some time later, he was advised by the district that they could not accommodate you part-time?

A. Right, that's what Mr. Dixon told me. Then I called when I got home. I called Joe House because I wanted to make sure that I covered all bases. I spoke to him. He said that Mr. Dixon said that he couldn't accommodate me.

Q. So it was a back and forth?

A. Back and forth, right, but it came down to the point that I could not return to work with the restrictions.

Q. And so the last thing Dr. Alexander really stated about you working was that you would have to work on some part-time basis?

A. Yes, and he did it the whole time that I was there. Even when he discharged me, he still put down that I -- the only way I could work was part-time.

Q. Now, those TTD checks, was there ever a time period when you were out of work that you were not paid the TTD checks?

A. Yes.

Q. Okay. Do you recall that time?

A. On June 19th -- my last day of work would have been June 16th.

Q. Okay.

A. And they stopped my check on June the 16th.

Q. Okay. Now, you went out in May, May 9th when you were injured, and June 16th ended the school year?

A. Yes, for me.

Q. Okay. June 16th, 2006, was the end of your ten month term?

A. Right.

Q. So that's -- how many weeks is that considered

in your contract? Is it listed week by week? It's like you work 40 weeks or --

A. It's listed by days, and I think it's like 230 days. I'm not sure.

Q. Okay. So your contract ended June 16th?

A. Right.

Q. From May 9 to June 16, what was your financial -- what was your income base? Was it still a regular paycheck from the district, or was it a workers' comp TTD check?

A. A workers' comp TTD check.

Q. Okay. So then May 10th, I guess, to June -- what day was it that you stopped?

A. I got a regular check the first two weeks after I got hurt, and then I was told that because I did not finish the school year, that I would not get any more money until August 11th. They sent me a full check and a part of another check.

Q. Okay. So if I'm understanding you correctly, the last two weeks in May, you got a regular paycheck?

A. Yes, and I got a check in June. It was a full paycheck, and then the last check I got was like June the 7th, I believe.

Q. But that was -- that was a part of your regular pay?

A. Right.
Q. And so the checks you got in June -- you get paid every two weeks; is that correct?
A. Right.
Q. So you got two checks, one full work check --
A. Right.
Q. -- and a half --
A. Right.
Q. -- which rolled into June?
A. Right.
Q. Okay. You were set to be paid through the whole year?
A. Right.
Q. But nothing came after that because you did not complete the school year?
A. Right.
Q. Okay. Then they said August 11th you would get another check. Was that a paycheck?
A. Yes.
Q. And that would start from the new school year?
A. Yes, but if I had not reported to work on the 3rd, I would not have even gotten that.
Q. Okay. Now, from June the 7th then, when was the next time you got a check from the district whether it be --

A. August 11th.
Q. So from June 7th up to August 11th, what did you do for income?
A. That's a rough one. I didn't have any income. What little money I did have I had to use. I had my mortgage payment. I had my bills. My daughter helped as much as she could as far as getting somebody to come in and clean. I did not know from day to day what was going to happen because I did not have no money to -- no substantial amount of money to fall back on, so it was hard.
Q. Now, during that time, you were out of work because either Mr. House or Mr. Dixon said they could not accommodate you; is that correct?
A. Right.
Q. Did you ever speak with Mr. House about when you would receive some kind of workers' comp check?
A. He told me that he would immediately put me back on workmen's comp, and he did, and then I started getting workmen's comp the first week in August or the second week in August.
Q. After you started that check, were there still some time frames missing that you did not --
A. I never got paid for the summer at all. I never got paid from June 16th. When I got my last check for --

June the 16th, I didn't get any more checks from workmen's comp until August.
Q. Do you remember about when in August?
A. He put me on 2ND August the 7th, and if I'm not mistaken, I believe I got a check that Friday. If I didn't get it that Friday, it was the following Friday.
Q. Okay. And it picked up then August 9th?
A. Yes.
Q. Now, I guess essentially it would have amounted to a full day of work August 3rd, and the half day you did for the in-service, you were paid for that?
A. By me returning to work on the 3rd, I got paid, yes.
Q. Okay. You got paid on the 11th?
A. Yes.
Q. And that was a check just for one day?
A. No, I got a full paycheck because I honored my contract and went back to work on the 3rd. The doctor said I could go to work, and I went to work.
Q. Tell me how you felt when you returned home on August 3rd after going and trying to work there four hours?
A. It was terrible. It was terrible even when I left the doctor's office because I had just had the nerve test, and the nerve test is when they shock you.

And I left there, left the doctor's office and went to work, and all I did was pull some things off the computer that needed to be done. I took them home with me so I could look through them because there was so much of it, and the pain was really bad. I was nervous because of the amount of shock that had been put on me because -- and I was shocked, and I was -- I had needles, the needles. They did that too. So when I got home, I was in pretty bad shape. I was just really out of it. All I could do was go to bed.
Q. And then for the in-service, I guess, who did you speak with there that you determined that you just had to leave the in-service?
A. Phyllis Shepherd.
Q. Who?
A. Phyllis Shepherd.
Q. And who is she?
A. She is the young lady that's over people accounting, and she is my supervisor for people accounting. In fact, as soon as I got there, she looked at me. She really didn't want me to stay, but I told her I was doing what I had to do, and finally I just couldn't do it anymore. She gave me my lunch and told me to take my lunch with me, and I left.
Q. So the last day you physically presented to work

Page 49

was August -- well, I guess August 7th?

A. That was considered -- that would be considered work, yes.

Q. Okay. Have you returned to the school to remove your items?

A. No. Some of my items were returned to me by a girlfriend. She brought them to me, but I did return to the school to turn in my retirement letter. I had returned to the school for a faculty meeting. The next day the principal wanted to tell the staff that I had retired and explain to them exactly what had gone on. He told them that I had retired because I could not perform 100 percent, and the type of person I am, if I can't do 100 percent, that he knew that I would not be able to function the way I wanted to. He told me to talk to the staff, to the faculty and the staff, and I did, and everybody was really upset.

Q. Now, this was when?

A. That was the Wednesday after -- I don't remember the date.

Q. What month?

A. I don't remember the date. I think it was -- it has to be September because -- it was either September or October. I can't remember.

Q. How did you come to make the decision that you

Page 51

Q. And that's what you're working on now?

A. Yes.

Q. And I want to talk to you about your visit with Dr. Aymond. What kind of testing did Dr. Aymond perform or have performed?

A. Dr. Aymond examined me, and he said I had a bulge on my neck on the right side. He also examined me. He had me to walk, and I was in a lot of pain that day with my legs. So then he examined my back, and he touched the lower part of my back, and I jumped, and he was asking me if that was sore, and he said that I needed an MRI. And before I even left, I was in the elevator when the office called me, and the MRI was done the very same day.

Q. Of the back?

A. Yes.

Q. Okay. So when you said that he wanted to do surgery on your back, that was without -- he had not seen -- he has not seen the MRI?

A. The MRI, no. I have a CD that I have to take to him.

Q. Okay. What, if anything, did he say about your back? What were the possibilities that he was trying to determine?

A. He said I have scoliosis.

Page 50

were retiring?

A. I spoke to somebody in benefits, and I spoke with someone at the state department and explained the situation to them. I knew that I could not do the job that I was required to do. They could not accommodate me with part-time. My job really wouldn't allow me to work part-time, but if they could have gotten somebody to come in in the afternoon, and I work in the morning, then, you know, that's what I thought they meant by accommodating me.

When I spoke to them, they told me that workman's comp does not pay benefits. And based on the fact that I had no income, I could not perform my job, I could not get up every morning and get to work on time and do everything that I was doing before I was injured, I made the decision to take reduced retirement to at least help out a little bit.

Q. You did the reduced retirement. Have you made any application for retirement disability?

A. Yes, I have.

Q. And is that still pending?

A. Yes, it is.

Q. And essentially what would be the difference for you with the disability retirement versus the regular?

A. It was 5 or $600 more.

Page 52

Q. Were you aware of that?

A. I had that since birth, yes.

Q. Okay.

A. And he said that the scoliosis was really bad. That's a curvature. He also said that he wanted an MRI to see if there was anything else there like a disc, a herniated disc. He also told me that the injury could have aggravated the scoliosis, and that's what was causing the pain. He said that he would not operate on my back because he thinks it would be worse if I was to have surgery on my back, but he recommended that I have surgery on my neck.

