

**IN THE STATE OF SOUTH CAROLINA**

**In the Court of Appeals**

**APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION**

**APPELLATE PANEL**

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**Case No. 2012-210487**

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Emma Hamilton

Appellant,

v.

Martin Color-Fi, Inc., Employer, and  
Liberty Mutual Insurance Company, Carrier,

Respondents.

**RECEIVED**  
NOV 01 2012  
**SC Court of Appeals**

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**RECORD ON APPEAL**

**VOLUME I**

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DECISION AND ORDER OF THE  
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0810330

|                                   |   |
|-----------------------------------|---|
| Emma Hamilton,                    | ) |
| Employee,                         | ) |
| Claimant,                         | ) |
| vs.                               | ) |
| Martin Color-Fi, Inc.,            | ) |
| Employer,                         | ) |
| and                               | ) |
| Liberty Mutual Insurance Company, | ) |
| Carrier,                          | ) |
| Defendants.                       | ) |

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**HEARING:**

Held in Camden, South Carolina on December 15, 2010.

**APPEARANCES:**

Claimant represented by Joseph T. McElveen, Jr., Esquire of Sumter, South Carolina.

Defendants represented by Candace G. Hindersman, Esquire of Willson Jones Carter & Baxley, P.A., Columbia, South Carolina.

**PURPOSE OF HEARING:**

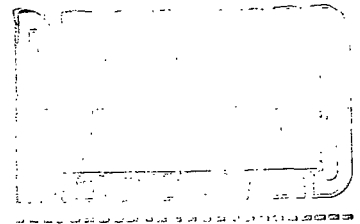
To determine the issues as set forth on the Forms 21, 50 and 51.

**DECISION AND ORDER:**

By G. Bryan Lyndon, Commissioner

**FILED:**

February 24, 2011.



## **I. APA SUBMISSIONS**

Under the Administrative Procedures Act, the following records were submitted into evidence at the time of the hearing:

### **Defendants' APA Submissions**

- APA #1: Records of Tuomey E.R., dated 7/22/08–11/20/08, consisting of pages 1-29.
- APA #2: Records of Tuomey Industrial Medicine & Wellness, dated 7/23/08–11/23/09, consisting of pages 30-64.
- APA #3: Records of Clarendon Memorial Hospital, dated 11/26/08, consisting of pages 65-66.
- APA #4: Records of Midland's Orthopaedic, dated 2/11/09, consisting of pages 67-70.
- APA #5: Reports of Moore Orthopaedic, dated 6/30/10, consisting of pages 71-72.

### **Claimant's APA Submissions**

- APA #6: Records of Tuomey Industrial Medicine & Wellness, dated 7/23/08-2/25/10, consisting of pages 73-109.
- APA #7: Records of Cornell Therapy Associates, dated 9/18/08-10/23/08, consisting of pages 110-130.
- APA #8: Records of Sumter Neurology and Pain Management (Dr. Marshall White), dated 11/3/08, consisting of pages 131-132.
- APA #9: Records of Progressive Physical Therapy, dated 6/19/09-10/28/09, consisting of pages 133-156.
- APA #10: Records of McLeod Health (John P. Zelenka, OTR/L), dated 12/31/09-1/26/10, consisting of pages 157-241.
- APA #11: Records of Kingstree Surgical Associates (Dr. Blake Moore), dated 6/1/09-9/4/10, consisting of pages 242-250.

### **Claimant's Exhibits**

- Ex. A: Martin Color-Fi Accident Investigation Report
- Ex. B: Martin Color-Fi Email
- Ex. C: Martin Color-Fi Employee attendance Counselling Sheet

## **II. STIPULATIONS**

Counsel for the respective parties stipulated at the time of the hearing to the following issues:

1. The purpose of the hearing is to determine the issues as set forth in the Forms 21, 50 and 51 and any other issues which may timely come before the Commission;
2. That the Claimant's accident occurred on July 22, 2008;
3. The Claimant's average weekly wage was \$516.51 with a corresponding compensation rate of \$344.35;
4. Notices were timely and properly served upon all parties of interest;
5. Venue, set in Camden, is proper as agreed by all parties;
6. That the South Carolina Workers' Compensation Commission has jurisdiction over the parties and issues involved;
7. The issues for determination are whether the Defendants are entitled to stop payment of temporary total compensation and the Claimant's entitlement to temporary total disability compensation, permanent partial disability compensation, total disability compensation, medical benefits and/or disfigurement, if any, and any other issues which may timely come before the Commission.

Without objection, the Commission's file was made a part of the record in this matter with the exception of any self-serving declaration or unstipulated medical reports.

### **III. STATEMENT OF THE CASE**

The Claimant sustained a work related injury to the right hand on July 22, 2008. On October 12, 2010, Defendants filed a Form 21 requesting a hearing. The Form 21 specifically requested that the Commission stop payment of temporary compensation due to the Claimant reaching maximum medical improvement, pay permanency, and request credit for overpayment of temporary compensation. On November 21, 2010, Claimant filed a Form 50 requesting additional treatment for the right wrist and hand. Defendants timely filed a Form 51 on December 21, 2010 admitting the accident, but denying the extent of the injuries as alleged by the Claimant and denying the Claimant's need for additional medical treatment. Defendants maintained that Claimant was at maximum medical improvement for all injuries, and the claim was ready for a

determination of permanency and stop payment of temporary compensation.

A hearing was held on December 15, 2010 to determine the issues set forth in the Forms 21, 50, and 51.

#### IV. EVIDENCE OF THE CASE

The Claimant is forty-six (46) years old and has a high school diploma. Claimant attended one and a half years of schooling to be a paralegal at Central Carolina Technical College. Claimant testified that she previously worked for the Sumter County Library, held a supervisory role at the South Carolina Vocational Rehabilitation Department and took the United States Postal exam. Claimant has also performed a variety of construction jobs and other labor intensive work in the past. Claimant began working for the Employer in 2001 as a machine operator.

On July 22, 2008, Claimant was involved in a work-related accident when she got her right hand and forearm caught in rollers. Claimant testified that she is right hand dominant. Claimant presented to Tuomey Emergency room on the day of the accident with complaints of right wrist and hand pain. (APA1, pp.1-2) The following day, July 23, 2008, Claimant was seen by an orthopaedist, Dr. James Gee. (APA 2, p. 30) Claimant began treatment with Dr. Gee on a nearly weekly basis, and on August 13, 2008, Dr. Gee noted "steady progress." (APA 2, p. 38) Dr. Gee placed the Claimant through additional physical therapy, and on October 22, 2008, Dr. Gee's records stated that "Ms. Hamilton really loves her physical therapy and is really pleased with the progress she has made." (APA 2, p.47) Due to her complaints of neurogenic type sensations, Dr. Gee recommended a nerve conduction study at that time. (APA 2, p.47) An MRI of the right wrist was also performed at Dr. Gee's request on November 26, 2008, which was essentially normal and showed no tendon or ligament injury. (APA 3, p. 65) On December 3, 2008, Dr. Gee met with the Claimant and explained that both her nerve conduction studies and MRI tests appeared to be

normal, and he felt she would have to just continue to improve with time. (APA 2, p. 54) Claimant testified that she was frustrated with the ongoing restrictions in her hand motion and became dissatisfied with the treatment she received from Dr. Gee. Claimant further testified that she felt Dr. Gee acted nasty towards her. The medicals note the Claimant was not nice or pleasant towards Dr. Gee. (APA 6, p. 105)

Claimant next saw Dr. Michael Green for an evaluation on February 11, 2009. At that time, the Claimant continued to present with complaints of numbness, tingling, pain and weakness in her hand. (APA 4, p.67) Dr. Green opined that the Claimant was at maximum medical improvement and had no work restrictions. Dr. Greene did not recommend any future treatment and assigned 1% impairment to the right hand as a result of the accident. (APA 4, pp. 69-70) Claimant testified that Dr. Green was nasty to her, much like Dr. Gee.

Following the Claimant's appointment with Dr. Green the carrier authorized Work Hardening. The Claimant voiced concerns to the provider about participating in the Work Hardening. (APA 2, p. 64) The Work Hardening provider discontinued the treatment because of Claimant's continued reports of pain. (APA 10, p. 221)

Claimant returned to see Dr. Gee again on May 27, 2009. At that time, Dr. Gee advised the Claimant that she had been evaluated by three physicians, a neurologist, an orthopaedic surgeon, and a hand specialist, she underwent both nerve conduction testing and an MRI examination, and nothing revealed any significant damage to any structures of the right wrist and arm. (APA 2, p.63) Dr. Gee stated that he agreed with Dr. Green that Claimant has some degree of impairment, but it would not be a large impairment. (APA 2, p.63) Dr. Gee stated that Claimant no longer required any medications and it was "up to her" to work on strengthening. (APA 2, p.63)

Claimant was also seen by Dr. Blake Moore on June 1, 2009, for an independent evaluation

scheduled by her attorney. Dr. Moore opined Claimant was not at maximum medical improvement and was a candidate for ongoing conservative treatment, including pharmacotherapy, orthotic bracing and possible TENS provisions. (APA 11, p.246) Dr. Moore assigned a tentative 7% impairment rating to the right upper extremity at that time. (APA 11, p.246)

Following her exam with Dr. Moore, Claimant returned to Dr. Gee on February 25, 2010. Dr. Gee recommended an evaluation with another hand specialist. (APA 6, p.108) As such, Defendants arranged for Claimant to be seen by Dr. David Fulton for an independent medical evaluation on June 30, 2010. Dr. Fulton saw no signs of ongoing swelling or loss of mobility, and he opined that any cystic changes in her lunate were chronic and unrelated to the injury. Dr. Fulton stated that all treatment to date was appropriate for her injury and placed the Claimant at maximum medical improvement as of June 30, 2010. Dr. Fulton stated that he saw no contraindication to return to work without restriction, no evidence of permanent impairment, and no need for additional future medical treatment or testing. (APA 5, p. 72)

Claimant testified she continued to work light duty in the lab for the Employer until December 2008, when she was laid off along with half of the other plant employees. Claimant testified that during the time she worked light duty, she continued to receive the same wages as prior to the accident. Outside of work, Claimant testified that she continues to be able to do her chores around the house and yard work. In response to questioning by the Commissioner, the Claimant testified that she used a posthole digger one time. Claimant further testified that she has not looked for any work because she is considering returning to school.

## V. FINDINGS OF FACT

### IT IS FOUND AS A FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and

provisions of the South Carolina Workers' Compensation Act, as amended, with Emma Hamilton as Employee-Claimant and Martin Color-Fi, Inc. as Employer and Liberty Mutual Insurance Company as Carrier, Defendants.

2. That Claimant was an employee of the above-named Employer on and prior to July 22, 2008, when Claimant injured her right hand in an ~~admitted~~ work-related accident. The injury affects the Claimant's right wrist.

3. That the average weekly wage of Employee at the time of the above-described accident was \$516.51, making a compensation rate of \$344.35 applicable in this matter.

4. That the Defendants are to pay all causally related authorized medicals.

5. That the Claimant was a machine operator for the Defendant. She has done construction work in the past and other labor intensive work.

6. That the Claimant was injured when she got her hand and forearm caught in rollers. She is right hand dominant.

7. That the Claimant was treated by Dr. Gee, but she was dissatisfied with him and eventually saw Dr. Green and Dr. Fulton. She was also dissatisfied with her treatment by them.

8. That the Claimant had an MRI, which was essentially unremarkable with no tendon or ligament injury.

9. That Claimant stated Dr. Green was nasty to her much like Dr. Gee. She then saw Dr. Fulton. The medical record notes the Claimant's attitude towards Dr. Gee was not nice or pleasant.

10. That the Claimant liked Dr. Fulton until he read her MRI. Claimant said Dr. Fulton was then also nasty to her.

11. That the Claimant had an unremarkable nerve conduction study and physical

therapy that she said did not help.

12. That the Claimant also had an FCE, which was valid and indicated that she could not return to her former duties.

13. That the Claimant testified that she previously tried to use a posthole digger and was unable to do so. The fact that she even considered this brings her credibility into question.

14. That the Claimant was placed at maximum medical improvement by Dr. Green on February 11, 2009 with a 2% impairment to the hand. Dr. Green released the Claimant to full duty and stated that she will not need future medicals.

15. That the Claimant was treated by Dr. Fulton, and on June 30, 2010, Dr. Fulton placed the Claimant at maximum medical improvement, Dr. Fulton gave the Claimant no work restrictions and stated she had no evidence of impairment to the right hand or wrist.

16. That the Claimant was also seen by Dr. Moore for the purpose of an independent medical evaluation.

17. That greater weight was given to the opinions of Dr. Green and Dr. Fulton, who are hand specialists, versus the opinion of Dr. Moore.

18. That the Claimant's testimony was evasive and confusing at times, which brought her credibility into question.

19. That the Defendants made a good faith effort to have Claimant seen by three doctors after being out for about two years.

20. That the report of Dr. Gee dated May 27, 2009 is very persuasive, and there is no mention of a follow-up MRI in this report. Dr. Gee placed the Claimant at maximum medical improvement. At the hearing, Claimant sought a second MRI.

21. That Claimant reached maximum medical improvement on June 30, 2010 for the

injuries resulting from the July 22, 2008 accident and that there is no evidence from an authorized provider that Claimant needs any additional medical treatment or imaging that would tend to lessen the period of Claimant's disability (see Form 14-Bs).

22. That Claimant has sustained 10% permanent partial disability to her right upper extremity as a result of the accidental injury on July 22, 2008.

23. That Defendants were entitled to stop payment of temporary total compensation effective June 30, 2010 and are entitled to a credit for the overpayment of temporary total compensation since June 30, 2010, against the award for permanent partial disability ordered herein.

24. That Claimant has failed to prove that she is entitled to any further medical benefits, any award for serious disfigurement or any other compensable element under the law, other than the award for disability as ordered herein.

## **VI. CONCLUSIONS OF LAW**

Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-1-160, Claimant did sustain an injury to her right upper extremity by accident arising out of and in the course and scope of her employment on July 22, 2008.

3. Under §§ 42-9-10 and 42-1-120, Claimant was entitled to compensation for a period of temporary total disability from January 16, 2009 until June 30, 2010, the date on which Claimant reached maximum medical improvement.

4. Under § 42-15-60, Claimant was entitled to medical, surgical, hospital and other authorized treatment until June 30, 2010, the date on which Claimant reached maximum medical improvement, but not thereafter, there being no evidence that any additional medical treatment would tend to lessen the period of her disability.

5. Under § 42-9-30, Claimant has sustained 10% permanent partial disability to the right upper extremity. From such award, Defendants are entitled to a credit for the overpayment of temporary total compensation since June 30, 2010.

## **VII. ORDER/AWARD**

**IT IS HEREBY ORDERED** that the Application of Employer/Carrier to stop payment of temporary total compensation is hereby granted, effective June 30, 2010, the date on which Claimant reached maximum medical improvement.