Q. But the surgery part on your back was if there was not a herniation?

A. Right. He said that if it's just the scoliosis, then there was nothing that could be done. It was something that I would just have to live with.

Q. So did he make any mention or do anything regarding the problems you have in your legs?

A. No, he didn't. Now, Dr. Stovall said that my legs, the pain in my legs, was probably coming from the back. Dr. Stovall told me that.

Q. Did he look at your back too?

A. No, he didn't. Dr. Stovall also told me that I had lost 10 percent mobility in my neck.

Q. Ms. Wilson, on the days that you say are really bad days, what are you able to do, or what do you do?

A. Basically nothing. I lie down, get up and go to the bathroom. If somebody -- if I have a friend coming to bring me some food, I'll open the door, get something to eat, do my treatments, and that's it.

Q. And as far as the school, have you aided in any way with training the person who replaced you?

A. Yes. She's called me on several occasions to ask me questions, but prior to that -- this is the new data clerk. But prior to that I helped from the day I was injured up until they hired somebody over the phone. I did -- I walked a young lady through different things to get ready for the end of the year reports. We made AYP and --

Q. What's AYP?

A. Adequate yearly progress.

Q. Okay.

A. And my principal told me it was because of me, along with other factors, that he made AYP, and I continued to work from home. Even with pain, I continued to work from home to help, putting in discipline, talking her through discipline, through attendance, through truancy.

Q. All right. Ms. Wilson, I don't have any other

questions. Ms. Whitten might follow-up.

MS. WHITTEN: I don't have anything else. Thank you.

A. I need to say one thing, please. I have a grandson that was born in 2002 in September. He was born in Japan premature. My grandson came from Japan on Sunday, January the 5th. My husband died January the 7th. It's only my daughter, my grandson, and me.

My daughter is in the Air Force. This past year she had to do a special duty. She asked me would I keep him for a year for her, which was supposed to start this past August. I went and I inquired about a school for him and everything. When this happened, my daughter had to take him back, and she had to find somebody to take care of this child.

It just happens that that day, the person that she met in January of last year was talking and was saying that, you know, if there was anything she could help do, and that's the only reason my daughter was able to have a little peace of mind because of the fact that she was able to find somebody to take care of him. She's a single parent.

This injury stopped me from working, it turned my life around, and it took my grandson from me, and I wanted that so bad. I had already arranged my house and

everything for him. I want that on the record because this is not my fault. I did not do anything to cause this.

(Deposition concluded at 11:34 a.m.)

STATE OF SOUTH CAROLINA)
: C-E-R-T-I-F-I-C-A-T-E
COUNTY OF CHARLESTON)

I, Deborah Horsley, Court Reporter and Notary Public, certify that I did have Sara Y. Wilson to appear before me at 10:11 a.m. on Tuesday, January 23, 2007, at the Law Offices of The Spann-Hilder Law Firm, LLC, 2131 Dorchester Road, N. Charleston, South Carolina; that the witness was sworn and cautioned to tell the truth, the pages constitute a true and accurate transcript of the testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 4th day of February, 2007.

Deborah Horsley
Notary Public for South Carolina
My Commission Expires 12/29/2009

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
HCO File No. 0608517

SARA Y. WILSON,
Claimant,
vs.
CHARLESTON COUNTY SCHOOL DISTRICT,
Employer,
CHARLESTON COUNTY SCHOOL DISTRICT,
Carrier,
Defendants.

DEPOSITION OF:
SARA YOUNG WILSON



COPY

DATE: April 18, [illegible]
TIME: 10:13 AM
LOCATION: Law Offices of
The Spann-Wilder Law Firm, LLC
2131 Dorchester Road
North Charleston, SC

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[redacted]
(VIA TELEPHONE)

INDEX

WITNESS PAGE

SARA YOUNG WILSON

Examination by Ms. Whitten 3

EXHIBITS

(No exhibits proffered)

PROCEEDINGS

Thereupon, SARA YOUNG WILSON, the deponent, called for examination by counsel for Defendants and, after having been duly sworn by the notary, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANTS

BY MS. WHITTEN:

Q Ms. Wilson, we've met before. I'm Leslie Whitten, the attorney for the school district.

A Yes.

Q I'm not there because I'm trying not to make y'all sick, but, hopefully, this won't take too terribly long.

And I'm sure you remember from before, you just need to verbalize everything, try to say yes and no instead of uh-huh and huh-uh and stuff like that.

You need to respond directly to me, and you can't talk to Tiffany again about your case until the depo is over. But if there's something that I've asked you that you don't understand, just let me know that, and I'll repeat it or whatever you need me to do.

And I'll assume that whatever question

you've answered you've understood. Does that make sense?

A Yes, it does.

Q Okay. Do you still live at 126 West Poplar Street?

A Yes, I do.

Q And you haven't been married in the past few years, have you?

A No, I haven't.

Q Okay. Any dependents?

A No.

Q Okay. Any education in the last few years?

A No.

Q Okay. Haven't been convicted of a crime, have you?

A No.

Q Okay. Have you worked anywhere since 2007?

A No, I haven't.

Q Let's see.. Any car accidents?

A No.

Q Any new injuries at all, falls or anything like that?

A No, I haven't.

Q Okay. Let's see. And you are on Social Security disability?
A Not disability, just early Social Security.
Q Social Security. Because of your age?
A Yes. I took it in -- when I was 62.
Q Gotcha. Okay. And are you a Medicare beneficiary?
A Yes, I am.
Q And do you still have Blue Cross?
A Yes, I do.
Q Okay. Let's see. Since we went to that hearing in October of 2007, what doctors have you treated with for this injury?
A Dr. Jervey.
Q Okay.
A Dr. DeMarco.
Q Okay.
A I've been to Charleston Physical Therapy.
Q Okay.
A And my medical doctor is Dr. Oliverio.
Q Okay.
A Dr. Ernst, Dr. Aymond sent me to Dr. Ernst. So Dr. Aymond, also, and then Dr. Ernst.

Q All right.
A And Dr. Geer.
Q Can you spell that last one for me?
A Capital G-E-E-R.
Q Great. And then Dr. Rosen, also?
A And Dr. Rosen, yes.
Q Okay. And how many times have you seen Dr. Rosen?
A I've been seeing Dr. Rosen regularly since 2008. It started off like every two weeks, and then might have been a month, but I've been seeing him regularly up until August of 2010.
And there was a period when I didn't see him because I was ill, and then I was with my daughter, but I just saw him recently.
Q Okay. And does he have you on any medications?
A Did he put me -- what did you -- say that again, please.
Q Does he have you on any medications?
A Yes, he does.
Q What does he have you taking?
A He has me taking -- I was on Cymbalta, 60 milligrams, and he just -- he just increased it on the 7th of April. No, 7th of -- yeah, this is

April. 7th of April to 90 milligrams.
Q Okay.
A And he has me on Valium.
Q And how long have you been on the Valium?
A If I was to estimate, I'll say I believe he changed it in 2008. He took me off one medication. He tried me on something else. I got sick from it, and then he put me on -- it's called diazepam. So it's sometime between the latter part of 2008, early 2009.
Q Okay. And how long have you been on the Cymbalta?
A Cymbalta, between him, Dr. Jervey, and Dr. Oliverio, all three of them decided that that was the best thing to put me on. I would say, and this is just a guess, early 2009.
Q Okay. And, let's see, what have you treated with Dr. Jervey for?
A Dr. Jervey did the nerve damage test.
Q Okay.
A So he's treating me basically right now for the pains that I'm having in my left arm. I'm having -- it's -- my left arm is in really bad shape.
Q How long has your left arm been hurting

that much?
A It's been like this since late 2008, and it gradually got worse, and now it's at a point where I wake up in the morning in pain, and I go to bed at night in pain. This is every day.
Dr. Jervey recently put me on some cream. He wanted to put me on Lortab, a narcotic, but he didn't know whether my system would be able to handle it.
So he put me on some cream called Keto/Gaba/Lido, and it's a numbing medicine, and I'm supposed to use it three times a day. And if I use it, it numbs the arm for a little while, and as soon as the numbing wear off -- it's like an anesthesia.
And what's in it is a combination of medications that I am allergic to, something that I can't take by mouth. So he put it into a cream, and it was done by a manufacturing company, by Delta Manufacturing Company.
Q Okay. And he did a nerve test in relation to your left arm?
A The nerve, yes.
Q And what did that show?
A Denervation.

Q I mean, did it show it was coming from your neck, or did he say anything like that?
A He didn't explain what the test said. He explained that it was some type of nerve problem, and it could have been caused by a physical injury.
Q Okay. Have you had any new MRIs or x-rays to your neck or your back or anything else in the past three years?
A I had an x-ray -- Dr. Aymond did an x-ray just before he sent me to Dr. Ernst.
Q Okay. What was the x-ray of?
A I believe that x-ray was on my neck.
Q Okay.
A I believe it was on my neck because he was trying to find out whether it showed anything else or something like that. Dr. DeMarco did an x-ray on my arm, my shoulder. I don't think he did one on my neck.
Q Left arm and left shoulder or right?
A Left.
Q Okay. All right. Do you know what those x-rays showed?
A No, I don't. I don't remember.
Q Okay. Who sent you to Charleston

Physical Therapy?
A Dr. DeMarco.
Q Okay. And that was for your arm and your shoulder?
A Yes.
Q When was that?
A All of this took place in 2009.
Q And how about Dr. Oliverio?
A Dr. Ernst?
Q Oh, I thought you said you saw Oliverio; is that right?
A No, that's my medical doctor. That's my primary care doctor. He referred me to different -- when I go to him and if there is a problem, he'll refer me to someone.
So that's how he referred me to Dr. Rosen. Between Dr. Aymond, Dr. Jervey -- they referred me to -- I'm sorry. Between Dr. Aymond and Dr. Oliverio, they referred me to Dr. Jervey.
Q Gotcha.
A Okay. Dr. Ernst was referred to me by Dr. Aymond.
Q Okay. And what did Dr. Ernst do for you?
A He check -- he checked me for carpal tunnel, but I did not have it. He said it was a

nerve -- I believe he said a nerve problem, and he referred me back to Dr. Aymond, and that's when Dr. Aymond sent me to Dr. Jervey.
Q Okay. And Dr. Jervey is giving you -- has he said specifically: This is what I think is wrong with you?
A Please repeat that.
Q Sure. Has Dr. Jervey said specifically what he thinks is wrong? Has he said like it's a neck issue or an arm? I mean, has he said anything specifically to you about what's going on?
A No, he hasn't said anything specifically.
Q And right now are you -- is he giving you any kind of treatment other than that cream and the Lortab?
A I'm not on the Lortab. I'm on Cymbalta. Cymbalta is for depression and pain.
Q Gotcha. Okay. So any sort of -- I mean, are you doing injections or anything like that?
A I had injections in 2009. I've tried to get injections in 2010, but with it being a workman's comp issue, I have to have a referral, and I have not had one. So...
Q All right. Who recommended the

injections?
A The injections was recommended by Dr. Aymond.
Q Okay.
A Yeah.
Q All right. And so are these the same injections he was recommending before we went to the hearing in October of '07?
A Right. I started taking the injections in 2008. My back pain started to get really bad. It got to the point and, as I said at the hearing, when I felt like I couldn't take it anymore, I would go ahead and do -- get the injection, and I did.
I started getting injections, and then in 2009, Dr. Jervey gave me a referral to get an injection up in my cervical -- a cervical injection, and I went and I had that done. That was to try to give me some relief with my neck and my shoulder and my arm.
Q Okay. All right. And I think Dr. Geer is the only one we haven't talked about. What has he done for you?
A Dr. Geer?
Q Yes.

A That's who's giving me the injections. He gave me two in my back and one cervical. The one cervical my insurance paid for it.
Q Okay. All right. So you've had, let's see, injections in your back and an injection in your neck.
A Well --
Q Cymbalta, Valium, that cream that Dr. Jervey has got you on. Any other treatment -- and physical therapy. Anything else that we haven't talked about?
A Okay. Now, the injection that I told you that was cervical was between my shoulder blades, but they call it a cervical.
Q Okay.
A Facet block. I think that's what it's called.
Q Let's see. Okay. Let's just talk specifically about your body parts and how they're feeling. Let's start with your neck. What's going on with your neck?
A My neck hurts. I'm sitting here right now, and I am in so much pain. My neck hurts every day.
Q Okay.

A Every day.
Q Can you turn side to side?
A Huh?
Q Can you turn it side to side without pain?
A I can move my neck as long as I take my time. I can't do no sudden movements. On a daily basis, my pain in my neck can range a 9 out of 10. It starts off that way in the morning.
It might ease up a little during the day, but by the end of the day, it's right back to that same 9, and this is every day. I go no day without pain. And --
Q I'm sorry. Go ahead.
A The neck and the arm all hurt. I mean, you know, one doesn't hurt without the other. It's just a constant pain. Just it hurts. That's the only way I can explain it. It hurts.
Q And when you're saying arm, you're talking about your left arm?
A Yes.
Q Okay. What about your right shoulder?
A My right shoulder is not as bad as my left arm, my left shoulder. I do have pain in my right shoulder, but thank God it's not as bad as

the right because I am right-handed. So it's not as bad as the left.
But the pain -- I do have pain in my left -- I mean, I'm sorry, in my right shoulder and my right arm, but the pain in the right is not as bad as the pain in the left, and it goes from my neck down to the tip of my fingers.
Q And when did it start getting that bad?
A It started off in 2008, and through 2009 it got increasingly worse.
Q Okay. And when it first started getting bad, did you go to a doctor then?
A Yes. I went to -- I told Dr. Oliverio. Dr. Oliverio referred me to Dr. DeMarco, and then Dr. DeMarco sent me to physical therapy.
All of this, like I said, transpired sometime between late 2008, 2009. I ended up going back to Dr. Aymond. Then Dr. Jervey came into the picture. I was referred to him.
And the pain has since got increasingly worse. So each day it's -- and when I say each day, you know, that's a short term, but it's become increasingly worse.
Q Okay. What about your low back?
A My lower back, my back pain on a normal

day would be about -- I guess I would have to say a 9 because I can be doing something as simple as sitting in a chair, and if I sit there too long, my back starts to bother me.
So I go and I lie down, and I'll get a little bit of relief when I lie down, putting something cold or something hot on it.
Q And did that start in '08, also?
A My back? No. My back got worse in '08. But my back was bothering me before. Even before the hearing my back was bothering me.
Q Right. But it got as bad as it is now in '08?
A No, not as bad as it is now. It got really bad in '08, and that's why I had to go get the injection. I didn't -- I couldn't handle -- I couldn't take it anymore.
Q And when you say you can't sit too long, when you have to lay down, how long can you usually sit?
A I sit in my recliner maybe about an hour. I'll go on, and then I'll lie down, and then sometimes I sit up in the bed and prop something behind my back, and that even bothers me.
And I'll get up, and I'll walk around the

house a little bit, and I'll come back, and I'll start doing the same thing all over again.

You asked me before about my neck, and I think I need to clarify something. My neck -- and I talked about this. My neck and my arm are as one.

Q Okay.

A All of that hurt the same time. And if I have to put that on a scale, it would be past 10. That's how bad it is. Okay?

Q Do medications help?

A Not really. That's why I'm on the cream now. There is -- everything that he has tried has not helped. And another thing I use, and I forgot to tell you, I use Lidoderm patches.

Q Okay.

A And that was giving me a little bit of relief. Now that's not even working.

Q Okay. Let's see. Do you still need the TENS unit?

A I have used it, but it's not -- it doesn't help me. It doesn't help me at all.

Q Okay. What about standing? How long can you stand?

A Oh, not long at all. Not long at all. I

wear a lot of flat shoes because I can't wear, like, pumps and stuff like that.

Q Okay.

A So I keep on flat shoes, and I can stand or walk because I have tried to do a little bit of walking to see if that would help with my back.

That makes it feel -- makes it worse. I wear the flat shoes to see if that would help with the standing and the walking.