**IT IS FURTHER ORDERED** that as a result of Claimant's accidental injury occurring on July 22, 2008, she has sustained 10% permanent partial disability to the right upper extremity, for which she is entitled to 22 weeks at the compensation rate of \$344.35 per week which represents \$7,575.70. The Defendants are entitled to a credit or offset for the overpayment of temporary total compensation from June 30, 2010. As of the February 12, 2011, the credit represents 32 weeks of overpayment in the amount of \$11,019.20

**IT IS FURTHER ORDERED** Claimant reached maximum medical improvement on June 30, 2010, and as such Defendants are not liable for any additional medical, surgical, hospital or other medical treatment to Claimant after said date, until and unless further ordered by this Commission.

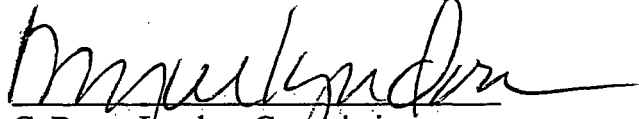
**IT IS FURTHER ORDERED** that Claimant has not sustained any serious and permanent

disfigurement as a result of this accident, and as such Defendants are not liable for same.

No hearing costs are assessed in this instance.

**IT IS SO ORDERED.**

SOUTH CAROLINA WORKERS'  
COMPENSATION COMMISSION



G. Bryan Lyndon, Commissioner

**APPELLATE PANEL  
DECISION AND ORDER  
OF THE  
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION  
WCC FILE NO.: 0810330**

Emma Hamilton,  
Employee/Claimant,  
Appellant

vs.

Martin Color-Fi, Inc.,  
Employer,

and

Liberty Mutual Insurance Company,  
Carrier,  
Defendants,  
Respondents.

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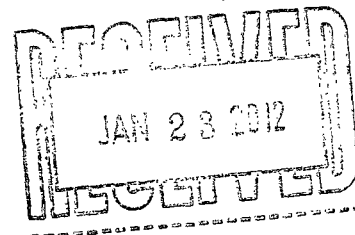
Appellate Panel Review held in Columbia, South Carolina on October 25, 2011 per  
Notices timely and properly served on all parties of interest.

Appellate Panel Decision and Order filed 1-23, 2012

Appearances:

Claimant/Appellant represented by Joseph T. McElveen, Jr., Esquire, of  
Bryan Law Firm, 17 E. Calhoun Street, P.O. Box 2038, Sumter, SC  
29151

Defendants/Respondents represented by Candace G. Hindersman, Esquire,  
of Willson, Jones, Carter & Baxley, 4500 Ft. Jackson Blvd., Columbia, SC  
29209.



### STATEMENT OF THE CASE

The parties were heard by Commissioner G. Bryan Lyndon on December 15, 2011 in Camden, South Carolina. As a result of said hearing, Commissioner Lyndon issued an Order dated February 24, 2011 from which the Claimant appealed.

The Hearing Commissioner's Decision and Order set forth the following Findings of Fact:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Emma Hamilton as Employee-Claimant and Martin Color-Fi, Inc. as Employer and Liberty Mutual Insurance Company as Carrier, Defendants.
2. That Claimant was an employee of the above-named Employer on and prior to July 22, 2008, when Claimant injured her right hand in an admitted work-related accident. The injury affects the Claimant's right wrist.
3. That the average weekly wage of Employee at the time of the above-described accident was \$516.51, making a compensation rate of \$344.35 applicable in this matter.
4. That the Defendants are to pay all causally related authorized medicals.
5. That the Claimant was a machine operator for the Defendant. She has done construction work in the past and other labor intensive work.
6. That the Claimant was injured when she got her hand and forearm caught in rollers. She is right hand dominant.
7. ~~That the~~ Claimant was treated by Dr. Gee, but she was dissatisfied with him and eventually saw Dr. Green and Dr. Fulton. She was also dissatisfied with her treatment by them.
8. That the Claimant had an MRI, which was ~~essentially unremarkable with no tendon~~

or ligament injury.

9. That Claimant stated Dr. Green was nasty to her much like Dr. Gee. She then saw Dr. Fulton. The medical record notes the Claimant's attitude towards Dr. Gee was not nice or pleasant.

10. That the Claimant liked Dr. Fulton until he read her MRI. Claimant said Dr. Fulton was then also nasty to her.

11. That the Claimant had an unremarkable nerve conduction study and physical therapy that she said did not help.

12. That the Claimant also had an ~~FCE~~, which was valid and indicated that she could not return to her former duties.

~~13.~~ That the Claimant testified that she previously tried to use a posthole digger and was unable to do so. The fact that she even considered this brings her credibility into question.

14. That the Claimant was placed at maximum medical improvement by Dr. Green on February 11, 2009 with a 2% impairment to the hand. Dr. Green released the Claimant to full duty and stated that she will not need future medicals.

15. That the Claimant was treated by Dr. Fulton, and on June 30, 2010, Dr. Fulton placed the Claimant at maximum medical improvement, Dr. Fulton gave the Claimant no work restrictions and stated she had no evidence of impairment to the right hand or wrist.

16. That the Claimant was also seen by Dr. Moore for the purpose of an independent medical evaluation.

17. That greater weight was given to the opinions of Dr. Green and Dr. Fulton, who are hand specialists, versus the opinion of Dr. Moore.

~~18.~~ That the Claimant's testimony was evasive and confusing at times, which brought

her credibility into question.

19. That the Defendants made a good faith effort to have Claimant seen by three doctors after **being out for about two** years.

20. That the report of Dr. Gee dated May 27, 2009 is very persuasive, and there is no mention of a follow-up MRI in this report. Dr. Gee placed the Claimant at maximum medical improvement. At the hearing, Claimant sought a second MRI.

21. That Claimant reached maximum medical improvement on June 30, 2010 for the injuries resulting from the July 22, 2008 accident and that there is no evidence from an authorized provider that Claimant needs any additional medical treatment or imaging that would tend to lessen the period of Claimant's disability (see Form 14-Bs).

22. That Claimant has sustained 10% permanent partial disability to her right upper extremity as a result of the accidental injury on July 22, 2008.

23. That Defendants were entitled to stop payment of temporary total compensation effective June 30, 2010 and are entitled to a credit for the overpayment of temporary total compensation since June 30, 2010, against the award for permanent partial disability ordered herein.

24. That Claimant has failed to prove that she is entitled to any further medical benefits, any award for serious disfigurement or any other compensable element under the law, other than the award for disability as ordered herein.

The Hearing Commissioner's Decision and Order also set forth the following Conclusions of Law:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-1-160, Claimant did sustain an injury to her right upper extremity by accident arising out of and in the course and scope of her employment on July 22, 2008.

3. Under §§ 42-9-10 and 42-1-120, Claimant was entitled to compensation for a period of temporary total disability from January 16, 2009 until June 30, 2010, the date on which Claimant reached maximum medical improvement.

4. Under § 42-15-60, Claimant was entitled to medical, surgical, hospital and other authorized treatment until June 30, 2010, the date on which Claimant reached maximum medical improvement, but not thereafter, there being no evidence that any additional medical treatment would tend to lessen the period of her disability.

5. Under § 42-9-30, Claimant has sustained 10% permanent partial disability to the right upper extremity. From such award, Defendants are entitled to a credit for the overpayment of temporary total compensation since June 30, 2010.

Within the statutory period, counsel for the Claimant filed an Application for Review in the case setting forth the following assignments of error:

1. In characterizing Claimant's injury as getting "her hand and forearm caught in roller" (Order, p. 7, para. 6), when the record established she suffered a "very significant roller type (crush) injury" (Defendants' APA p. 44), the error being that a "crush injury" of the dominant hand is a very serious injury.
2. In characterizing the November 26, 2008, MRI as "essentially normal" (Order, p. 7, para. 8), when the MRI itself showed "subtle sclerosis" and "small subchondral cystic degenerative changes along the ulnar aspect of the lunate bone" (Defendants' APA p. 65), the error being that no doctor commented upon these potential problems until Dr. Moore suggested the possibility of ulnar abutment or avascular necrosis (Claimant's APA p. 248) in June, 2010.
3. In finding that Defendants made a good faith effort to get Claimant the treatment she needed (Order, p. 8, para. 19), the error being that the authorized treating physician attempted to refer Claimant to Dr. Marshall White, the neurologist who performed a nerve conduction

study/electromyography on November 3, 2008 (Defendants' APA pp. 131-132), for a follow-up appointment to determine whether or not Claimant had "true reflex dystrophy" and whether certain treatment would be helpful; but such treatment was never provided (Defendants' APA pp. 54, 56; Claimant's APA p. 83).

4. In failing to order a return appointment to a neurologist to determine whether or not Claimant has reflex sympathetic dystrophy or other undiagnosed problem and whether further specialized treatment was needed, the error being that Claimant did not receive treatment ordered by the authorized treating physician and has continued to suffer problems with her dominant right hand with no physician pin-pointing what her problem is and what can be done to improve it.
5. In finding that Defendants made a good faith effort to get Claimant the treatment she needed (Order, p. 8, para. 19), the error being that the authorized treating physician attempted to refer Claimant for a repeat MRI on February 18, 2010, and February 25, 2010, to see "if anything has changed since the previous MRI" (Defendants' APA pp. 105, 107, and 109); but such treatment was never provided.
6. In failing to order a repeat MRI to determine whether or not whether Claimant's condition had changed, the error being that Claimant has continued to suffer problems with her dominant right hand with no physician pin-pointing what her problem is and what can be done to improve it.
7. In failing to allow the referrals recommended by the authorized treating physician for a neurological referral and a repeat MRI, the error being that the Defendants unreasonably denied necessary medical treatment which might tend to lessen her disability.
8. In drawing conclusions about the credibility of the Claimant based upon her assessment that the physicians to whom the Defendants referred Claimant treated her rudely (Order, p. 7, paras. 7, 9 and 10), the error being that the Claimant's assessment of the manners or demeanor of her doctors could well be correct and that there is no way to prove that they did nor did not treat her civilly and respectfully. Comments of Dr. Gee in his prepared records referenced by the Commissioner that there was some degree of animosity between him and Claimant [support the Claimant's concerns]. Were the doctors disrespectful to Claimant before she was to them, or was it the opposite? There is no way to tell; and, anyway, such is irrelevant in deciding this claim.
9. In finding that the nerve conduction study/electromyography was "unremarkable", the error being that, for instance, the "normal Amp" is

greater than three, and Claimant's left arm "Amp (mV)" is 7.2 at the wrist, while the right arm is 3.2 at the wrist, suggesting that the situation with the injured, dominant right hand is considerably less stable than the left. Attention is invited to the fact that the authorized treating physician tried unsuccessfully to have Claimant seen again by the neurologist who performed the test.

10. In failing to give considerable weight to the "valid" functional capacity evaluation that indicated Claimant cannot return to her former duties, the error being that the report was prepared by an authorized provider, McLeod Health, which had just completed a 21-visit course of work hardening with Claimant, and showed greatly reduced capacity for work and considerable functional problems, including pain. This evaluation should have led to more treatment or greater permanent disability.
11. In finding that Claimant's attempt to use post-hole diggers "brought her credibility into question" (Order, p. 8, para. 13), the error being that Claimant only tried to use the tool because she was determined to get better and to do all that she could do, but found that she could not use the post-hole diggers. The hearing Commissioner did not determine that Claimant lied about using the tool, he said the fact that she tried to use the tool reflects on the believability of her testimony, which is not a logical sequence. Claimant's activity throughout the time since her injury shows her as determined to work and to do as much as she can.
12. In giving any weight to the opinion of Dr. Green (Order, p. 8, para. 14), because Dr. Green assessed 2% permanent impairment one day and 1% (Defendants' APA p. 70), the next, the error being that, as Dr. Moore pointed out, reducing an rating by fifty percent without giving any reason raises questions about the reliability of the impairment was determined. Attention should be given to the fact that Dr. Green, like Dr. Fulton and Dr. Moore, was not a treating physician, but an independent medical examiner who did not form a patient-physician relationship with Claimant.
13. In giving any weight to the opinion of Dr. Fulton, the error being that he gave no consideration to the functional capacity evaluation which showed Claimant is unable to return to work.
14. In finding that Claimant had reached maximum medical improvement and ordering reimbursement of temporary total disability compensation, the error being that Dr. Green and Dr. Fulton were independent medical examiners, not authorized treating physicians, and the authorized treating physician, Dr. Gee, has not made a definitive statement as to maximum medical improvement, as required by Regulations 67-505 and 596. Dr. Moore, also an independent medical examiner, concluded that Claimant was not at maximum medical improvement. Treatment requested by Dr.

Gee was not approved by the carrier, so that Claimant is not at maximum medical improvement.

15. In awarding only 10% permanent disability to the right arm, the error being that the severity of Claimant's injury and her functional loss due to the work injury require significantly greater permanent disability, especially where Claimant cannot return to the level of work she has done her entire life.
16. In questioning the credibility of Claimant, the error being that the overall tenor of the medical records shows Claimant to be an injured worker who fought unsuccessfully to save her job, tried everything she could to continue working, sought medical treatment that would allow her to get better and return to work, worked hard in physical therapy and work hardening to improve her function, understated her pain in an effort to be allowed to return to work, and gave full and valid effort on her functional capacity evaluation. If the Claimant's attitude at the hearing was troubling, it was from frustration and exasperation at being denied medical treatment ordered by the approved doctor, being told one thing only to have something else happen, and not being able to get better and return to work.
17. In finding that "Claimant's testimony was evasive and confusing at times, which brought her credibility into question" (Order, p. 8, para. 18), the error being that the Claimant's testimony was not evasive and confusing and no one can decipher how the hearing Commissioner reached this finding because no examples to back up the finding are given in the order.
18. In finding that Dr. Gee, the authorized treating physician, placed the Claimant at maximum medical improvement, the error being that Dr. Gee never concluded that the Claimant had reached maximum medical improvement. In fact, Dr. Gee ordered further treatment through work hardening in his report dated May 27, 2009.
19. In finding that the Claimant did not need a follow-up MRI and neurological appointment, the error being that the Commissioner should have at least determined why Dr. Gee asked for a second MRI more than once and a repeat neurological consult, which requests were denied, overlooked, and forgotten.
20. In finding and concluding that the Claimant's entitlement to temporary compensation ended on June 30, 2010, the error being that the Defendants did not file for stop payment until October 12, 2010, and that, if the Claimant has in fact reached maximum medical improvement, any credit for overpayment should not have been allowed prior to the date of filing of the stop payment request. The Claimant resubmits her argument that she

has not been found to be at maximum medical improvement by the authorized treating physician.

Copies of the above assignments of error were furnished to all interested parties prior to oral argument presented before the Appellate Panel on October 25, 2011.