And, of course, I know it would feel better than it would feel than if I had on pumps, but, you know, it hurts. It just -- there's nothing else I can say. It just hurts.

Q Okay. You said in '07 that you sometimes used a cane to walk. Do you still use that?

A Yes, I do.

Q Okay. How often do you use it?

A I really very seldom leave the house. I go -- like, if I'm going to the doctor, if I -- I didn't bring it with me this morning. My brother was with me. So he helped me. And most of the time when I go out, that's who's with me and takes me out.

And I use the cane, like I said, when I go to the doctor. If I just want to walk in my

walkway, I'll use my cane. When I go to the store, my brother does most of the pushing the basket and all like that. Sometimes I just sit in the car and tell him what I need, and he'll get it.

So the cane I use, I guess, on an -- maybe about three or four times -- as many times as I go to the doctor. Let me put it like that. So if I go to the doctor four or five times a month, then I would use the cane four or five times a month.

I use it when I go to church, not every Sunday because, again, my brother takes me to church, and we do have a ramp. So he helps me with that. But I do use it.

Q Okay. How are your legs doing?

A My legs, they're hurting right now. That's another thing. When I'm in pain, sometimes I get these pains in my leg. It feels like it's about to give out on me.

I -- the left, again, is worse than the right, but both of them hurt. I tend to -- when I get the pain, I tend to get cold. So I try to keep my legs warm, and that helps some.

But it just seems like nothing on me is

working right now. It seems like every part of my body when it comes to my neck and my arms and my leg and even to the point of my head, I'm just in constant pain.

Q Okay. When did the anxiety start for you to have to be on these medications?

A I've been -- I've had -- you know, I've had -- we've talked about this before. I've had anxiety before after the death of my husband, but I did not have -- I was never depressed.

I've gotten to the point now where the anxiety has caused -- along with the pain, has caused me to become depressed.

Q Okay.

A On a normal day, I can sleep all day long.

Q Okay.

A Sometimes I don't even want to get out of bed because the way I feel is if I get out of bed, what I'm going to do? I can't do any housework. You know, whatever I do, what little I can do, I have to space myself as to how I do it.

So the -- I started going to Dr. Rosen in 2008 after Dr. Oliverio said he think -- thought that I needed some therapy because I was in pain.

I was depressed. I wasn't sleeping. I was having, like I said, anxiety attacks. And that's how I started off.

And Cymbalta wasn't the first thing he put me on. He had me on -- he tried me on a couple of other things for the depression.

Q Okay.

A I can't remember the name of them, but -- and Cymbalta was the one that he finally put me on, and he just talked the other day about maybe trying something else.

Q Okay. So is this treatment helping you?

A That's a hard one to answer because if I didn't have the pain, I would maybe say yes.

Q Okay.

A But if you're in pain every single solitary day, how can you help not being depressed? I feel helpless. I feel hopeless. And I feel useless.

Everything that I was able to do prior to 2006, aside from bathing myself and fixing me some food, just maybe trying to do a little bit of this and that around my house, everything else -- my life changed on that day.

Q Okay.

A And it's something that I can't get back. I can't get it back.

Q Okay. A couple of real quick questions, and then we're done. When we went to that hearing, I think you were getting $544 a week for Social Security. Is that still what you're getting?

A No. That was a total before taxes, I believe. I only get $503 now. My insurance has to come out. My Medicare comes out of that. I get 500 -- no, $506 from Social Security.

Q Okay. All right. Any other income you have coming in?

A I have -- on a total, my income is $1200 a month. That's another thing that's got me depressed, also. The pain. The pain. The pain. And I have $1200 a month income.

Q All right.

MS. WHITTEN: That's all I've got, Tiffany.

MS. SPANN-WILDER: I don't have anything, Leslie.

(The deposition concluded at 10:43 AM, and the deponent does not waive signature.)

STATE OF SOUTH CAROLINA
C-E-R-T-I-F-I-C-A-T-E
COUNTY OF DORCHESTER

I, Lana McManus, CSR and Notary Public, certify that I did have SARA YOUNG WILSON to appear before me at 10:13 AM on April 18, 2011, in the Law Offices of The Spann-Wilder Law Firm, LLC, 2131 Dorchester Road, North Charleston, South Carolina; that the witness was duly sworn and cautioned to tell the truth, the whole truth and nothing but the truth; that the foregoing pages constitute a true and accurate transcript of her testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF I have hereunto set my hand and seal this the 19th day of April, 2011.

COPY

Lana McManus
Certified Shorthand Reporter and
Notary Public for South Carolina
My Commission Expires August 9, 2012

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

SARA Y. WILSON, Employee/Claimant,	W.C.C. File No. 0608517
vs.	DEPOSITION OF:
CHARLESTON COUNTY SCHOOL DISTRICT, Employer,	WILLIAM C. DIXON, JR.
and	
CHARLESTON COUNTY SCHOOL DISTRICT, Carrier, Defendants.	

DATE: Tuesday, January 23, 2007
TIME: 12:03 p.m.
LOCATION: The Spann-Hilder Law Firm, LLC
2131 Dorchester Road
N. Charleston, South Carolina 29405
REPORTER: Deborah Horsley

DEBORAH HORSLEY
Independent Court Reporter
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APPEARANCES

For the Employee/Claimant: The Spann-Hilder Law Firm, LLC
By: Tiffany R. Spann-Hilder, Esq.
2131 Dorchester Road
N. Charleston, South Carolina 29405

For the Employer/Carrier: Young Clement Rivers, LLP
By: Leslie N. Whitten, Esq.
28 Broad Street
Charleston, South Carolina 29401

INDEX TO EXAMINATIONS:

	PAGE
Direct Examination by Ms. Spann-Hilder	3

INDEX TO EXHIBITS:

No exhibits were proffered during this deposition.

It was stipulated by and between counsel for the parties that this deposition is taken for the purpose of discovery; that all objections, save as to the form of the question, are reserved until the time of trial; that the deponent was explained his right to read and sign the deposition and reserved that right.

(WILLIAM C. DIXON, JR., being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MS. SPANN-HILDER:

Q. Good morning.

A. Good morning.

Q. Would you please give us your full name and spell your last name?

A. William Curtis Dixon, Jr., and the last name is spelled D-I-X-O-N.

Q. Mr. Dixon, my name is Tiffany Spann-Hilder. I've requested through your attorneys for Charleston County that you be present to speak with me as a corporate designee in regards to the workers' compensation claim of Sara Wilson. You may utilize your personal knowledge, any personal records you have in front of you to help answer the questions. I am just trying to understand some more about Ms. Wilson and her job with Charleston County.

I need you to answer all questions verbally with a yes or a no so that the court reporter understands completely what is being said. If you answer a question -- if there's a question asked that you don't understand, please just ask me to repeat it or rephrase it so that whatever answer you give, we're clear that that is a straight answer based on a question that was clearly understood by you, okay?

A. (The witness did not respond.)

Q. Do you understand then your role here today on behalf of Charleston County?

A. I do.

Q. Okay. Please give us the name of your employer and how long you have worked there?

A. Charleston County School District, James Simons Elementary School, specifically been there 18 months, and I worked in Charleston County for almost two and a half, three years, since July of 2006 -- I mean, 5.

Q. Okay.

A. Excuse me, '04. I apologize for that.

Q. And where -- where are the other positions -- what are the other positions you've had?

A. In Charleston County?

Q. Yes, sir.

A. I've been an assistant principal of Buist

Page 5

Academy, and I've been an interim principal at James Simons Elementary School where I currently work.

Q. And prior to the Charleston County School District, what other districts have you worked for?

A. I have worked for the Charleston County School District. I have worked for the Richland County School District. I have worked for Orangeburg 7 School District. I worked for Hampton School District 2. And I've worked for Marlboro County School District.

Q. Okay. So all in all, how long have you been an educator?

A. Since 1993.

Q. As the principal at James Simons, what do your duties entail?

A. My general duties are to oversee the daily operations of the school from a management standpoint, making sure that we have a highly qualified staff, making sure that student learning is taking place, and making sure that the adult staff members in the building are following their job descriptions, and making sure they're giving our students a conducive learning environment in an ideal learning situation.