Pursuant to S.C. Code Ann. § 42-17-50 (1985), the Appellate Panel reviewed the Award and weighed the evidence in the record as presented at the initial hearing. The Panel also considered all issues raised in the brief of the Appellant and Respondents. The Panel makes the following Findings of Fact and Conclusions of Law:

### **FINDINGS OF FACT**

#### **IT IS FOUND AS A FACT:**

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Emma Hamilton as Employee-Claimant and Martin Color-Fi, Inc. as Employer and Liberty Mutual Insurance Company as Carrier, Defendants.
2. That Claimant was an employee of the above-named Employer on and prior to July 22, 2008, when Claimant injured her right hand in an admitted work-related accident. The injury affects the Claimant's right wrist.
3. That the average weekly wage of Employee at the time of the above-described accident was \$516.51, making a compensation rate of \$344.35 applicable in this matter.
4. That the Defendants are to pay all causally related authorized medicals.
5. That the Claimant was a machine operator for the Defendant. She has done construction work in the past and other labor intensive work.
6. That the Claimant was injured when she got her hand and forearm caught in rollers. She is right hand dominant.

7. That the Claimant was treated by Dr. Gee, but she was dissatisfied with him and eventually saw Dr. Green and Dr. Fulton. She was also dissatisfied with her treatment by them.

8. That the Claimant had an MRI, which was essentially unremarkable with no tendon or ligament injury.

9. That Claimant stated Dr. Green was nasty to her much like Dr. Gee. She then saw Dr. Fulton. The medical record notes the Claimant's attitude towards Dr. Gee was not nice or pleasant.

10. That the Claimant liked Dr. Fulton until he read her MRI. Claimant said Dr. Fulton was then also nasty to her.

11. That the Claimant had an unremarkable nerve conduction study and physical therapy that she said did not help.

12. That the Claimant also had an FCE, which was valid and indicated that she could not return to her former duties.

13. That the Claimant testified that she previously tried to use a posthole digger and was unable to do so. The fact that she even considered this brings her credibility into question.

14. That the Claimant was placed at maximum medical improvement by Dr. Green on February 11, 2009 with a 2% impairment to the hand. Dr. Green released the Claimant to full duty and stated that she will not need future medicals.

15. That the Claimant was treated by Dr. Fulton, and on June 30, 2010, Dr. Fulton placed the Claimant at maximum medical improvement, Dr. Fulton gave the Claimant no work restrictions and stated she had no evidence of impairment to the right hand or wrist.

16. That the Claimant was also seen by Dr. Moore for the purpose of an independent medical evaluation.

17. That greater weight was given to the opinions of Dr. Green and Dr. Fulton, who are hand specialists, versus the opinion of Dr. Moore.

18. That the Claimant's testimony was evasive and confusing at times, which brought her credibility into question.

19. That the Defendants made a good faith effort to have Claimant seen by three doctors after **being out for about two years**.

20. That the report of Dr. Gee dated May 27, 2009 is very persuasive, and there is no mention of a follow-up MRI in this report. Dr. Gee placed the Claimant at maximum medical improvement. At the hearing, Claimant sought a second MRI.

21. That Claimant reached maximum medical improvement on June 30, 2010 for the injuries resulting from the July 22, 2008 accident and that there is no evidence from an authorized provider that Claimant needs any additional medical treatment or imaging that would tend to lessen the period of Claimant's disability (see Form 14-Bs).

22. That Claimant has sustained 10% permanent partial disability to her right upper extremity as a result of the accidental injury on July 22, 2008.

23. That Defendants were entitled to stop payment of temporary total compensation effective June 30, 2010 and are entitled to a credit for the overpayment of temporary total compensation since June 30, 2010, against the award for permanent partial disability ordered herein.

24. That Claimant has failed to prove that she is entitled to any further medical benefits, any award for serious disfigurement or any other compensable element under the law, other than the award for disability as ordered herein.

### CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-50, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-1-160, Claimant did sustain an injury to her right upper extremity by accident arising out of and in the course and scope of her employment on July 22, 2008.

3. Under §§ 42-9-10 and 42-1-120, Claimant was entitled to compensation for a period of temporary total disability from January 16, 2009 until June 30, 2010, the date on which Claimant reached maximum medical improvement.

4. Under § 42-15-60, Claimant was entitled to medical, surgical, hospital and other authorized treatment until June 30, 2010, the date on which Claimant reached maximum medical improvement, but not thereafter, there being no evidence that any additional medical treatment would tend to lessen the period of her disability.

5. Under § 42-9-30, Claimant has sustained 10% permanent partial disability to the right upper extremity. From such award, Defendants are entitled to a credit for the overpayment of temporary total compensation since June 30, 2010.

After careful review in the present case, the Appellate Panel of the South Carolina Workers' Compensation Commission has determined the Order of the Hearing Commissioner is hereby **AFFIRMED IN FULL**. The Findings of Fact and Conclusions of Law found in the Hearing Commissioner's Decision and Order, and as specified above, are hereby **AFFIRMED IN FULL**.

**ORDER**

**IT IS HEREBY ORDERED** that the Order of the Single Commissioner from which this appeal has been taken is hereby **AFFIRMED IN FULL**.

**IT IS AFFIRMED** that the Application of Employer/Carrier to stop payment of temporary total compensation is hereby granted, effective June 30, 2010, the date on which Claimant reached maximum medical improvement.

**IT IS AFFIRMED** that as a result of Claimant's accidental injury occurring on July 22, 2008, she has sustained 10% permanent partial disability to the right upper extremity, for which she is entitled to 22 weeks at the compensation rate of \$344.35 per week which represents \$7,575.70. The Defendants are entitled to a credit or offset for the overpayment of temporary total compensation from June 30, 2010. As of the February 12, 2011, the credit represents 32 weeks of overpayment in the amount of \$11,019.20

**IT IS AFFIRMED** that Claimant reached maximum medical improvement on June 30, 2010, and as such Defendants are not liable for any additional medical, surgical, hospital or other medical treatment to Claimant after said date, until and unless further ordered by this Commission.

**IT IS AFFIRMED** that Claimant has not sustained any serious and permanent disfigurement as a result of this accident, and as such Defendants are not liable for same.

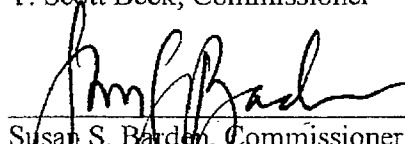
IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'  
COMPENSATION COMMISSION

  
Andrea C. Roche, Commissioner  
For the Appellate Panel

Concur:

  
T. Scott Beck, Commissioner

  
Susan S. Barden, Commissioner

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 23 day of January, 2012  
By Valerie D. Deller

Administrative Assistant to the Commissioner

Candace G. Hinderstman  
Joseph T McElveen Jr

**olina Workers' Compensation Commission**  
 715 • 1612 Marion Street  
 Columbia, South Carolina 29202-1715  
 803-737-5700

WCC File # 0810330  
 Carrier File # WC550-614499  
 Carrier Code #  
 Employer FEIN

|                                      |  |                                                 |       |                                     |                |
|--------------------------------------|--|-------------------------------------------------|-------|-------------------------------------|----------------|
| Claimant's Name                      |  | SSN                                             |       | Employer's Name                     |                |
| Candace G. Hindersman                |  | 249-17-0683                                     |       | Martin Color-Fi, Inc.               |                |
| Address                              |  | City                                            | State | Address                             | City State Zip |
| 227 Bobwhite Drive, Sumter, SC 29154 |  |                                                 |       | 320 Neeley Street, Sumter, SC 29150 |                |
| (803) 840-5388                       |  |                                                 |       | Liberty Mutual Insurance Company    |                |
| Home Phone                           |  | Work Phone                                      |       | Insurance Carrier                   |                |
| Candace G. Hindersman                |  | 4500 Fort Jackson Boulevard, Columbia, SC 29209 |       | (803) 227-2888                      |                |
| Preparer's Name                      |  | Address                                         |       | Phone #                             |                |

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND  
 JOSEPH T. MCELVEEN, JR., ESQUIRE, ATTORNEY FOR CLAIMANT

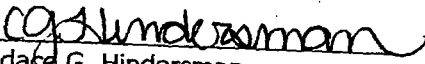
YOU ARE HEREBY NOTIFIED THAT DEFENDANTS, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330, (1976, as amended), herewith submits the following medical reports as direct evidence on behalf of the defendants, to wit:

| NAME OF PHYSICIAN/OTHER                       | DATE OF REPORT        | PAGE    |
|-----------------------------------------------|-----------------------|---------|
| APA #1: Tuomey ER                             | 07/22/08 and 11/20/08 | 1 - 29  |
| APA #2: Tuomey Industrial Medicine & Wellness | 07/23/08 - 11/23/09   | 30 - 64 |
| APA #3: Clarendon Memorial Hospital           | 11/26/08              | 65 - 66 |
| APA #4: Midland's Orthopaedic                 | 02/11/09              | 67 - 70 |
| APA #5: Moore Orthopaedic                     | 06/30/10              | 71 - 72 |

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 the evidence on behalf of the employer-defendant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the defendants: See Pre-Hearing Brief.

  
 Candace G. Hindersman  
 Willson Jones Carter & Baxley, P.A.  
 4500 Fort Jackson Boulevard  
 Columbia, SC 29209

November 29, 2010

December 15, 2010  
 (hearing date)



Claimant's Name: Emma Hamilton  
Address: 2227 Bobwhite Drive  
City: Sumter State: SC Zip: 29154  
Home Phone: (803) 840-5388 Work Phone: \_\_\_\_\_  
Preparer's Name: Candace G. Hindersman, Attorney for Defendants

Employer's Name: Martin Color-Fi, Inc.  
Address: 320 Neeley Street  
City: Sumter State: SC Zip: 29150  
Carrier: Liberty Mutual Insurance Company  
Preparer's Phone #: (803) 227-2888

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$344.35 2. AWW: \$516.51 Date of Injury: July 22, 2008
3. Type of injury and body part(s): Right hand.
4. Facts in controversy: Whether Claimant is at MMI? If so, to what, if any, additional benefits is Claimant entitled? Are Defendants entitled to credit for overpayment?
5. Legal issues involved: § 42-15-60; § 42-9-30; Curiel vs. Environmental Management Services; Shealy vs. Algernon Blair, Inc. 250 S.C. 106 and other applicable statutes, regulations, and case law.
6. Unusual aspects: Defendants reserve the right to and may move to either postpone or adjourn the scheduled hearing to exercise due process rights afforded by law to cross examine, respond to, and otherwise oppose evidence presented by the claimant.
7. Witnesses (designate if expert):\* Employer Representative(s)
8. Exhibits: Claimant's Employment/Personnel File; Payroll Records; Deposition of Claimant
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): SEE APA SUBMISSION
10. Name, address, and specialty, if any, of the treating physician: James Gee, M.D.; Tuomey Industrial Medical & Wellness; 250 West Wesmark Blvd., Building 2; Sumter, SC 29150; Dr. Michael Green; Midlands Orthopaedics, PA; 1910 Blanding St.; Columbia, SC 29201
11. Impairment rating(s); body part(s); physician and date of opinion: A 14B was completed by treating physician, Dr. Gee, on May 7, 2009. He asserted Dr. Green is a hand specialist and I defer to his opinion. 2%; right hand, Dr. Michael Green; Date of MMI – February 11, 2009; March 31, 2009 1%; Right hand; Dr. Michael Green; Date of MMI – February 11, 2009; April 1, 2009 No impairment; right hand; Dr. Fulton; June 30, 2010.
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:   
Candace G. Hindersman, Willson Jones Carter & Baxley, P.A.

Email: cghindersman@wjlaw.net

Date of hearing: December 15, 2010

Time needed for hearing: 30 minutes

On behalf of ☐ Claimant ☒ Employer

I certify that I have served this document pursuant to R.67-212 by delivering a copy to JOSEPH T. MCELVEEN, JR., Esquire,  
Name

17 E. Calhoun Street, P.O. Box 2038, Sumter, SC 29151-2038; and The Honorable G. Bryan Lyndon, SC WCC, P.O. Box 1715, Columbia, SC 29202-1715  
Address

on the 29th day of November, 2010 by ☒ first class mail; ☐ personal service; ☐ certified mail.

Ivey L. Gable, Certifier

November 29, 2010  
Date

ER

## ADMISSION RECORD

|                                                                                                                                                                                                                                     |  |                                                                                                              |            |                 |                                               |                            |               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|------------|-----------------|-----------------------------------------------|----------------------------|---------------|
| Patient Name / Address<br>HAMILTON, EMMA R<br>2227 BOB WHITE DRIVE<br>SUMTER, SC 29154<br>Phone 803-773-7879<br>Social Security No. 249-17-0683<br>Employer MARTIN COLOR-FI                                                         |  | Account No.<br>12964385                                                                                      | Room / Bed | Type<br>ER      | Location / Service<br>ED                      | Medical Rec. No.<br>238287 |               |
| Guarantor / Address<br>HAMILTON, EMMA R<br>2227 BOB WHITE DRIVE<br>SUMTER, SC 29154<br>Phone 803-773-7879<br>Relationship SAME AS PATIENT<br>Guarantor Employer MARTIN COLOR-FI                                                     |  | Date of Birth<br>12/04/84                                                                                    | Age<br>43  | Sex<br>F        | MarStat<br>D                                  | Religion<br>BAP            | Race<br>W     |
| Financial Class<br>A                                                                                                                                                                                                                |  | Person to Notify / Address<br>RUSSELL, MARY LOU<br>LEWIS ROAD<br>SUMTER, SC 29150<br>Home Phone 803-236-4449 |            |                 | Relationship<br>M                             |                            |               |
| Insurance Name<br>LIBERTY MUTUAL                                                                                                                                                                                                    |  | Policy Number<br>249170683                                                                                   |            | Coverage Number | Subscriber / Insured Name<br>HAMILTON, EMMA R |                            |               |
| Accident Information<br>ACCIDENT/EMPL R                                                                                                                                                                                             |  | Reason for Visit<br>HAND CRUSHED IN MACHINE                                                                  |            |                 | Other Phone                                   |                            |               |
| Accident Date / Time<br>07/22/08                                                                                                                                                                                                    |  | Comments                                                                                                     |            |                 | Height / Weight                               |                            | Arrival Mode  |
| Admit Date / Time<br>07/22/08 1308                                                                                                                                                                                                  |  | Admitting Physician                                                                                          |            |                 | Attending Physician<br>FAMILY HEALTH CENTER   |                            | User<br>ADJRJ |
| Hospital Days<br>HOME OMI SNF ICF HH DIED AUTOPSY<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  | Surgeon                                                                                                      |            | Consult         |                                               | Discharge Date / Time      |               |
|                                                                                                                                                                                                                                     |  | Anesthesiologist                                                                                             |            | Consult         |                                               |                            |               |

Admitting Diagnosis

Diagnosis and Procedure  
Code

Principal Diagnosis

Secondary Diagnosis

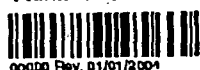
Procedure

Does pt have Advance Directive (Living Will)? No  
 Does pt have Health Care Power of Attorney? No  
 Does patient want info on Advance Directive? No  
 Are you an organ donor? No

If yes, Living Will copy received? N  
 If yes, Health Care Power of Attorney copy received?

  
**TUOMEY**  
 129 North Washington Street  
 Sumter, South Carolina 29150

Admission Record (ER)



0000 Rev. 01/01/2004



HAMILTON, EMMA R  
 Acct: 12964385 Unit: 238287  
 FAMILY HEALTH CENTER  
 ER DOS: 07/22/08  
 F W Age: 43 DOB: 12/04/84

Tuomey Healthcare System  
Emergency Room Record

07/22/08

Patient: HAMILTON, EMMA R  
Unit #: 238267

Account #: 12964385

TUOMEY HEALTHCARE  
EMERGENCY RECORD

TRIAGE (13:04 SRA)

COMPLAINT: COMPLAINT: CRUSHED HAND.

ADMISSION: URGENCY: 1 - Emergent, BED: LOBBY.

PATIENT: NAME: Emma R Hamilton, AGE: 43, GENDER: female, DOB: Fri  
Dec 04, 1964. Pt wants EDHIV test?: Patient does not want EDHIV test,  
Fall related visit: No, New onset weakness: No, ZIP CODE: 29150, KG  
WEIGHT: 81.6, PHONE: 803-316-3864, MEDICAL RECORD NUMBER: 238267,  
PAYMENT: Blue Cross.

PREVIOUS VISIT ALLERGIES: Sulfur.

ASSESSMENT: .

ALERT AND ORIENTED. SKIN WARM AND DRY. RESP EVEN AND NONLABORED. C/O  
PAIN TO RIGHT HAND/WRIST. PT'S HAND WAS CAUGHT IN A MACHINE. +RADIAL  
PULSE AND CAP REFILL. STATES UNABLE TO MOVE FINGERS. +SENSATION. PT WAS  
GIVEN 4MG OF MORPHINE PER EMS.

TREATMENTS IN PROGRESS: Site: L arm, Gauge: 20.

VITAL SIGNS: BP 132/87, Pulse 76, Resp 20, Temp 97.4, Pain 10, O2  
Sat 100, on RA, Time 7/22/2008 12:57.

KNOWN ALLERGIES

Sulfur.

CURRENT MEDICATIONS: No recorded medications

HPI HAND (13:16 DRAG)

CHIEF COMPLAINT: Patient presents for the evaluation of right,  
hand injury, hand swelling, hand pain, hand complications, specifically  
decreased range of motion, hand weakness.

HISTORIAN: History obtained from patient.

MECHANISM: Complaint occurred by caught in machine at work.

OCCURRED: Just prior to presentation. Patient currently has  
symptoms.

LOCATION: No localizing symptoms, Dominant Hand: Right.

QUALITY: Patient describes pain as throbbing.

SEVERITY: Maximum severity is severe, Currently symptoms are  
severe.

RELIEVED BY: Patient's condition relieved by nothing.

EXACERBATED BY: Patient's condition exacerbated by flexion of  
fingers, flexion of wrist.ASSOCIATED WITH: Patient denies clavicle pain, shoulder pain,  
elbow pain. Patient states wrist pain is present, hand pain is present,  
finger pain is present, Patient denies distal neuro c/o, Patient denies  
proximal injury, distal injury.NOTES: pt with c/o r hand pain secondary to being caught in  
machine at work. decreased rom. no numbness/tingling. no other injury.

PAST MEDICAL HISTORY

MEDICAL HISTORY: Additional history includes: History of  
pulmonary disease, including asthma, with use of inhaler. . (13:04  
SRA)

SURGICAL HISTORY: History of tonsillectomy. (13:04 SRA)

PSYCHIATRIC HISTORY: No previous psychiatric history. (13:04  
SRA)

TUOMEY REGIONAL MEDICAL CTR PCI \*LIVE\* (PCI: OE Database TUH)

Run: 07/23/08-11:19 by MARTIN, DELCENIA S.

Page 1 of 9

Tuomey Healthcare System  
Emergency Room Record

07/22/08

Patient: HAMILTON, EMMA R  
Unit #: 238267

Account #: 12964385

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 12964385  
Prepared: Tue Jul 22, 2008 16:57 by Page: 1 of 5TUOMEY HEALTHCARE  
EMERGENCY RECORDSOCIAL HISTORY: Denies drug abuse, Lives with others, Denies  
alcohol abuse, SMOKES 1 PPD. (13:04 SRA)FAMILY HISTORY: Family history is not contributory to this case.  
(13:16 DRAG)NOTES: Nursing records reviewed; Agree with nursing records,  
Emergency medical services record reviewed, Medication list reviewed.  
(13:16 DRAG)

ROS (13:16 DRAG)

MUSCULOSKELETAL: Historian reports arthralgias, injury. No  
myalgias.

SKIN: No skin lesions.

NEUROLOGIC: No paresthesias, focal weakness, sensory changes.

HEMO/LYMPHATIC: No anemia, easy bleeding, abnormal clotting.

PSYCHIATRIC: No drug abuse, alcohol abuse.

ALL SYSTEMS NEGATIVE: All relevant systems reviewed and all  
negative except for the above.

PHYSICAL EXAM (13:18 DRAG)

CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed.

Patient has normal pulse, normal blood pressure, normal respiratory  
rate, Well appearing, Alert and oriented X 3. Patient appears  
uncomfortable, to be in pain. Patient has moderate pain distress.

CARDIOVASCULAR: strong radial/ulnar pulse.

UPPER EXTREMITY: Hand evaluation shows, no deformity, no  
erythema, radial pulse intact, ulnar pulse intact, capillary refill  
less than 2 seconds, distal sensory intact. Ecchymosis noted, dorsally,  
Swelling noted, dorsally, Hematoma noted dorsally. Tenderness to  
palpation, of dorsal hand, Active range of motion:, limited, causes  
pain, Passive range of motion, limited, causes pain, ecchymosis dorsal  
wrist. diffuse wrist/hand tenderness. no skin break. no obvious  
deformity. .NEURO: GCS is 15. No focal motor deficits, focal sensory  
deficits, cerebellar deficits, Speech normal, Gait normal, Memory  
normal.SKIN: Skin is warm, Skin is dry, Skin is normal color, Skin exam  
normal except as noted.

PSYCHIATRIC: Oriented X 3. Normal affect, insight, concentration.

## VITAL SIGNS

VITAL SIGNS: BP: 132/87, Pulse: 76, Resp: 20, Temp: 97.4, Pain:  
10, O2 sat: 100 on RA, Time: 7/22/2008 12:57. (13:04 SRA)  
BP: 120/73, Pulse: 80, Resp: 16, O2 sat: 100% on ra, Time: 7/22/2008  
14:31. (14:32 MEF)

## ORDERS

Vital Signs Every 2 Hours by DRAG for DRAG on Tue Jul 22, 2008 13:10  
Status: Done by MEF Tue Jul 22, 2008 13:14.

TUOMEY REGIONAL MEDICAL CTR PCI \*LIVE\* (PCI: OE Database TUH)

Run: 07/23/08-11:19 by MARTIN, DELCENIA S.

Page 2 of 9

Tuomey Healthcare System  
Emergency Room Record

07/22/08

Patient: HAMILTON, EMMA R  
Unit #: 238267

Account #: 12964385

INT by DRAG for DRAG on Tue Jul 22, 2008 13:09 Status: Done by MEF Tue  
Jul 22, 2008 13:15.XR HAND - RIGHT 3 VIEWS 1563 by DRAG for DRAG on Tue Jul 22, 2008 13:10  
Status: Active.Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 12964385  
Prepared: Tue Jul 22, 2008 16:57 by Page: 2 of 5TUOMEY HEALTHCARE  
EMERGENCY RECORDVital Signs Every 2 Hours by DRAG for DRAG on Tue Jul 22, 2008 13:09  
Status: Done by MEF Tue Jul 22, 2008 13:14.

## DOCTOR NOTES (14:14 DRAG)

TEXT: pt with hand/wrist injury. compartments soft. ~~moderate~~  
~~swelling~~ nv intact. neg xray for fx. pt placed in splint. d/w ortho.  
will f/u with ortho for recheck as pt at risk for developing  
compartment secondary to mechanism. d/w pt to return for increased  
pain/swelling/numbness/decreased rom/ pt able to move all fingers at  
time of dispo. d/w pt that she must keep her arm elevated above her  
heart. pt voices understanding and agrees with dispo and plan.INTERVENTIONS: Pain medications administered:, HYDROMORPHONE,  
KETOROLAC, Pain medications were given IV.PATIENT STATUS: Patient has stabilized since arrival to emergency  
department.D/W: Discussed with appropriate consultants, Discussed this case  
with Dr. Ford, Orthopedic surgery, Risk and benefits discussed. with  
patient.

DATA REVIEWED: Xray data reviewed, Discussed with consultants.

LEVEL OF RISK: Minimal level of risk.

## MEDICATION SERVICE

Dilaudid: Order: Dilaudid (Hydromorphone Hydrochloride) : 1  
milligram(s) : Intravenous

Ordered by: Aaron Garrett

Entered by: Aaron Garrett Tue Jul 22, 2008 13:09

Acknowledged by: Marybeth Fralick Tue Jul 22, 2008 13:15

Documented as given by: Marybeth Fralick Tue Jul 22, 2008 13:26

Patient, Medication, Dose, Route and Time verified prior to  
administration.Time given: 1325, Amount given: 1MG, IV site 1, Medication administered  
into left AC, IVP, Initial medication, Slowly, Catheter placement  
confirmed via flush prior to administration, IV site without signs or  
symptoms of infiltration during medication administration, No swelling  
during administration, No drainage during administration, IV flushed  
after administration, Correct patient, time, route, dose and medication  
confirmed prior to administration, Patient advised of actions and  
side-effects prior to administration, Allergies confirmed and  
medications reviewed prior to administration. (13:09 DRAG): Follow Up : Time: 1345. No change in pain, On a scale 0-10  
patient rates pain as 10. (13:47 MEF)

Toradol IV/IM: Order: Toradol IV/IM (Ketorolac Tromethamine) :

TUOMEY REGIONAL MEDICAL CTR PCI \*LIVE\* (PCI: OE Database TUH)

Run: 07/23/08-11:19 by MARTIN, DELCENIA S.

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Tuomey Healthcare System  
Emergency Room Record

07/22/08

Patient: HAMILTON, EMMA R  
Unit #: 238267

Account #: 12964385

30 milligram(s) : IVP  
Ordered by: Aaron Garrett  
Entered by: Aaron Garrett Tue Jul 22, 2008 14:14  
Documented as given by: Marybeth Fralick Tue Jul 22, 2008 14:31  
Patient, Medication, Dose, Route and Time verified prior to administration.  
Time given: 1425, Amount given: 30mg, IV site 1, Medication administered into left AC, IVP, Subsequent different medication, Slowly, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No  
Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 12964385  
Prepared: Tue Jul 22, 2008 16:57 by Page: 3 of 5

TUOMEY HEALTHCARE  
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swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration. (14:14 DRAG)

## MEDICATION ADMINISTRATION SUMMARY (16:57)

Drug Name: Toradol IV/IM, Dose: 30 milligram(s), Route: IVP, Status: Given, Ordered: 14:31 7/22/2008,

Drug Name: Dilaudid, Dose: 1 milligram(s), Route: Intravenous, Status: Given, Ordered: 13:26 7/22/2008, Detailed record available in Medication Service section.

## O2SAT INTERPRETATION (13:18 DRAG)

O2SAT: O2 saturation reading 100%, O2 AMT: R.A., O2 Sat normal, None needed.

## RADIOLOGY INTERPRETATION (14:05 DRAG)

UPPER EXTREMITIES: Radiological interpretation of, the right hand shows, hand negative, no fractures, no dislocations, no foreign bodies, no bony lesions, no degenerative joint disease, no soft tissue swelling.

INTERPRETER: Preliminary review of x-rays by ED Physician.

## ORTHO SPLINTING (13:55 SGO)

TIME OUT: Side/site verified. Patient identification confirmed.

ORTHO SPLINTING: Verbal consent obtained, Performed by physician extender, Indicated for pain, Thumb spica post mold applied, Applied to left hand. Post splinting neurovascular check: Capillary refill normal, Distal sensation is intact, Distal motor function is normal, Well aligned. Patient tolerated procedure well.

## DIAGNOSIS (14:14 DRAG)

FINAL: PRIMARY: Crush - hand and wrist, ADDITIONAL: Wrist sprain.

## PRESCRIPTION (14:15 DRAG)

Naprosyn: Tablet : 500 mg : Oral=Quantity: \*\*\*1\*\*\* Unit: tab  
Route: Oral Schedule: 2 times a day Dispense: \*\*\*30\*\*\*

POTENTIAL SEVERE INTERACTION: Toradol IV/IM (Ketorolac Tromethamine).  
Percocet 5/325: Tablet : 325 Mg-5 Mg : Oral=Quantity: \*\*\*1\*\*\*

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Patient: HAMILTON, EMMA R  
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Account #: 12964385

Unit: tab Route: Oral Schedule: every 6 hours as needed Dispense:  
\*\*\*15\*\*\*.

INSTRUCTION (14:16 DRAG)

DISCHARGE: COMPARTMENT SYNDROME, PRECAUTIONS, WRIST SPRAIN -  
WITH SPLINT, CRUSH INJURY, FINGER/TOE - WITH XRAY.FOLLOWUP: DANNY H FORD 100 N. Sumter Street Suite 200 SUMTER SC  
29150 803-774-7621.

SPECIAL: Take medication as prescribed

Return if worse

Follow up with your private MD in the AM. Return to ED if worse.

Ice and elevate (Keep arm elevated above your heart)

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 12964385

Prepared: Tue Jul 22, 2008 16:57 by

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TUOMEY HEALTHCARE  
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Follow up with referral physician first thing in the morning.

## DISPOSITION

PATIENT: Disposition: Home, Disposition Transport: Family/Friend  
Drive, Condition: Stable. (14:14 DRAG)Pain Scale: 05, O2 used while in ED?: No, IV stop time docd?: NA, Remove  
from ER. (14:32 MEF)

NURSING PROCEDURE: TRANSPORT TO TESTS (13:25 MEF)

TIME: Procedure was performed at 1325. Patient transported to,

X-ray, Patient transported via, cart, Patient accompanied by, ER tech.

NURSING PROCEDURE: NURSE NOTES (13:48 MEF)

TIME: Time: 1345, Pt returned from xray. Pt states pain has not

decreased since administration of pain medications. Skin w/d.

Respirations equal and unlabored bilaterally. Awaiting xray results to  
post chart for MD review.

NURSING PROCEDURE: DISCHARGE NOTE (14:32 MEF)

TIME: Patient discharged at 1428, Patient discharged to, home,

Patient, ambulates without assistance, Transported via friend/family  
driving, Accompanied by friend, IV discontinued with catheter intact.

Dressing placed to IV site, Discharge instructions given to, patient,

Simple/moderate discharge teaching performed, Prescription given and

additional instructions on side effects of same given, Medication

reconciliation form given to patient, Above Person(s) verbalized

understanding of discharge instructions and follow-up care.