Q. Okay. Mr. Dixon, when there are work-related injuries -- I know that you're the top of the line there at the school, but to whom do you report?

Page 6

A. I report directly to Earl Choice who is the Associate Superintendent for District 20 and 23.

Q. So if there's an injury, you take it on up to Mr. Choice?

A. I take it to -- I let him know about it. We also refer injuries to Mr. Joe House --

Q. Okay.

A. -- from Risk Management, and also those reports, I take them to the school nurse if they happen at school.

Q. And who is the school nurse?

A. Janet Washington.

Q. Is she permanently at your school?

A. She's permanent.

Q. All right. Mr. Dixon, are you personally familiar on site recognition with Sara Wilson?

A. Yes.

Q. Okay. And how did you come to know her?

A. She was my full-time data clerk.

Q. Okay. And so did you meet her at James Simons? She was already employed there when you arrived?

A. I met her at James Simons Elementary School. She was employed there before I was.

Q. Okay. And what did her duties entail? What things did she take care of for you at the school?

Page 7

A. In general, her duties were all relevant data towards our school including the student attendance on a daily basis, as well as academic assistance plans, data for discipline as far as discipline referrals, discipline incidents, contact the parents to find out and follow through with parents on why their kids were not in school, to also follow-up with teachers to make sure that academic assistance plans were appropriately filed to make sure that students needs were being addressed.

Q. All right. Were there any special skills or educational requirements for that position?

A. Yes.

Q. And they were what?

A. Well, I don't know what they were when she was originally hired.

Q. Okay.

A. I just know that they have to have -- an associate's background is generally preferred. They have to type a minimum number of words per minute, and, of course, have people skills, general communication skills, and just have to have a basic knowledge of the program that we operate, which is called SASSY.

Q. Okay. And so at this point the job requires an associate's degree?

Page 8

A. To my knowledge.

Q. Okay.

A. They prefer you to have an associate's degree. I don't know if that's the mandate. I know some persons who actually work there with some technical college education and have a high school background.

Q. Okay. What was her work schedule?

A. Her work schedule was from 7:00 until 3:30.

Q. And how many months was she contracted?

A. She was a -- I want to say a 10 month employee.

Q. Okay. How does that work then?

A. I think that was based on the data standard. There was a data -- well, it works the nine months with the kids.

Q. Okay.

A. Traditional school years are nine months or 180 days, and then by being a 10 month employee, you would have additional weeks allotment.

Q. Okay. And then after that, she'd just be off for the summer?

A. She might come in two weeks before school starts, stay two weeks after school ends.

Q. Okay. So that's about the 10 months? Two weeks before, two weeks after?

A. Uh-huh.

Page 9

Q. Now, were you there long enough with her that you would have performed any kind of job evaluations for her?

A. I did.

Q. How many?

A. To the best of my knowledge an interim evaluation, which would have been somewhere in December and --

Q. Okay.

A. Excuse me.

Q. December of what year?

A. 2005.

Q. Okay.

A. And also a spring evaluation, which would have been spring 2006, which would have been somewhere around March '06.

Q. And those evaluations, are they done and filed? Are they documents that you actually review with the employee?

A. Both.

Q. And to the best of your recollection, what type of reviews did Ms. Wilson have?

A. Ms. Wilson was a fine employee, one of the best.

Q. And those evaluations, I guess, are sent onto the district?

Page 10

A. Those evaluations, not the actual -- the detailed versions but just your recommendations, if you want to rehire the employee. If you have any concerns, of course, you send those to the appropriate personnel.

Q. Okay.

A. So she's always been recommended.

Q. So where would the detailed evaluations be?

A. I have copies of the evaluations. Not with me, but I have them, and I usually give them a copy as well. I don't know if she still has that.

Q. Okay. So in your spring evaluation, would your recommendation have been for her to return for the '06-'07 school year?

A. Yes.

Q. Okay. I want to get to May 9th of 2006, the day that she was injured. How did you first become aware of that?

A. I was in my office, the door was closed, and I was having a meeting with another Charleston County employee.

Q. And what brought this event to your attention?

A. Well, I heard somewhat of a noise, an unlikely noise, a noise I wouldn't hear in the office area, which was sort of a scream, a quick scream or a yelp, and I immediately, just because I heard it, just went to

Page 11

respond to the situation.

Q. And what did you see when you got up?

A. Just several people in the office area, and Ms. Wilson obviously in some pain.

Q. When did you -- where did you see her? Where was she physically located?

A. She was near the office counter area. It's kind of hard to explain, but she was near the office counter between the secretary's desk and the office counter.

Q. And what did you surmise had taken place, or what was advised to you?

A. Well, of course, her medical attention was most important at that time, and we mainly just made sure that the school nurse came down to see her and make sure that her needs were addressed from that standpoint. The second thing was just getting the office to be more calm because there were several students in the office who were in transition to and from PACE along with another employee, and so just trying to make sure we got the office calmed down and everyone situated.

Q. When, I guess, or at what point did you find out what had taken place, and what was advised to you?

A. I don't understand the question.

Q. I guess, who was the first person to say to you "X", "Y", and "Z" happened, and this is how come Sara is

Page 12

right here, or did she actually verbalize to you what had taken place?

A. I don't recall that episode. My main concern was her and just make sure Ms. Washington saw her, the school nurse. And I think the "X", "Y", "Z" was once we got everything cleared in the office and once Nurse Washington saw her, her main concern was just making sure, if I'm not mistaken, that she was in a wheelchair. I could be wrong, but she saw her and made sure she went to the doctor. And that's what Ms. Washington kind of made me aware that, you know, she needed to go home, and she may be out for a couple of days. We'll just wait to hear.

Q. When then did you become aware of how she had become injured?

A. As far as?

Q. How it took place?

A. Being out the rest of the year?

Q. No, sir, how she became injured?

A. When was I aware of how she became injured?

Q. Yes, sir.

A. I was aware of that probably within the next -- well, right away I know what happened as far as her being pinned, but, I mean, as far as how it happened, I didn't find that out until I took witness statements

Page 13

from the students --
Q. Okay.
A. -- and from the adults who were --
Q. And so you had written statements?
A. What we call written statements.
Q. But they were written?
A. Uh-huh.
Q. Okay. And these are in your possession?
A. I may have one or two of those. Both of those students are no longer with us, so I don't know if I have those records or not. I may have them in my own personal file, but --
Q. You took --
A. -- we send records to the other schools, and one of the other students is no longer with us.
Q. Okay. So from talking with Ms. Brown, Olenda Brown, and Ms. Wilson, it appears that there were about four students in the office, at least four students perhaps?
A. Yes.
Q. Okay. And who were the, I guess, staff members that you took statements from?
A. I don't recall who I took statements from. I just know I talked to Olenda Brown, Folaina Jefferson, the school secretary, and the teacher coach, and that

Page 14

was pretty much it. And Janet Washington didn't give me a statement, but she just gave me her, you know, recommendation of just her little follow-up she does with any employee who gets hurt on the job.
Q. Okay. And I've heard Ms. Jefferson's name and Ms. Brown. Who was the teacher coach? Is that --
A. Ms. Brown, she was the literacy coach.
Q. Okay.
A. She's the teacher coach now.
Q. Okay.
A. I apologize for that.
Q. Okay. Now, based on those statements you got from the students and the other employees, what became your understanding of what had happened?
A. That something to the degree where the kids were in a place they shouldn't have been from the standpoint of they're generally not behind the counter.
Q. Okay.
A. And what I gathered, there was some horse playing between those two, and in the midst of the horse playing of interacting with each other, they accidentally pinned Ms. Wilson.
Q. When you use the term pinned, what do you --
A. I wasn't there, so I'm just going by what was told to me, but something to the effect of just in them

Page 15

trying to get towards each other, and Ms. Wilson is, you know, smaller -- small pretty much in stature than then --
Q. Okay.
A. -- they pretty much just pinned her against the counter by mistake, I think, but I wasn't there.
Q. Okay. And those kids were larger than she was?
A. I would say they're larger than she is. One of them is more larger than the other one and a little more healthier, but sixth graders are generally larger.
Q. Okay. So you have sixth graders at your school?
A. Uh-huh.
Q. Now, they were sixth graders?
A. One was a sixth grader, and one was a fifth grader.
Q. Sixth and fifth. Were they age appropriate for their grade level, or were they -- I'm learning my educational terms, but were they appropriately in these grade levels, or were they over-age students still in the elementary setting?
A. They both were 12 years old. That's the only way I can answer that question.
Q. Okay. And fifth graders are typically about 10?
A. I've seen them be 10 or 11. It just depends on where you are, when the birthday falls. I don't -- one

Page 16

of the students was fairly new to us. I don't know what his situation was as far as was he behind or whatever, but I just know that he was in fifth grade coming to us. He socially promoted him in the middle of the year to sixth.
Q. Okay.
A. So he would have been behind, so I think he was back on the grade level. The other student, when I got there he was in fifth grade so --
Q. Okay. Now, you already testified that the nurse assisted her and told you that she might be out for a few days?
A. Right.
Q. At what point did she return to work?
A. She did not return to work that school term.
Q. Okay. When did you next see her at work?
A. She came by once or twice in the summer just to give us an update on how she was doing, and I want to even say she tried to come in at some point in August of 2006, and I don't think she stayed a full day because she had doctor's appointments, so I would say one day as far as a work situation.
Q. One day into the --
A. That I can recall.
Q. Into that new school year?

Page 17

A. Right, the new school year we're currently in.
Q. That day that she worked, do you recall how it went? Was she able to do the work, or did she have complaints?
A. She complained that she had a difficult time sitting down. She couldn't get much done. Even when she stood for awhile, it was painful. When she sat down, it was painful. And she's always done a good job at what she does, so she just couldn't -- something to the point she couldn't do the job she wanted to do with the standards she always had done it and do it the right way.
Q. Okay. Did you and Ms. Wilson, do you recall any conversations between the two of you where she may have just verbally said it or even brought any notes about working on a part-time basis a few hours a day?
A. Yes.
Q. Okay. And just sitting down?
A. Yes.
Q. Okay. And were you willing to accommodate that?
A. Yes.
Q. And why did that not continue?
A. I'm uncertain. I'm assuming -- let me go back to that period for a minute. Again, I just think that she was having some pain. She had a lot of therapy and

Page 18

those kind of things, and eventually it got to the point where she couldn't work, and then it just got to the point where the Charleston County Risk Management Office, as far as the workers' comp and as far as just having someone in place, just got involved.
Q. Okay. And when the risk management got involved, their decision was what?
A. Well, initially it was just to put her I think on short-term leave where she would be out until -- I think she would have into the fall, some time later in the fall to get better or whatnot. That didn't happen, and I think there could be a discharge or a termination. I'm not sure.
Q. Okay.
A. Now, this is my first year doing that, but we had a sub in for her.
Q. Okay. Now, with the part-time work, who, if anyone, made the decision that the part-time work -- the part-time working could not be done?
A. What do you mean who made the decision?
Q. Who advised you that she was not able to work there part-time?
A. I don't remember anybody particularly advising me to do anything about her working part-time. I think it was just pretty much a joint situation. She wasn't

Page 19

able to perform like she wanted to. She was in pain. And the Risk Management Officer, Mr. House, at the time did say something to the effect though where if she can't do the job to the way she could do it, then we'll just look at some temporary work.
So if you want to call him advising, I just think it came down to a decision where he felt like it wasn't going well for her or for the school because she couldn't do her job to the maximum ability that she's capable of doing in the reputation she had earned all those years.
Q. Okay. So essentially it was if she couldn't do it the way it needed to be done, then she could just get the weekly benefit check? She would just go out of work?
A. Right, temporarily.
Q. At what point did you have to make a decision about whether or not you could continue having a sub in for her?
A. I didn't have to make that decision.
Q. You didn't?
A. No, it didn't come down to that.
Q. When did you become aware that Ms. Wilson was going to retire?
A. Well, you know, I went to visit her in August,

Page 20

and we talked about several possibilities, but as far as formally retired, it took place some time -- I found out some time in late September or October that she wouldn't be coming back, or that she was going to retire.
Q. But for the physical problems that she has advised that she's having, would you have wanted her back there with you this year?
A. I would want Sara Wilson back, yeah.
Q. Okay.
A. I would want Sara Wilson back, yeah. You mean with the injuries or without the injuries?
Q. With or without, if she were capable, would you have wanted her back?
A. Yeah, I would have wanted her. Yeah.
Q. Had she discussed with you, even before this injury, when she intended to retire or if that had even been a conversation for her?
A. We talked -- we talked not on the record or anything but just sidebar conversations about she may walk away from it. And, of course, I asked her to stay, you know, stick it out another year or two if she could, and she said she had planned on working for at least two more years.
Q. So to the best of your knowledge, the last time she came to work, she had restrictions about what she

could do?
A. Yes.
Q. Did she ever discuss with you what things were bothering her?
A. Neck, spinal.
Q. Before the injury, was she the kind of employee that you could count on would be at work, would do her job?
A. Yes, although she did have a number of just, I guess, routine doctor's appointments where she missed some days during that school year, but when she was at work, she was very dependable.
Q. The report that Ms. Washington did, I believe that's the nurse, Ms. Washington --
A. Uh-huh.
Q. -- do you recall if it specified what injuries Ms. Wilson had or later complained about?
A. No.
Q. If Ms. Wilson advised you of some problem that she believed she had as a result of this injury, would you have any reason not to believe her?
A. No. I trust that she was telling the truth about the situation on the injuries.
Q. Now, you noted that you did visit her on one occasion in her home?

A. Uh-huh.
Q. Have you had an opportunity to interact with her in any other outside setting; something for school, outside of school where you may have noticed her conditions?
A. No. I mean, there was a function at school that I didn't attend that I was told that she went to probably in August of '06. One of our teacher assistants were doing a program that she went to according to some staff members, and I recently saw her in December at the Taste for Charleston but nothing else.
Q. And at that event did you have an opportunity to speak with her about her health or anything?
A. She still talked about it was day to day, and she was still having some difficulty.
Q. I think that's pretty much all of my questions, but I need to speak with Ms. Wilson and make certain there's nothing that I left out, and then, otherwise, we're done.
(Whereupon the deposition went off record for a brief period of time.)
Q. Mr. Dixon, you testified earlier about Ms. Washington needing a wheelchair or getting a wheelchair or some kind of chair for Ms. Wilson on the day of the

injury. Do you recall that statement?
A. I recall saying something to that degree, yes.
Q. Okay. Did she leave the school in a wheelchair?
A. I want to say she did leave in a wheelchair with Ms. Washington pushing her. I could be --
Q. Okay.
A. I'm pretty sure that's what happened.
Q. And so on that day she had some issues with walking?
A. Well, I mean, she's always just been highly regarded at the school as being the mother of the school. I mean, it's just a certain amount of respect we have for her. It was obvious that she was in pain that day. I don't know if she could walk or not. Again, Ms. Washington is the expert on that part of it, but we were just more concerned about just getting her in a situation getting her needs addressed and just making sure that these kids were held accountable as best as possible and getting the rest of the kids moved back to their educational setting.
Q. Have you had any discussion beyond the day she was injured with, I guess, risk management or anyone else in a position above you about Ms. Wilson in this workers' comp claim?
A. No, not until I received the subpoena.

Q. Okay. I don't have any other questions, but Ms. Whitten might.
MS. WHITTEN: No, I don't have any.
(Deposition concluded at 12:34 p.m.)

STATE OF SOUTH CAROLINA)
: C-E-R-T-I-F-I-C-A-T-E
COUNTY OF CHARLESTON)

I, Deborah Horsley, Court Reporter and Notary Public, certify that I did have William C. Dixon, Jr. to appear before me at 12:03 p.m. on Tuesday, January 23, 2007, at the Law Offices of The Spann-Wilder Law Firm, LLC, 2131 Dorchester Road, N. Charleston, South Carolina; that the witness was sworn and cautioned to tell the truth, the pages constitute a true and accurate transcript of the testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this the 4th day of February, 2007.