VITAL SIGNS: BP: 120, / 73, Pulse: 80, Resp: 16, O2 sat: 100%,  
ra.

NURSING PROCEDURE: DISCHARGE NOTE (16:56 TEF)

TIME: D/A screen completed per Sophia, EDT.

ADMIN

DIGITAL SIGNATURE: Garrett, Aaron. (15:15 DRAG)

Floyd, Tonya. (16:57 TEF)

Key:

DRAG=Garrett, Aaron MEF=Frailick, Marybeth SGO=Stevens, PA-C, Shelley

SRA=Avins, RN, Stacy TEF=Floyd, Tonya

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Tuomey Healthcare System  
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Patient: HAMILTON, EMMA R  
Unit #: 238267

Account #: 12964385

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 12964385  
Prepared: Tue Jul 22, 2008 16:57 by Page: 5 of 5

## INSTRUCTIONS

- \* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic.

\*

## FINAL DIAGNOSIS Crush - hand and wrist

ADDITIONAL DIAGNOSIS Wrist sprain FOLLOWUP CONTACTS. DANNY H FORD 100 N. Sumter Street Suite 200 SUMTER SC 29150 Phone: 803-774-7621 SPECIAL

INSTRUCTIONS Take medication as prescribed Return if worse Follow up with your private MD in the AM. Return to ED if worse. Ice and elevate (Keep arm elevated above your heart) Follow up with referral physician first thing in the morning MEDICAL INSTRUCTIONS COMPARTMENT SYNDROME, PRECAUTIONS

You have had an injury that may put you at risk of developing COMPARTMENT SYNDROME. Your arms, legs, and even hands and feet have several compartments that separate groups of muscles and tendons. Compartments hold muscle, nerves, arteries, veins and bones. These compartments are surrounded by strong fibrous tissues that do not stretch or expand. If there is significant swelling inside the compartment, the muscles and nerves may be severely damaged because the pressure that builds up will crush the tissue and cut off its blood supply. Symptoms of compartment syndrome may include:

- Pain of the extremity. Pain is the hallmark (main symptom) of compartment syndrome and is usually constant, increasing and often severe. You may also have severe pain with movement of the fingers or toes, ankle, or wrist. You may also have severe pain if someone else moves tries to move your fingers or toes or bumps against you.
- "Pins and needles" sensation or numbness (loss of feeling) in the extremity.
- Cold, pale extremity with decreased pulse. Loss of a pulse in compartment syndrome is a very late finding, happening only after severe damage to the muscle in the extremity has already happened.
- Paralysis-Inability to move the affected area.

Use the following general instructions:

- REST: Limit the use of the injured body part.
- ICE: By applying ice to the affected area, swelling and pain can be reduced. Place some ice cubes in a re-sealable (Ziploc) bag and add some water. Put a thin washcloth between the bag and your skin. Apply the ice bag to the area for at least 20 minutes. Do this at least 4 times per day. Using the ice for longer times and more frequently is OK. NEVER APPLY ICE DIRECTLY TO THE SKIN.
- ELEVATE: Elevation of the injured extremity is VERY IMPORTANT. This will help to reduce swelling and inflammation, and may also help to prevent compartment syndrome. For example, an arm can be elevated by using a sling while standing, or by propping it up on pillows while lying down. Proper elevation should raise the injured limb above the level of the heart.

WARNING: Compartment syndrome is a serious condition and may result in severe and permanent damage to the muscles, nerves and bones. In severe cases, there is the possibility of loss of the limb. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY

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Patient: HAMILTON, EMMA R  
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DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS: - Constant, increasing, severe pain in the extremity. - Swelling associated with pain. - "Pins and needles" sensation or numbness (loss of feeling) in the extremity. - Severe pain with movement of the wrist, ankle, fingers, toes of the injured extremity. - If the injured extremity becomes pale and/or the pulse in the extremity becomes weak or disappears. **WRIST SPRAIN - WITH SPLINT** You have been diagnosed with a sprain of the wrist. A sprain is an injury to a ligament, usually a tear or partial tear. Ligaments are the tough bands that hold the bones in your wrist together. Sprains are often as painful as fractures (broken bones). Sprains are often divided into 3 types, depending on how bad the injury is: a first-degree sprain is considered a minor tear whereas a third-degree sprain often involves a chip fracture of the bone that the ligament is attached to. The general care of a sprain includes the use of pain medicine, the use of a splint to reduce movement and Resting, Icing, Compressing and Elevating the injured area. Remember this as "RICE." - Rest: Limit the use of the injured body part. - ICE: By applying ice to the affected area, swelling and pain can be reduced. Place some ice cubes in a re-sealable (Ziploc) bag and add some water. Put a thin washcloth between the bag and your skin. Apply the ice bag to the area for at least 20 minutes. Do this at least 4 times per day. Using the ice for longer times and more frequently is OK. NEVER APPLY ICE DIRECTLY TO THE SKIN. - COMPRESS: Compression means to apply pressure around the injured area such as with a splint, cast or an ace bandage. Compression decreases swelling and improves comfort. Compression should be tight enough to relieve swelling but not so tight as to decrease circulation. Increasing pain, numbness, tingling, or change in skin color, are all signs of decreased circulation. - Elevate: Elevate the injured part. For example, a sprained wrist can be placed in a sling while awake and propped up on pillows while lying down. You have been given a SPLINT for your sprain to decrease pain and help to keep the injured area from moving around. You should use the following SPLINT CARE INSTRUCTIONS and do the following things often throughout the day: - Check the capillary refill (circulation) by pressing on the nail bed and then releasing the nail bed. It should turn white when you press on it and then promptly return to pink in less than 2 seconds after you let go. - Watch for swelling of the area beyond the splint. - If the skin of the hand/foot or fingers/toes seems cold, pale or numb to the touch, the splint may be too tight. The wrap holding the splint in place can be loosened or you can return here or go to the nearest Emergency Department to have it adjusted. You should use the splint: - Until follow-up with your doctor or the referral orthopedic (bone) doctor. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS: - You experience a severe increase in pain in the affected area. - You develop new numbness and tingling in or below the affected area. - You develop a cold, pale hand or foot that appears to have a problem with its blood supply. **CRUSH INJURY, FINGER/TOE - WITH XRAY** After evaluation here today, you have been diagnosed with a crush injury. Crush injuries are common, painful injuries usually involving the fingers and toes. Treatment of crush injuries depends on extent of injury and associated injuries (lacerations or cuts, broken bones, nail bed

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Patient: HAMILTON, EMMA R  
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lacerations). Elevation is VERY important. Elevation (above the level of the heart) will help to reduce pain and swelling. Elevation is recommended for the first 24 hours after the injury. X-rays were obtained and do not reveal any fractures (broken bones). Keep the wound clean and dry for the next 24 hours and avoid excessive moisture. You can wash the wound gently with soap and water, and then apply a dry bandage. DO NOT allow your wound to soak in water (i.e. doing dishes or swimming). You can shower, but be careful not to be too abrasive to your stitches. Allow wound to dry before putting another bandage on. Remove old dressings daily and apply a clean dry dressing. Change the dressing if it becomes wet. - If the dressing sticks to the wound, slightly moisten it with water. This will allow it to come off more easily. - To help remove a scab, cleanse the area with a mixture of half hydrogen peroxide and half water. This will also help us to remove the sutures when they are ready to come out. - Allow the area to dry thoroughly. - Unless instructed to do otherwise, you can place a thin layer of antibiotic ointment over the wound. You can buy Polysporin (Triple Antibiotic), Bacitracin, or Neosporin over-the-counter. Neosporin can sometimes cause irritation to your skin. If this happens, stop using it and switch to another topical antibiotic. - Apply a clean, dry bandage over the wound if necessary to protect the wound. Keep the affected area elevated for the next 24 hours to decrease swelling and pain. You may also want to apply ice to the area. - By applying ice to the affected area, swelling and pain can be reduced. Place some ice cubes in a resealable (Ziploc) bag and add some water. Put a thin washcloth between the bag and your skin. Apply the ice bag to the area for at least 20 minutes. Do this at least 4 times per day. Longer times and more frequently are OK. NEVER APPLY ICE DIRECTLY TO THE SKIN. You MAY have been given a local anesthetic to help with your pain. It will wear off in about 2 hours. Until that time, you must be careful not to injure yourself because of decreased feeling to the area. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS: - Unusual redness or swelling. - Red streaks starting up the arm or leg. - Foul drainage or odor from wound. - Fever, chills, increasing pain and/or swelling. - Worsening numbness and/or tingling sensation, paleness. - If the injured area becomes cold and turns blue. PRESCRIPTIONS Naprosyn : Tablet : 500 mg : Oral Dispense: 30, Quantity: 1, Schedule: 2 times a day Percocet 5/325 : Tablet : 325 Mg-5 Mg : Oral Dispense: 15, Quantity: 1, Schedule: every 6 hours as needed

\* X-rays. X-rays are read initially by the emergency physician. The X-ray will be read by a radiology physician specialist within 24 hours.

If the radiologist notes any differences, you will be contacted by the emergency department. \*\* Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.\* IMPORTANT: If your condition gets worse or you have any concerns and you cannot contact your physician, return promptly to Tuomey Healthcare Systems Emergency Department. (803)774-9111\*\*Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by

Tuomey Healthcare System  
Emergency Room Record

07/22/08

Patient: HAMILTON, EMMA R  
Unit #: 238267

Account #: 12964385

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patient/family to Tuomey ED staff.\*\* DISCHARGE INSTRUCTIONS RECEIPT FINAL  
DIAGNOSIS Crush - hand and wrist ADDITIONAL DIAGNOSIS Wrist sprain  
FOLLOWUP CONTACTS DANNY H FORD 100 N. Sumter Street Suite 200 SUMTER SC  
29150 Phone: 803-774-7621 THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN  
Take medication as prescribed Return if worse Follow up with your private  
MD in the AM. Return to ED if worse. Ice and elevate(Keep arm elevated  
above your heart) Follow up with referral physician first thing in the  
morning THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN COMPARTMENT  
SYNDROME, PRECAUTIONS WRIST SPRAIN - WITH SPLINT CRUSH INJURY,  
FINGER/TOE - WITH XRAY THE FOLLOWING PRESCRIPTIONS WERE GIVEN Naprosyn :  
Tablet : 500 mg : Oral Dispense: 30, Quantity: 1, Schedule: 2 times a  
day Percocet 5/325 : Tablet : 325 Mg-5 Mg : Oral Dispense: 15,  
Quantity: 1, Schedule: every 6 hours as  
needed \_\_\_\_\_ Patient  
Signature \_\_\_\_\_ : \_\_\_\_\_ Rn/LPN Ini. TIME

08-082-745 TRIP NO.

PATIENT IDENTIFICATION (Please Print) NAME (10-20) FIRST NAME (30-45) MI (46) LAST NAME (110-120) STREET (121-130) CITY (131-140) STATE (141-150) ZIP CODE (151-160) SEX (161-170) RACE (171-180) AGE (181-190) PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126-137) PRIMARY IMPRESSION (138-140) TREATMENT PROCEDURES (141-174) DRUGS USED (226-241) REVISED TRAUMA SCORE VITAL SIGNS COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI) TIME RECORD RECEIVING AGENCY SENDING AGENCY PROVIDER TIME (OPTIONAL) ATTENDANT'S SIGNATURE & CERTIFICATION NO.



HAMILTON, EMMA R  
Acct: 12964385 Unit: 238267

ED DOS: 07/22/08  
F W Age: 43 OOB: 12/04/64

WORKERS'  
COMPENSATION

TUOMEY HEALTHCARE SYSTEM  
(N. Washington St., • Sumter, SC 29150 • (803) 778 - 9000  
**EMERGENCY DEPARTMENT WORK STATUS REPORT**

D/A Required

**PATIENT INFORMATION**

Today's Date 7/22/08 Time \_\_\_\_\_ am / pm

Patient Name Hamilton, Emma R Account # 12964385

Employer \_\_\_\_\_ Employer's Fax \_\_\_\_\_

**DIAGNOSIS**

Treating Physician (Print) Aaron Garrett MD

Description of Injury Crush injury R hand / wrist sprain

X-Ray & Lab X-ray Hand/wrist - Negative

Diagnosis: 1. Crush injury  
2. Wrist sprain

**TREATMENT**

\_\_\_ Minor first aid \_\_\_ Anti-inflammatory meds \_\_\_ Physical Therapy \_\_\_ Antibiotics  
\_\_\_ Over the counter meds \_\_\_ Muscle relaxants \_\_\_ Sutures/Wound care \_\_\_ Bloodborne pathogen protocol  
\_\_\_ Tetanus \_\_\_ Scheduled pain meds \_\_\_ Splint/Cast/Boot/Sling/Crutches \_\_\_ Other \_\_\_\_\_

**WORK STATUS** Check only the restriction that apply.

\_\_\_ No restrictions \_\_\_ May work with restrictions \_\_\_ Unable to work - until seen by orthopedic surgery

| Back and Lower Extremity     | None         | Rarely        | Moderate | Constant |
|------------------------------|--------------|---------------|----------|----------|
| Sitting                      | [ ]          | [ ]           | [ ]      | [ ]      |
| Walking or standing          | [ ]          | [ ]           | [ ]      | [ ]      |
| Bend / squat / twist / crawl | [ ]          | [ ]           | [ ]      | [ ]      |
| Climb / work on heights      | [ ]          | [ ]           | [ ]      | [ ]      |
| Upper Extremity              |              |               |          |          |
| Grasp/pinch                  | [ ]          | [ ]           | [ ]      | [ ]      |
| Reach above shoulder         | [ ]          | [ ]           | [ ]      | [ ]      |
| Reach beyond forearm limits  | [ ]          | [ ]           | [ ]      | [ ]      |
| Restrictions apply to        | ___ Left Arm | ___ Right Arm | ___ Both |          |

Work level: Lifting / Pushing / Pulling  
Sedentary [ ] Negligible - 10 lbs. max.  
Light [ ] 10 lbs. freq. - 20 lbs. max.  
Medium [ ] 25 lbs. freq. - 50 lbs. max.  
Heavy [ ] 50 lbs. freq. - 100 lbs. max.  
Very Heavy [ ] over 100 lbs  
Activity and hour restrictions (if applicable)  
\_\_\_ Not to operate hazardous machinery  
\_\_\_ Not to drive car / truck / forklift  
\_\_\_ Not to \_\_\_\_\_

Other restrictions or clarifications \_\_\_\_\_

**FOLLOW UP INSTRUCTIONS**

Patient referred to: \_\_\_ Industrial Medicine and Wellness Call 778-8842 to make  
250 W. Wesmark Blvd. • Sumter, SC 29150 next day  
\_\_\_ Other Referral Dr Ford - Orthopedic

General Instructions  
\_\_\_ Tylenol / Motrin / Aleve  
\_\_\_ Take meds as directed  
\_\_\_ Stop smoking  
\_\_\_ Re-check BP  
\_\_\_ Other Instructions: Arm elevation

Wound care instructions  
\_\_\_ Keep wounds clean and dry  
\_\_\_ Watch for infection  
\_\_\_ Wash, dress daily  
\_\_\_ Sutures out in \_\_\_\_\_ days

\_\_\_ Ice / Heat / Massage  
\_\_\_ Stretch / Exercise / Walk  
\_\_\_ Maintain activity with care and caution

Physician Signature \_\_\_\_\_

**INFORMATION RELEASE and ACKNOWLEDGEMENT**

- 1) By signing, I authorize attending physician and/or the Tuomey Healthcare System to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- 2) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above.