Deborah Horsley
Notary Public for South Carolina
My Commission Expires 12/29/2009

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION
WCC File No. 0608517

SARA Y. WILSON,
Claimant,
vs.
CHARLESTON COUNTY SCHOOL DISTRICT,
Employer,
CHARLESTON COUNTY SCHOOL DISTRICT,
Carrier,
Defendants.

DEPOSITION OF:
JAMES KIRK AYMOND, M.D.



COPY

DATE: June 21, 2011
TIME: 5:33 PM
LOCATION: Medical Offices of Orthopaedic Specialists of Charleston, P.A.
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For the Defendants: Young Clement Rivers, LLP
By: Leslie H. Whitten
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Charleston, SC 29401
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Also present: Sara Young Wilson

INDEX

WITNESS	PAGE
JAMES KIRK AYMOND, M.D.	
Examination by Ms. Whitten	3
Examination by Ms. Spann-Wilder	18
Further Examination by Ms. Whitten	20

EXHIBITS

(No exhibits proffered.)

PROCEEDINGS

Thereupon, JAMES KIRK AYMOND, M.D., the deponent, called for examination by counsel for Defendant and, after having been duly sworn by the notary, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR THE DEFENDANT
BY MS. WHITTEN:

Q Dr. Aymond, my name is Leslie Whitten. I'm an attorney downtown at Young Clement Rivers, and I represent the Charleston County School District in the workers' compensation claim filed by Ms. Wilson.

We did take your deposition back in September of 2007 on this case, and I just have -- some new issues have come up. So we need to take your deposition again.

Hopefully, it won't take too terribly long. And since we've already got your background and everything in the last deposition transcript, if you can just let me know, do you have anything new, any new board certifications or anything since September '07?

A I don't think so. I think I had my recertification just about that time.

Q Okay. All right. So the first note I have from you regarding Ms. Wilson is January 16, 2007. Is that the first note that you have?

A Yes.

Q Okay. And what problems did she present to you with on that day?

A At that time, Ms. Wilson was giving a history that she had a work-related injury in May of 2006 while working at an elementary school. She stated that she was pushed into a countertop at work during an altercation between two students.

Q Okay. And did she have any diagnostics with her on that day?

A She had undergone an MRI scan of her cervical spine, and we did have that for review.

Q Okay. And did you recommend any diagnostics on that day?

A Yes. At that time, the patient had complaints of lower back pain as well as some hip discomfort as well as neck pain and the upper extremity tingling and pain.

So we had also reviewed some x-rays of her lower back that revealed a curvature of the back --

Q Okay.
A -- or scoliosis. So at the time of her initial evaluation, we recommended an MRI scan of her lower back.
Q And what did that reveal?
A That study was performed at Charleston Imaging, January 16, 2007, and that study revealed the scoliosis previously noted as well as some very mild changes without evidence of disc herniation.
She had some mild changes in what we call the facet joints at L4-5 and L5-S1, mostly in the form of degeneration or mild arthritis.
Q Okay. And then if we could just skip to your July 20th, 2007 visit.
MS. WHITTEN: For the record, this is APA 1, page 5.
BY MS. WHITTEN:
Q I know that you had done a cervical fusion in the interim there, but what complaints did Ms. Wilson have on July 20th, 2007?
A July 20th, patient was four months out from her cervical fusion, was not having any further neck discomfort, was having some degree of lower back discomfort.

At that time, she had very good range of motion of her cervical spine. At that time, we recommended a restriction -- that she remain on lifting restriction of 20 pounds or less, did not feel that we could make her cervical spine any better improvement at that time.
So she was rated at maximum medical improvement with respect to her neck injury and the subsequent surgery.
Q Did she have any continued complaints of lower back pain?
A Yes.
Q And what had you recommended regarding her low back pain?
A Well, one option that we could have -- that we said we could entertain at that time was consideration of some injections such as pain management for treatment of her lower back pain.
Q Okay. And then, let's see, I think the next visit was November 13th, 2007.
A Yes.
MS. WHITTEN: And, for the record, this is APA 1, page 6.
BY MS. WHITTEN:
Q What were her complaints on that day?

A The patient states that she was beginning to have some insidious onset of posterior cervical pain, which is the back of the neck, approximately 10 to 12 days prior to this date of November 13th.
She had not returned to any employment and does not recall any specific activity that began her symptoms. At that time, she was eight months out from her cervical fusion.
Physical exam revealed no change in the range of motion of the patient's neck. Muscle strength testing as well as sensation was normal.
At that point, radiographs or x-rays were done of her neck and revealed no change in her fusion which revealed complete consolidation or fusion of the level where we had worked on.
And we recommended a muscle relaxer to aid her in some of the relief of her localized neck pain.
Q Any changes in her restrictions on that day?
A No.
Q Okay. And was she set up for a new appointment on that day?
A No, I don't believe so. We just said we would see her in follow-up as needed.

Q And then the next note I have is December 7th, 2007; is that right?
A Yes.
Q Okay. And what were her complaints on that day?
A Continuing to have aching type pain in her lower back as well as some mid-back discomfort. We had said in my notes the previous MRI scan performed in January of '07 revealed some mild facet changes, did not feel that she was a candidate for any form of surgical intervention. Recommended referral for pain management for her lower back, residual pain.
Q And, to your knowledge, have any new lumbar MRIs been done since January of 2007?
A I do not know of any.
Q And have you ever requested any be done that you know of?
A No.
Q Okay. And why not?
A Well, the last time we saw her, she was having some localized lower back pain and no neurologic changes that I felt would be necessary to have a new or updated MRI scan.
Q And I don't want to put words in your

mouth, but you would expect her MRI to be the same as it was in January of '07?
A Based on her symptoms at the time and complaints of December of '07, I would, yes.
Q Okay. And then the next record I have is October 21st, 2008. Did you see her at all in between those two dates?
A I don't have any notes to say that I did.
Q And what was your opinion on October 21st, 2007?
A Patient was having some intermittent posterior neck pain. She had undergone the previous fusion. That was 18 months prior at that time.
The next sentence states that: Patient also complains of intermittent lower back discomfort and remains in the care of Dr. Geer, who is an anesthesia physician for pain management.
X-rays at that time revealed normal alignment of her neck with no change, and we recommend that -- let's see, that her current symptoms are from her previous work-related injury as well as subsequent surgery.
And this is not a new problem for her as

far as her lower back as well as her neck and that she remained at maximum improvement with the previously noted impairment rating.
Q Okay. Any new recommendations on that day as far as her treatment plan?
A No.
Q All right. And then, let's see, the next record I have is May 8th, 2009. Is that the next one that you have?
A Yes.
Q And I'm not sure how to pronounce this. Dysesthesias?
A Dysesthesias.
Q Yes. And from your review of this record, can you tell when her dysesthesias started in her left arm?
A No. I can just read what's in my notes.
Q Okay.
A It says that in the interim between the time that I saw her October of '08 and May of '09, the patient has had some pain in her left shoulder and was evaluated by Dr. Oliverio, an internist, as well as Dr. DeMarco, who is an orthopedic physician.
The note states that she had had some

physical therapy and later on in February of 2009 began having some left upper extremity tingling or dysesthesias or abnormal feeling in her upper extremity.
And it looks like some plain x-rays that were taken revealed a cyst in her humeral head as well as some acromioclavicular joint arthritis.
Q And could a cyst in the humeral head and acromioclavicular joint arthritis cause the symptoms that she was having?
A It could cause shoulder pain. That's correct.
Q And did you order a new cervical MRI on that day?
A Yes, we did.
Q Okay. And what did that reveal?
A I may not have the actual -- well, let's see. I may not have the actual report, but my interpretation of the scan was performed in May of 2009.
Q Okay.
A Reveals evidence of previous fusion at C6-7, but I did not see any abnormality above or below her level of prior surgery.
Q If there had been something on the MRI to

explain her left arm symptoms, would you have noted that in your report?
A Yes.
Q Okay. All right. And then the next note I have is June 2nd, 2009. Is that what you have?
A Yes.
Q Any tests in the interim between the last visit and this visit?
A Between May and June?
Q Right.
A Yes. Well, we had recommended an electrical study of the left upper extremity, and that's normally performed by a neurologist.
Q And had you reviewed that test at the June 2nd appointment?
A Yes.
Q Okay. And did that test, to you, show definitively one way or the other what was causing her problems with her left arm?
A Not particularly. So I wanted her to see Dr. Ernst of our group because there were some mild changes in the electrical study.
And I wanted his opinion as to whether or not the patient had any form of carpal tunnel or cubital tunnel that would require any form of

treatment that could be the reason for her having the upper extremity tingling.