Patient Signature \_\_\_\_\_

**TUOMEY HEALTHCARE SYSTEM**  
129 N. Washington St., • Sumter, SC 29150 • (803) 778 - 9000  
**EMERGENCY DEPARTMENT WORK STATUS REPORT**

*D/A Required*

**PATIENT INFORMATION**

Today's Date 7/22/08 Time \_\_\_\_\_ am / pm  
Patient Name Hamilton, Emma R Account # 12964385  
Employer \_\_\_\_\_ Employer's Fax \_\_\_\_\_

**DIAGNOSIS**

Treating Physician (Print) Aaron Garrett  
Description of Injury [Redacted]  
X-Ray & Lab X-ray hand/wrist - Negative  
[Redacted]  
[Redacted]

**TREATMENT**

☐ Minor first aid ☒ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☒ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other \_\_\_\_\_

**WORK STATUS**

Check only the restriction that apply.

☐ No restrictions ☐ May work with restrictions ☒ Unable to work - *until seen by orthopedic surgeon*

| Back and Lower Extremity     | None                     | Rarely                   | Moderate                 | Constant                 |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend / squat / twist / crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb / work on heights      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Upper Extremity             | None                     | Rarely                   | Moderate                 | Constant                 |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Restrictions apply to ☐ Left Arm ☐ Right Arm ☐ Both

Work level: **Lifting / Pushing / Pulling**

|            |                          |               |                 |
|------------|--------------------------|---------------|-----------------|
| Sedentary  | <input type="checkbox"/> | Negligible    | - 10 lbs. max.  |
| Light      | <input type="checkbox"/> | 10 lbs. freq. | - 20 lbs. max.  |
| Medium     | <input type="checkbox"/> | 25 lbs. freq. | - 50 lbs. max.  |
| Heavy      | <input type="checkbox"/> | 50 lbs. freq. | - 100 lbs. max. |
| Very Heavy | <input type="checkbox"/> | over 100 lbs  |                 |

**Activity and hour restrictions (if applicable)**

☐ Not to operate hazardous machinery  
☐ Not to drive car / truck / forklift  
☐ Not to work no more than \_\_\_\_\_ hrs. per day

Other restrictions or clarifications \_\_\_\_\_

**FOLLOW UP INSTRUCTIONS**

Patient referred to: ☐ Industrial Medicine and Wellness ☒ Call 778-8842 to make appointment.  
250 W. Wesmark Blvd. • Sumter, SC 29150 next day - 2 days  
☒ Other Referral Dr. Ford - Orthopedic Surgeon

|                                                           |                                                    |                                                                           |
|-----------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------|
| <b>General Instructions</b>                               | <b>Wound care instructions</b>                     | <b>Muscle and skeletal injury instructions</b>                            |
| <input type="checkbox"/> Tylenol / Motrin / Aleve         | <input type="checkbox"/> Keep wounds clean and dry | <input checked="" type="checkbox"/> Gentle range of motion exercise daily |
| <input checked="" type="checkbox"/> Take meds as directed | <input type="checkbox"/> Watch for infection       | <input type="checkbox"/> Ice / Heat / Massage                             |
| <input type="checkbox"/> Stop smoking                     | <input type="checkbox"/> Wash, dress daily         | <input type="checkbox"/> Stretch / Exercise / Walk                        |
| <input type="checkbox"/> Re-check BP                      | <input type="checkbox"/> Sutures out in _____ days | <input type="checkbox"/> Maintain activity with care and caution          |

Other Instructions: Arm & torso

Physician Signature Aaron Garrett

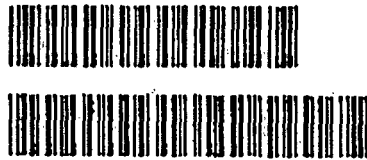
**INFORMATION RELEASE and ACKNOWLEDGEMENT**

- 1) By signing, I authorize attending physician and/or the Tuomey Healthcare System to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- 2) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above.

Patient Signature \_\_\_\_\_ 17



3A214880241



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Name: Hamilton, Emma R  
Age: 43Y DOB: Dec 04, 1964  
Gender: F Wt: 81.6 Kg  
MedRec: 238267  
AcctNum: 12964385  
Attending: DRAG  
Primary RN: MEF  
Bed: ED 2-ER 11

## TUOMEY HEALTHCARE DISCHARGE INSTRUCTIONS RECEIPT

### FINAL DIAGNOSIS

Crush - hand and wrist

### ADDITIONAL DIAGNOSIS

Wrist sprain

### FOLLOWUP CONTACTS

DANNY H FORD  
100 N. Sumter Street  
Suite 200  
SUMTER SC 29150  
Phone: 803-774-7621

### THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN

Take medication as prescribed

Return if worse

Follow up with your private MD in the AM. Return to ED if worse.

Ice and elevate (Keep arm elevated above your heart)

Follow up with referral physician first thing in the morning

### THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN

COMPARTMENT SYNDROME, PRECAUTIONS

WRIST SPRAIN - WITH SPLINT

CRUSH INJURY, FINGER/TOE - WITH XRAY

### THE FOLLOWING PRESCRIPTIONS WERE GIVEN

Naprosyn : Tablet : 500 mg : Oral

Dispense: 30, Quantity: 1, Schedule: 2 times a day

Percocet 5/325 : Tablet : 325 Mg-5 Mg : Oral

Dispense: 15, Quantity: 1, Schedule: every 6 hours as needed

*Emma Hamilton*  
Patient Signature

Rn/LPN Ini.

TIME

Prepared: Tue Jul 22, 2008 14:16 by DRAG 1 of 1  
Copyright 2006. Picis.

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Patient Name: HAMILTON, EMMA R  
Unit No: 238267  
Exam Date: 07/22/2008

REASON: CRUSH INJURY

Three views are negative for any significant radiographic abnormality.

IMPRESSION: NORMAL STUDY.

CC: AARON GARRETT

Technologist: ANGELA A MCCORD, RT(R)

ACR Code:

Transcribed Date/Time: 07/22/2008 (1452)

Transcriptionist: INPHACT

Printed Date/Time: 07/23/2008 (1119)

PATRICK JR, RICHARD

PAGE 1

Signed Report Printed From PCI

XR HAND - RIGHT 3 VIEWS 1563

Name: HAMILTON, EMMA R

Phys: GARRETT, AARON

DOB: 12/04/1964 AGE: 43 SEX: F

Acct No: 12964385 LOCATION: ED

Exam Date: 07/22/2008 Status: DEP ER

Unit No: 238267

ER

## ADMISSION RECORD

|                                                                                                                                                                                        |  |                                                                                                              |            |                            |                                             |                 |                            |                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|------------|----------------------------|---------------------------------------------|-----------------|----------------------------|-----------------------------------------------|
| Patient Name / Address<br>HAMILTON, EMMA R<br>2227 BOB WHITE DRIVE<br>SUMTER, SC 29154<br>Phone 803-481-9425<br>Social Security No. 249-17-0683<br>Employer MARTIN COLOR-FI            |  | Account No.<br>13024100                                                                                      | Room / Bed | Type<br>ER                 | Location / Service<br>ED                    |                 | Medical Rec. No.<br>238287 |                                               |
| Date of Birth<br>12/04/64                                                                                                                                                              |  | Age<br>43                                                                                                    | Sex<br>F   | MarStat<br>D               | Religion<br>BAP                             | Race<br>W       | Smoker<br>N                |                                               |
| Guarantor / Address<br>HAMILTON, EMMA R<br>2227 BOB WHITE DRIVE<br>SUMTER, SC 29154<br>Phone 803-481-9425<br>Relationship SAME AS PATIENT<br>Guarantor Employer MARTIN COLOR-FI        |  | Person to Notify / Address<br>RUSSELL, MARY LOU<br>LEWIS ROAD<br>SUMTER, SC 29150<br>Home Phone 803-236-4449 |            | Relationship<br>M          |                                             | Other Phone     |                            |                                               |
| Next of Kin / Address<br>RUSSELL, MARY LOU<br>LEWIS ROAD<br>SUMTER, SC 29150<br>Home Phone 803-236-4449                                                                                |  | Relationship<br>M                                                                                            |            | Other Phone                |                                             |                 |                            |                                               |
| Financial Class<br>A                                                                                                                                                                   |  | Insurance Name<br>LIBERTY MUTUAL INSURAN                                                                     |            | Policy Number<br>249170683 |                                             | Coverage Number |                            | Subscriber / Insured Name<br>HAMILTON, EMMA R |
| Accident Information<br>ACCIDENT/EMPL R                                                                                                                                                |  | Reason for Visit<br>ALLERGIC RX TO STEROIDS                                                                  |            |                            |                                             |                 |                            |                                               |
| Accident Date / Time<br>11/20/08                                                                                                                                                       |  | Comments                                                                                                     |            |                            | Height / Weight                             |                 | Arrival Mode               |                                               |
| Admit Date / Time<br>11/20/08 0922                                                                                                                                                     |  | Admitting Physician                                                                                          |            |                            | Attending Physician<br>FAMILY HEALTH CENTER |                 | User<br>ADDHG              |                                               |
| Hospital Days                                                                                                                                                                          |  | Surgeon                                                                                                      |            |                            | Consult                                     |                 | Discharge Date / Time      |                                               |
| HOME <input type="checkbox"/> OMI <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HH <input type="checkbox"/> DIED AUTOPSY <input type="checkbox"/> |  | Anesthesiologist                                                                                             |            |                            | Consult                                     |                 | Discharge Code             |                                               |

Admitting Diagnosis

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No

Does pt have Health Care Power of Attorney? No

Does patient want info on Advance Directive? No

Are you an organ donor? No

If yes, Living Will copy received? N

If yes, Health Care Power of Attorney copy received?



**TUOMEY**  
HOSPITAL  
Sumter, South Carolina 29150

129 North Washington Street  
Sumter, South Carolina 29150

Admission Record (ER)



00000 Rev 01/01/2004



HAMILTON, EMMA R  
Acct: 13024100 Unit: 238287  
FAMILY HEALTH CENTER  
ER  
F W Age: 43  
DOB: 12/04/64  
DOS: 11/20/08

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TUOMEY HEALTHCARE  
EMERGENCY RECORD

TRIAGE (Thu Nov 20, 2008 09:39 MAL)

COMPLAINT: COMPLAINT: ? Allergic Reaction.

ADMISSION: URGENCY: 2 - Urgent, ADMISSION SOURCE: Home,

TRANSPORT: Walked, BED: LOBBY.

PATIENT: NAME: Emma R Hamilton, AGE: 43, GENDER: female, DOB: Fri  
Dec 04, 1964, TIME OF GREET: Thu Nov 20, 2008 09:23. Pt wants EDHIV  
test?: Patient wants EDHIV test, Fall related visit: No, New onset  
weakness: No, ZIP CODE: 29154, KG WEIGHT: 86.6, PHONE: 803-481-9425,  
MEDICAL RECORD NUMBER: 238267, ACCOUNT NUMBER: 13024100, PAYMENT:  
Workmen's compensation. ATTENDING: No Doctor.

PREVIOUS VISIT ALLERGIES: Sulfur.

ASSESSMENT:

Started taking Prednisone on Friday the 14th for a hand injury. Since  
she has started taking she has the following c/o: weakness, feeling  
like she has pressure/swelling to upper body/neck and face. States her  
face is red and swollen. Sore/achy feeling all over. Denies itching.  
Lungs CTA. No resp distress. No rash. Keeps saying "too much  
pressure."

LMP: Last menstrual period: 11-5-2008, Pt not on birth control.

VITAL SIGNS: BP 144/92, Pulse 92, Resp 20, Temp 97.3, Pain 10, O2

Sat 97, on RA, Time 11/20/2008 09:34.

KNOWN ALLERGIES

Sulfa drugs, Sulfur.

CURRENT MEDICATIONS (09:40 MAL)

PrednisONE: Dose Pack As Directed.

PAST MEDICAL HISTORY (Thu Nov 20, 2008 09:39 MAL)

MEDICAL HISTORY: Childhood asthma.

SURGICAL HISTORY: History of tonsillectomy.

PSYCHIATRIC HISTORY: No previous psychiatric history.

SOCIAL HISTORY: Denies drug abuse, Lives with others, Denies  
alcohol abuse, SMOKES 1 PPD.

FAMILY HISTORY: Family history is not contributory to this case.

VITAL SIGNS (Thu Nov 20, 2008 09:39 MAL)

VITAL SIGNS: BP: 144/92, Pulse: 92, Resp: 20, Temp: 97.3, Pain:  
10, O2 sat: 97 on RA, Time: 11/20/2008 09:34.

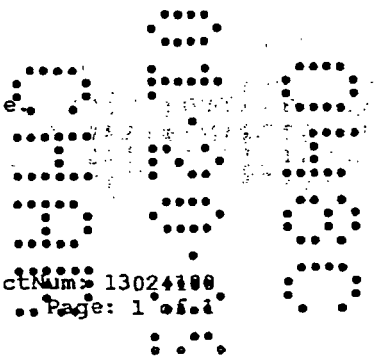
PRESCRIPTION: No recorded prescriptions

Key:

MAL=Lambert, Melissa

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100

Prepared: Thu Nov 20, 2008 09:59 by



TUOMEY HEALTHCARE  
EMERGENCY RECORD

TRIAGE (Thu Nov 20, 2008 09:39 MAL)

COMPLAINT: COMPLAINT: ? Allergic Reaction.

ADMISSION: URGENCY: 2 - Urgent, ADMISSION SOURCE: Home,  
TRANSPORT: Walked, BED: LOBBY.

PATIENT: NAME: Emma R Hamilton, AGE: 43, GENDER: female, DOB: Fri  
Dec 04, 1964, TIME OF GREET: Thu Nov 20, 2008 09:23. Pt wants EDHIV  
test?: Patient wants EDHIV test, Fall related visit: No, New onset  
weakness: No, ZIP CODE: 29154, KG WEIGHT: 86.6, PHONE: 803-481-9425,  
MEDICAL RECORD NUMBER: 238267, ACCOUNT NUMBER: 13024100, PAYMENT:  
Workmen's compensation. ATTENDING: No Doctor.

PREVIOUS VISIT ALLERGIES: Sulfur.

ASSESSMENT: .