Q Have you seen any diagnostic study before or after June 2nd, 2009 that would indicate that her arm issues were related to her neck?

A I don't understand the question.

Q Certainly. Well, you indicated that the MRI would not explain what's going on with her shoulder, that you had an x-ray to her shoulder showing a cyst and some arthritis in her shoulder.

Have you seen any diagnostic studies that would indicate that what's going on in her shoulder would be related to anything other than the cyst and the arthritis?

A I have not.

Q Okay. And now is June 2nd, 2009 the last time you saw Ms. Wilson? That's the note that I have.

A That's correct.

Q Okay. And since the October of 2008 visit when you indicated that she was at maximum medical improvement and remained at maximum medical improvement, did you note or address her low back at all?

A I have not.

Q Okay. All right. And then I want to just go over with you the letter that you completed for Ms. Spann-Wilder on May 10th of 2011. Do you have a copy of that?

A Somewhere in here. Just give me about five minutes, and I will find it.

Q All right.

A Mine looks like yours, but I think I have it here. From May 3rd?

Q Yes, sir.

A Yes.

Q Okay. Now, you noted in Question 2 that your deposition testimony was that Ms. Wilson needed injections only if her condition worsened. And I do want to refer you to your deposition. Do you have a copy of that old deposition?

A Yes.

Q On page 11, looks like this is in answer to my question on line 6. It says: Right. My note said that I will plan to have her notify us if she desires to proceed with these injections. So if her symptoms were to worsen or if she decided to have them, we could do it at any time.

So just to clarify, was your testimony in that deposition that it was only if her symptoms

worsened or if she had just decided that she wanted to have them all together?

A Well, either way.

Q Okay. So if she had just changed her mind about wanting the injections, you would have been okay with going forward with them?

A That's right.

Q All right. And in Question 4, you indicate that her low back condition has worsened. Is that based solely on the fact that she wanted the injections, or is there something else?

A The fact that she was requesting injections.

Q Okay. And if she had increased pain in her lower back, does that alone indicate that she's had a physical change of condition to her lower back?

A Not necessarily.

Q If you had suspected that she had sustained a physical condition to her lower back, would you have ordered a new MRI?

A Yes.

Q But your opinion was that she -- when she last complained of low back pain in October of 2008, was that it was not a new problem, and she

remained at maximum medical improvement. Is that opinion different now?

A No.

Q Since your last medical record mentioning the low back indicates that her condition is the same, are you still able to stand by this opinion that she sustained a change of condition to her low back?

A I didn't understand your question.

Q Certainly. The last medical record where you mention low back pain is October 2008.

A Flipping and flopping here.

Q Sorry. October 21st, 2008.

A October 21st, 2008?

Q Yes, sir.

A Okay.

Q And we have established, I think, that this is the last time that there's any mention of low back problems and that on this date you indicated that she remained at maximum medical improvement for her low back.

So if that's the case, can you still stand by your opinion that she has sustained a change of condition to her low back?

A No. She has complained more of pain in

her lower back, but not sustained any different condition.

Q Okay. All right. And then back to the questionnaire, Question 4, I think. No, I'm sorry, Question 5. You indicate that Ms. Wilson's denervation is related to her C6-7 fusion.

And I guess maybe I'm just not understanding what all that means, but just in referring to your June 2nd, '09 note, I thought you had indicated that you couldn't say that that was the case. Or am I missing something?

A I would defer that to the neurologist.

Q Okay.

A And let him decide what exactly denervation changes are with respect to cervical spine versus a disc problem, prior surgery versus changes that would be just normal to intrinsic changes to the nerve. So I would defer that to Dr. Jervey.

Q But you have not given an opinion that she's had any sort of physical change of condition to her neck since 2007?

A I have not.

Q And you have not given an opinion as to when this denervation started, if it did start?

A That's correct.

Q That's all I have.

EXAMINATION BY COUNSEL FOR THE CLAIMANT

BY MS. SPANN-WILDER:

Q Dr. Aymond, you did refer Ms. Wilson to Dr. Ernst; is that correct?

A Yes.

Q Do you have a copy of that office visit of June 19th, 2009?

A I do.

Q And as a result of that consult, was it your decision and Dr. Ernst's to refer Ms. Wilson to Dr. Jervey or just Dr. Ernst to send her on?

A I have not seen Ms. Wilson since --

Q June 2nd of '09?

A -- June 2nd. So that would most likely have just been Dr. Ernst's referral to Dr. Jervey.

Q Okay. Did you receive copies from Dr. Jervey from his consult with Ms. Wilson?

A No. I mean, the only thing I have received --

Q Yes, sir.

A -- electrical study.

Q The electrical study?

A That's correct.

Q And his impression there was a sensory neuropathy and then I think a follow-up that was May 19th, then a follow-up note on June 26th, 2009 to you. Do you recall seeing that?

A No. I mean, I do not remember seeing this, but I have read it as of now.

Q Okay. And from your experience with the type of surgery that Ms. Wilson had, do patients sometimes develop denervation due to --

A Well, again, I would defer that to Dr. Jervey.

Q Okay. And I think I have one last question. As to the lumbar spine and the injections, do most people take injections at the outset, or is there just a different level of pain people experience before they go to that?

A It's very dependent on person to person as to what -- how bad one has perceived the pain and how it affects their activities and quality of life. So it's very patient dependent.

Q Okay. And over the course of the six or seven months that you saw Ms. Wilson from January through July of '07, she was never inclined to take injections; is that correct?

A That's correct.

Q And it appears that after her visit in December of 2007 was the first time that she accepted that treatment. She was referred to Dr. Wooten -- or Dr. Geer? I'm sorry.

A That's correct. That's the first time that my notes depict that we had referred her to pain management for her lower back.

Q And that was the first referral?

A Yes.

Q And once a patient is being followed for pain management with the injections, do you see them periodically, or is that just solely at the discretion of the pain management physician?

A Sometimes just solely at the discretion of the patient. Sometimes it is the other physicians involved. Sometimes I do see them.

Sometimes I have to keep referring them back to the pain management doctor. Sometimes I don't see them anymore. So that's very patient as well as physician dependent, as well.

Q Thank you. No further questions.

FURTHER EXAMINATION BY COUNSEL FOR THE DEFENDANT

BY MS. WHITTEN:

Q Dr. Aymond, again, just one more time. Again, an increase in pain does not necessarily

indicate a physical change of condition?
A That's correct.
Q And have all your opinions today been to a reasonable degree of medical certainty?
A Yes.
Q That's all I have.
(The deposition concluded at 5:58 PM, and the deponent waived signature.)

STATE OF SOUTH CAROLINA
C-E-R-T-I-F-I-C-A-T-E
COUNTY OF DORCHESTER

I, Lana McManus, CSR and Notary Public, certify that I did have JAMES KIRK AYMOND, M.D., to appear before me at 5:35 PM on June 21, 2011, in the Medical Offices of Orthopaedic Specialists of Charleston, P.A., 2093 Henry Tecklenburg Drive, Suite 200-E, Charleston, South Carolina; that the witness was duly sworn and cautioned to tell the truth, the whole truth and nothing but the truth; that the foregoing pages constitute a true and accurate transcript of his testimony given at that time and place.

I further certify that I am not of counsel or kin to any of the parties to this cause of action, nor am I interested in any manner in its outcome.

IN WITNESS WHEREOF I have hereunto set my hand and seal this the 25th day of June, 2011.

COPY

Lana McManus
Certified Shorthand Reporter and
Notary Public for South Carolina
My Commission Expires August 9, 2012

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

J.C. Nicholson, Jr., Circuit Court Judge

Case No. 2012-CP-10-5429

Sara Y. Wilson,. . . . . Appellant,

v.

Charleston County School District,. . . . . Respondent.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

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September 1, 2015