Started taking Prednisone on Friday the 14th for a hand injury. Since  
she has started taking she has the following c/o: weakness, feeling  
like she has pressure/swelling to upper body/neck and face. States her  
face is red and swollen. Sore/achy feeling all over. Denies itching.  
Lungs CTA. No resp distress. No rash. Keeps saying "too much  
pressure."

LMP: Last menstrual period: 11-5-2008, Pt not on birth control.

VITAL SIGNS: BP 144/92, Pulse 92, Resp 20, Temp 97.3, Pain 10, O2  
Sat 97, on RA, Time 11/20/2008 09:34.

KNOWN ALLERGIES

Sulfa drugs, Sulfur.

CURRENT MEDICATIONS (09:40 MAL)

Prednisone: Dose Pack As Directed.

HPI BLANK (10:42 ESW)

CHIEF COMPLAINT: Patient states that ever since starting on  
steroids for a hand injury she has been having episodes of flushing and  
fullness. Patient states that when this happens she gets red all over  
and then gets a pressure to her head, neck and upper chest. No lower  
chest pain, dyspnea, abdominal pain, urinary problems. Patient does  
relate that the pressure is increased with palpation and she stopped  
the steroids yesterday after calling her doctor. No n,v,d,c, fevers  
chills.

HISTORIAN: History obtained from patient.

TIME COURSE: Onset of symptoms reported as gradual, Onset was 6  
days prior to arrival. Patient currently has symptoms. Complaint is  
persistent, intermittent.

SEVERITY: Maximum severity is moderate, Currently symptoms are  
moderate.

PAST MEDICAL HISTORY

MEDICAL HISTORY: Childhood asthma. (Thu Nov 20, 2008 09:39  
MAL)

SURGICAL HISTORY: History of tonsillectomy. (Thu Nov 20, 2008  
09:39 MAL)

PSYCHIATRIC HISTORY: No previous psychiatric history. (Thu Nov  
20, 2008 09:39 MAL)

SOCIAL HISTORY: Denies drug abuse, Lives with others, Denies

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100

Prepared: Thu Nov 20, 2008 19:07 by

Page: 1 of 6

TUOMEY HEALTHCARE

EMERGENCY RECORD

alcohol abuse, SMOKES 1 PPD. (Thu Nov 20, 2008 09:39 MAL)  
FAMILY HISTORY: Family history is not contributory to this case.  
(Thu Nov 20, 2008 09:39 MAL)  
NOTES: Nursing records reviewed, Agree with nursing records.  
(10:43 ESW)  
ROS (10:43 ESW)  
CONSTITUTIONAL: No fever, chills.  
CARDIOVASCULAR: Historian reports chest pain. Chest pain on the  
upper chest, Radiation to jaw. No diaphoresis, palpitations, edema.  
RESPIRATORY: No SOB.  
GI: No abdominal pain, nausea, diarrhea, vomiting, constipation.  
NEUROLOGIC: No dizziness, headache, speech changes.  
NOTES: All systems were reviewed and are negative except as  
described above.  
PHYSICAL EXAM (10:46 ESW)  
CONSTITUTIONAL: Patient is afebrile. Vital signs reviewed.  
Patient has normal pulse, normal blood pressure, normal respiratory  
rate, Well appearing. Patient appears comfortable, Alert and oriented X  
3.  
HEAD: Atraumatic, Normocephalic.  
EYES: Eyes are normal to inspection, Pupils equal, round and  
reactive to light. No discharge from eyes, Extraocular muscles intact.  
Sclera are normal. Conjunctiva are normal.  
ENT: Ears normal to inspection, Nose examination normal,  
Posterior pharynx normal, Mouth normal to inspection.  
NECK: Normal ROM. No jugular venous distention, meningeal signs,  
Cervical spine nontender.  
RESPIRATORY CHEST: Chest is nontender. Breath sounds normal. No  
respiratory distress.  
CARDIOVASCULAR: RRR. No murmurs. Normal S1 S2, No rub, No gallop,  
ABDOMEN: Abdomen is nontender. No masses, Bowel sounds normal, No  
distension, peritoneal signs.  
BACK: There is no CVA Tenderness, There is no tenderness to  
palpation. Normal inspection.  
UPPER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema.  
Normal range of motion.  
LOWER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema.  
Normal range of motion, No calf tenderness.  
NEURO: GCS is 15. No focal motor deficits, focal sensory  
deficits, cerebellar deficits, Speech normal, Gait normal, Memory  
normal.  
SKIN: Skin is warm, Skin is dry, Skin is normal color.  
VITAL SIGNS  
VITAL SIGNS: BP: 144/92, Pulse: 92, Resp: 20, Temp: 97.3, Pain:  
10, O2 sat: 97 on RA, Time: 11/20/2008 09:34. (Thu Nov 20, 2008 09:39  
MAL)  
BP: 110/81, Pulse: 80, Resp: 24, Pain: 6, O2 sat: 100 on ra, Time:  
11/20/2008 11:56. (11:58 CMS1)  
Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100  
Prepared: Thu Nov 20, 2008 19:07 by Page: 2 of 6

TUOMEY HEALTHCARE  
EMERGENCY RECORD

ORDERS

EDHIV by CMS1 for EDDR on Thu Nov 20, 2008 10:00 Status: Done by System  
Thu Nov 20, 2008 11:02.  
INT by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Done by CMS1 Thu Nov  
20, 2008 10:21.  
PROTHROMBIN TIME by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Done by  
System Thu Nov 20, 2008 10:59.  
EKG by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Active.  
CBC (WITH DIFF) by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Done by  
System Thu Nov 20, 2008 11:06.  
PTT by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Active.  
D-DIMER QUANT by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Active.  
COMPREHENSIVE METABOLIC PANEL by ESW for ESW on Thu Nov 20, 2008 10:15  
Status: Done by System Thu Nov 20, 2008 11:03.  
XR CHEST PORTABLE 1 VIEW 0608 by ESW for ESW on Thu Nov 20, 2008 10:15  
Status: Active.  
Vital Signs Every 2 Hours by ESW for ESW on Thu Nov 20, 2008 10:15  
Status: Done by CMS1 Thu Nov 20, 2008 10:21.  
URINALYSIS -COMPLETE by ESW for ESW on Thu Nov 20, 2008 10:15 Status:  
Done by System Thu Nov 20, 2008 11:24.  
TROPONIN- I by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Done by  
System Thu Nov 20, 2008 11:52.  
CKMB +TOTAL CK by ESW for ESW on Thu Nov 20, 2008 10:15 Status: Active.

DOCTOR NOTES (13:11 ESW)

INTERVENTIONS: Diphenhydramine, IV. Patient received IV fluids,  
O2 Sat normal.

PATIENT STATUS: Patient has improved since arrival to emergency  
department, stabilized since arrival to emergency department.

PATIENT PLAN: The patient will be discharged, The patient will  
follow up with primary care physician.

DATA REVIEWED: Lab data reviewed, Xray data reviewed, Reviewed  
EKG, Discussed with family.

MEDICATION SERVICE (10:15 ESW)

Benadryl: Order: Benadryl (Diphenhydramine Hydrochloride) : 25  
milligram(s) : IVP

Ordered by: Eric Wernsman

Entered by: Eric Wernsman Thu Nov 20, 2008 10:15

Acknowledged by: Kelbe Miles Thu Nov 20, 2008 10:20

Documented as given by: Mel Spring Thu Nov 20, 2008 11:04

Patient, Medication, Dose, Route and Time verified prior to  
administration.

Time given: 1038, Amount given: 25mg, IV site 1, Medication administered  
into left AC, Concentration confirmed prior to administration, IVP,  
Initial medication, Slowly, Catheter placement confirmed via flush  
prior to administration, IV site without signs or symptoms of  
infiltration during medication administration, No swelling during  
administration, No drainage during administration, IV flushed after  
administration, Correct patient, time, route, dose and medication  
confirmed prior to administration, Patient advised of actions and  
side-effects prior to administration, Allergies confirmed and

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100

Prepared: Thu Nov 20, 2008 19:07 by

Page: 3 of 6

TUOMEY HEALTHCARE

# EMERGENCY RECORD

medications reviewed prior to administration.

Pepcid: Order: Pepcid (Famotidine) : 20 milligram(s) : IVP  
 Ordered by: Eric Wernsman  
 Entered by: Eric Wernsman Thu Nov 20, 2008 10:15  
 Acknowledged by: Kelbe Miles Thu Nov 20, 2008 10:20  
 Documented as given by: Mel Spring Thu Nov 20, 2008 11:05  
 Patient, Medication, Dose, Route and Time verified prior to  
 administration.

Time given: 1039, Amount given: 20mg, IV site 1, Medication administered  
 into left AC, Catheter placement confirmed via flush prior to  
 administration, IV site without signs or symptoms of infiltration  
 during medication administration, No swelling during administration, No  
 drainage during administration, IV flushed after administration,  
 Correct patient, time, route, dose and medication confirmed prior to  
 administration, Patient advised of actions and side-effects prior to  
 administration, Allergies confirmed and medications reviewed prior to  
 administration.

## MEDICATION ADMINISTRATION SUMMARY (19:07)

Drug Name: Pepcid, Dose: 20 milligram(s), Route: IVP, Status: Given,  
 Ordered: 11:05 11/20/2008,  
 Drug Name: Benadryl, Dose: 25 milligram(s), Route: IVP, Status: Given,  
 Ordered: 11:04 11/20/2008, Detailed record available in Medication  
 Service section.

## O2SAT INTERPRETATION (13:11 ESW)

O2SAT: O2 saturation reading 97%, O2 AMT: R.A., O2 Sat normal,  
 None needed.

## EKG INTERPRETATION (10:34 ESW)

12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED  
 Physician, Compared with previous EKG, from 12/20/2002. 12 Lead EKG  
 Interpretation shows rhythm is Normal Sinus, Rate is normal, Conduction  
 is normal. No acute ST changes, acute T wave changes, non-specific EKG.

## LAB INTERPRETATION (13:10 ESW)

INTERPRETATION: Elevated WBC, CBC otherwise normal, Decreased  
 Glucose. Normal Cardiac enzymes, Normal liver functions, PT/PTT.  
 Urinalysis is normal, Normal D-dimer level.

## RADIOLOGY INTERPRETATION (13:11 ESW)

INTERPRETER: Preliminary review of x-rays by Radiologist.

CHEST: Interpretation of chest X-ray shows, chest x-ray negative,  
 no infiltrates, no pneumothorax, no hemothorax, no masses, no  
 cardiomegaly, no CHF, no effusion, no free air.

## DIAGNOSIS (13:12 ESW)

FINAL: PRIMARY: Medication Reaction - Resolving, ADDITIONAL:  
 Musculoskeletal Chest Pain.

## PRESCRIPTION (13:12 ESW)

Zantac 150: Tablet : 150 mg : Oral-Quantity: \*\*\*1\*\*\* Unit: tab

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100

Prepared: Thu Nov 20, 2008 19:07 by Page: 4 of 6

## TUOMEY HEALTHCARE EMERGENCY RECORD

Route: Oral Schedule: 2 times a day Dispense: \*\*\*28\*\*\*.

## INSTRUCTION (13:13 ESW)

DISCHARGE: MEDICATION REACTION - NON-ALLERGIC.

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FOLLOWUP: Center Family Health 1278 N. Lafayette Dr. Sumter SC  
29150 774-4500.

SPECIAL: Take medication as prescribed

Follow up with your private MD in the AM. Return to ED if worse.

Tylenol or Advil for Pain

Encourage fluids.

DISPOSITION

PATIENT: Disposition: Home, Disposition Transport: Ambulatory,

Condition: Stable. (13:13 ESW)

Pain Scale: 04, O2 used while in ED?: No, IV stop time docd?: NA, Remove  
from ER. (13:29 CMS1)

NURSING PROCEDURE: IV (10:00 CMS1)

SITE 1: Patient's identity verified by. patient stating name,  
stating birth date, hospital ID bracelet, Other indication lab  
collection, Procedure performed at 0950, IV established for venous  
access, 20 gauge catheter inserted, into left antecubital. in 1  
attempt, Saline lock established, flushed with normal saline, amount  
10, ml, Labs drawn at time of placement, Specimen labeled in the  
presence of the patient and sent to lab, After procedure, no swelling  
noted at site, After procedure, no drainage noted at site, After  
procedure, no redness, Sterile dressing applied.

NURSING PROCEDURE: EKG CHART (10:32 SDA1)

TIME: Patient's identity verified by. patient stating name,  
hospital ID bracelet, EKG was performed at 1030, 12 lead EKG  
Performed-left chest, After procedure, EKG for interpretation given to  
Dr. Wernsman. Patient tolerated procedure well.

SAFETY: Side rails up, Cart in lowest position, Family at  
bedside, Call light within reach.

NURSING PROCEDURE: URINE COLLECTION (10:46 SDA1)

URINE COLLECTION FEMALE: Patient's identity verified by. patient  
stating name, hospital ID bracelet, Procedure performed at 1040,  
Voided/clean catch. in 1 attempt, Amount 100, ml, Color: Yellow.  
Patient tolerated procedure well.

SAFETY: Side rails up, Cart in lowest position, Family at  
bedside, Call light within reach.

NURSING PROCEDURE: NURSE NOTES (11:58 CMS1)

TIME: Time: 1145, pt asleep in bed, nadn, resp even and  
nonlabored, easily aroused, no needs or complaints voiced.

VITAL SIGNS: BP: 110, / 81, Pulse: 80, Resp: 24, Pain: 6, O2 sat:  
100, on: ra, Time: 1124.

NURSING PROCEDURE: DISCHARGE NOTE (13:29 CMS1)

TIME: Patient discharged at 1328, Patient discharged to, home,  
Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100  
Prepared: Thu Nov 20, 2008 19:07 by

Page: 5 of 6

TUOMEY HEALTHCARE  
EMERGENCY RECORD

Patient, ambulates without assistance, Transported via patient driving,  
Patient unaccompanied, IV discontinued with catheter intact. Dressing  
placed to IV site, Discharge instructions given to, patient,  
Simple/moderate discharge teaching performed, Name of prescription(s)  
given: Zantac, Prescription given and additional instructions on side  
effects of same given, Medication reconciliation form given to patient,  
Above Person(s) verbalized understanding of discharge instructions and

follow-up care, Patient treated and evaluated by physician.

ADMIN (19:03 ESW)

DIGITAL SIGNATURE: Wernsman, Eric.

Key:

CMS1=Spring, Mel ESW=Wernsman, Eric MAL=Lambert, Melissa

SDA1=Dozier-Allen, Sharon

Name: Hamilton, Emma R DOB: 12/4/1964 F43 MedRec: 238267 AcctNum: 13024100

Prepared: Thu Nov 20, 2008 19:07 by

Page: 6 of 6

#### INSTRUCTIONS

- \* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic.

\* 21021000254  
FINAL DIAGNOSIS Medication Reaction - Resolving

ADDITIONAL DIAGNOSIS Musculoskeletal Chest Pain FOLLOWUP CONTACTS Center Family Health 1278 N. Lafayette Dr. Sumter SC 29150 Phone: 774-4500 SPECIAL INSTRUCTIONS Take medication as prescribed Follow up with your private MD in the AM. Return to ED if worse. Tylenol or Advil for Pain Encourage

fluids MEDICAL INSTRUCTIONS MEDICATION REACTION - NON-ALLERGIC You have been seen for an unusual reaction to a medication. Your symptoms are probably due to a reaction to one of the medications that you used. Because the effects of the medication are minor or almost gone now, it is safe for you to be discharged at this time. Bad or unexpected reactions to drugs are not uncommon. Almost every medication has POSSIBLE side-effects. Most of these are minor, but occasionally the effects can be more severe. When many medications are taken at the same time, there is the additional possibility that some of the medications can react badly with one another.

Medications are usually safe when taken as prescribed, but it may be dangerous to take even one more pill than you are supposed to. This is why it is VERY IMPORTANT to follow the instructions on your medication bottles.

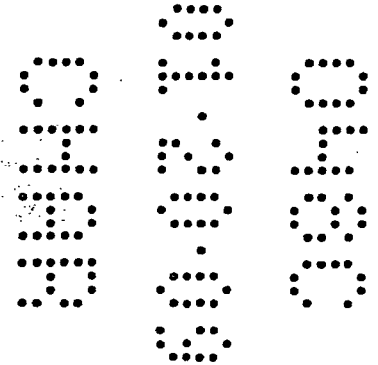
Use the following general instructions: - ALWAYS take your medications as prescribed. - If you forget to take a medication or miss a pill, ask your physician or pharmacist for advice before taking an extra pill to make up for the missed dose. - NEVER take someone else's medication that was not prescribed to you. - If you are having symptoms that may be caused by medication, tell your physician before taking more of the medicine. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS: - Signs of an allergic reaction: Rash, shortness of breath, swelling of the lips or tongue. - You become lightheaded, dizzy or confused, or pass out after taking a medication. - You feel like you might harm yourself or anyone else or you have frequent thoughts of suicide. - Vomiting or severe headache. - You develop any symptoms that you think are severe or possibly dangerous. PRESCRIPTIONS Zantac 150 : Tablet : 150 mg : Oral

Dispense: 28, Quantity: 1, Schedule: 2 times a day

\* X-rays. X-rays are read initially by the emergency physician. The X-ray will be read by a radiology physician specialist within 24 hours. If the radiologist notes any differences, you will be contacted by the emergency department. \*\* Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.\* IMPORTANT: If your

condition gets worse or you have any concerns and you cannot contact your physician, return promptly to Tuomey Healthcare Systems Emergency Department. (803)774-9111\*\*Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by patient/family to Tuomey ED staff.\*\* DISCHARGE INSTRUCTIONS RECEIPT FINAL DIAGNOSIS Medication Reaction - Resolving ADDITIONAL DIAGNOSIS Musculoskeletal Chest Pain FOLLOWUP CONTACTS Center Family Health 1278 N. Lafayette Dr. Sumter SC 29150 Phone: 774-4500 THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN Take medication as prescribed Follow up with your private MD in the AM. Return to ED if worse. Tylenol or Advil for Pain Encourage fluids THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN MEDICATION REACTION - NON-ALLERGIC THE FOLLOWING PRESCRIPTIONS WERE GIVEN Zantac 150 : Tablet : 150 mg : Oral Dispense: 28, Quantity: 1, Schedule: 2 times a day \_\_\_\_\_ Patient Signature \_\_\_\_\_ : \_\_\_\_\_ Rn/LPN Ini. TIME

21021090354



28

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: 7/23/08

Ms. Hamilton had a roller type injury to her right hand yesterday while at work. She was seen in the emergency room and treated appropriately with physical evaluation, x-rays, medications, splinting and advised. She is seen here today in follow-up.

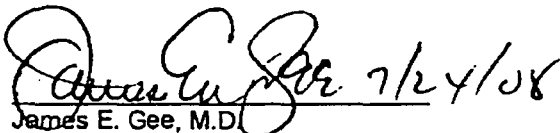
It is quite obvious that this patient has had the "crush type" injury that we see with the roller injury. There is some discoloration and soft tissue injury primarily over the dorsal aspect of her right hand and wrist. It seems to be more in the radial side. There are some early ecchymotic areas also. Circulation is good and all motions (tendons) are intact, although motions are limited because of pain. Again, the thumb is the most tender area but function is intact.

X-rays taken at Tuomey Emergency Room last evening are normal.

**IMPRESSION:** Roller type crush injury, right hand and wrist without evidence of circulatory embarrassment, neurological deficit or compartment syndrome.

The patient has had difficulty with the medications that she was given and we are going to make some changes. After a long discussion, we advised her to take 600 to 800 mg of Ibuprofen after every meal and discussed side effects. We gave her 800 mg in the office today because she was painful. She will continue elevation higher than the heart for another 24 hours or until I see her again tomorrow. She will continue the splint and we will make adjustments when we see her tomorrow. She will not go to work today and I will make further disposition when she returns. She is aware that she needs to call or return to the emergency room if she has increased pain, paresthesias, or other problems which we discussed.

Addendum Note: I did give her a prescription for Darvocet and advised her to take the Ibuprofen, the Darvocet or Tylenol rather than medicine she was given in the emergency room.

  
James E. Gee, M.D.

JEG/mlm DWR



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**INDUSTRIAL MEDICINE AND WELLNESS**

250 W. Wasmark Blvd., Sumter, SC 29150  
Phone: (803) 774-8842 FAX: (803) 774-5283

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-9425  
249-17-0683 07/23/08

## WORK STATUS REPORT

INITIAL VISIT ☒  
FOLLOW UP ☐

### PATIENT INFORMATION

Time in: 11:20 Time out: 12:10 Date of Injury: 7-22-08 Today's Date: 7-23-08  
Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

[Redacted] cpt \_\_\_\_\_  
[Redacted] cpt \_\_\_\_\_  
3. [Redacted] cpt 6/1/08

### TREATMENT

☐ Minor first aid ☒ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☒ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☒ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☒ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

Sitting  
Walking or standing  
Bend/squat/twist/crawl  
Climb/work on heights

#### Upper Extremity

Grasp/pinch  
Reach above shoulder  
Reach beyond forearm  
Restrictions apply to

DO WR  
THING T AS  
W/ NO  
MARK OUTS?

#### Work level: Lifting/Pushing/Pulling

Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

no work until I see agent

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes Thursday Date 07-24 Time 3:30pm

Patient Referred to: [Signature] Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: [Signature] James Gee, MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

- By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: Emma R Hamilton

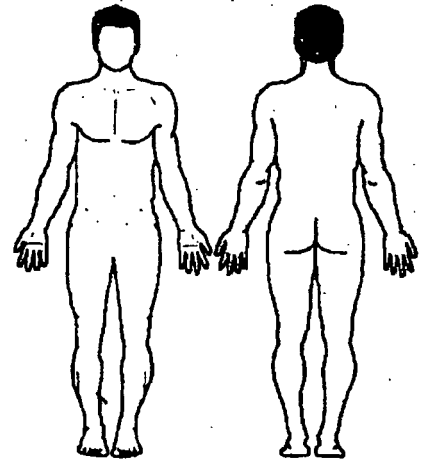
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IM0175676 F 12/04/64 43281  
 HAMILTON, EMMA 803-481-9425  
 249-17-0683 07/23/08

**MEDICAL ASSESSMENT****ASSESSMENT**Date of Injury: 7-22-08BP    /    /    T    P    RR 18Vision R 20/    L 20/    Corr.    UnCorr.   Improvement: Same    Worse    Better   MEDICATIONS:   ALLERGIES: Sulfa**NURSING ASSESSMENT:**

It present herself w/ injury to  
(R) hand. states yesterday afternoon hand  
got caught in fibers rollers. Went to ER yesterday.  
no slight pain (esp inside hand)

**MEDICAL EVALUATION:** Above Noted    History reviewed and noted   

INITIAL: Am7-23-08

rule  
split

Exp. (Admit @ home) 600-800 p ear  
Dan 25 2100 # 36

Tomorrowdetached m linePHYSICIAN'S SIGNATURE:   

36444 Rev: 04/17/2008

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

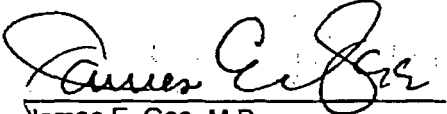
Emma Hamilton

Date: July 24, 2008

She is improved. The hand looks better. The circulation is good. Motion is a little better.

I placed her in a thumb spica (soft). She will return to this office next week. She may perform very light work using only the left hand next Monday but she can't work until then.

Addendum Note: I asked her to work on range of motion and discussed this in detail with her.

 7/30/08  
James E. Gee, M.D.

JEG/mlm

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 HAMILTON, EMMA 803-481-9425  
 249-17-0683 07/24/08  
 PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP ☒

### PATIENT INFORMATION

Time in: 1511 Time out: 1600 Date of Injury: 07-22-08 Today's Date: 07-24-08  
 Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
 2. Spine cpt \_\_\_\_\_  
 3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☒ No work see below Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

| Back and Lower Extremity                                 | None                     | Occ.                     | Often                    | Regularly                | Work level: Lifting/Pushing/Pulling                         |
|----------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------------------------------|
| Sitting                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sedentary <input type="checkbox"/> Negligible - 10 lbs. max |
| Walking or standing                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Light <input type="checkbox"/> 10 lbs. freq - 20 lbs. max   |
| Bend/squat/twist/crawl                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medium <input type="checkbox"/> 25 lbs. freq - 50 lbs. max  |
| Climb/work on heights                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heavy <input type="checkbox"/> 50 lbs. freq - 100 lbs. max  |
| Upper Extremity                                          |                          |                          |                          |                          | Very Heavy <input type="checkbox"/> over 100 lbs.           |
| Grasp/pinch                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Activity and hour restrictions (if applicable)              |
| Reach above shoulder                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Not to operate hazardous machinery |
| Reach beyond forearm limits                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Not to drive car/truck/forklift    |
| Restrictions apply to _____ L Arm _____ R Arm _____ Both |                          |                          |                          |                          | To work no more than _____ hrs. per day                     |

### Other Restrictions or Clarifications:

no work until Monday 7/28/08  
then can use L arm & hand only

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes Wed Date July 30 Time 3:15pm  
 Patient Referred to: [Signature] Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 PHYSICIAN'S SIGNATURE: [Signature] James Gap, MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

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PATIENT SIGNATURE: Emma R. Hamilton



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PATIENT LABEL

IM0175676 F 12/04/64 43281

HAMILTON, EMMA

249-17-0683

803-481-9425

07/24/08

## MEDICAL ASSESSMENT

## ASSESSMENT

Date of Injury: 7/22

BP \_\_\_/\_\_\_/\_\_\_ T \_\_\_ P \_\_\_ RR 18

Vision R 20/\_\_\_ L 20/\_\_\_ Corr. \_\_\_ UnCorr. \_\_\_

Improvement: Same \_\_\_ Worse \_\_\_ Better \_\_\_

MEDICATIONS:

Dawcet, Advil

ALLERGIES:

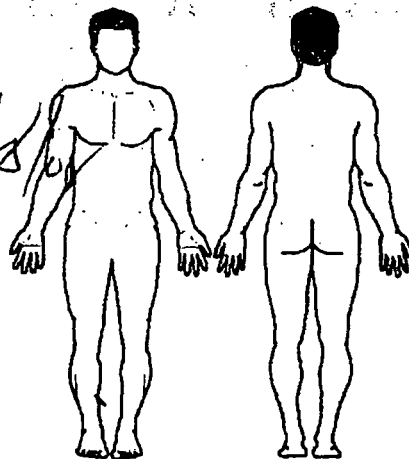
Sulfa

## NURSING ASSESSMENT:

F/u (P) hand crush injury.  
 States at present she feels sharp,  
 stabbing pains

MEDICAL EVALUATION: Above Noted \_\_\_ History reviewed and noted \_\_\_

INITIAL: DM



much better  
 soft thumb spica  
 not well in  
 Lt. - (changed) - work

initiated in lab

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

36444 Rev: 04/17/2008

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton

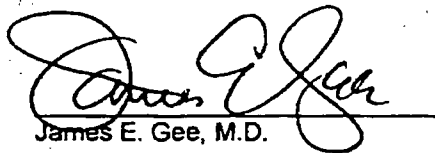
Date: July 30, 2008

She is making steady progress. She still has some discomfort but she is improving very nicely. I am really rather amazed at how quickly she has improved her motion in view of a very significant crush-type injury.

Exam today is about the same but improved.

I advised her it is just going to take some time now. She will continue to use the splint when she is out of the house but she can discontinue it for in-house activities as we discussed. She will continue her medications. She will return in two weeks.

Addendum Note: I will consider repeating an x-ray of her wrist and obtaining a navicular view if she continues to have pain on the radial aspect of her wrist.

 7/31/08  
James E. Gee, M.D.

JEG/mlm

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HAMILTON, EMMA 803-481-9425  
249-17-0683 07/30/08

PATIENT LABEL

**WORK STATUS REPORT**

INITIAL VISIT \_\_\_\_\_

FOLLOW UP ☒**PATIENT INFORMATION**Time in: 1500 Time out: 3:22 Date of Injury: 7-22-08 Today's Date: 7-30-08  
Employer: Color Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654**DIAGNOSIS**Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_**TREATMENT**☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_**WORK STATUS**☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_**Back and Lower Extremity**None Occ. Often Regularly  
Sitting ☐ ☐ ☐ ☐  
Walking or standing ☐ ☐ ☐ ☐  
Bend/squat/twist/crawl ☐ ☐ ☐ ☐  
Climb/work on heights ☐ ☐ ☐ ☐**Upper Extremity**same  
Grasp/pinch ☐ ☐ ☐ ☐  
Reach above shoulder ☐ ☐ ☐ ☐  
Reach beyond forearm limits ☐ ☐ ☐ ☐  
Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both**Work level: Lifting/Pushing/Pulling**Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.**Activity and hour restrictions (if applicable)**☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

**Other Restrictions or Clarifications:****FOLLOW UP**Return Appointment: ☐ No ☒ Yes 2 weeks Date 8-13 Time 4:00

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: James Gee, MD Eric Byrd, MD**INFORMATION RELEASE & ACKNOWLEDGEMENT**

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- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: Emma Hamilton

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

43281

PROGRESS NOTE

Emma Hamilton  
Date: August 13, 2008

She is making steady progress. All function is intact but she still has some difficulty with discomfort and certainly she has weakness. She keeps her wrist somewhat flexed. It almost looked as though she had a degree of "wrist drop" but that is not the case. She can dorsiflex against gravity. She can extend her fingers and she makes a reasonably good fist.

It is just a matter of favoring this hand and gradually increasing strength and motion.

I fitted her with a new splint. A small one fits better. I also advised her to take medicines as needed rather than routine. She will return in three weeks.

Addendum Note: I would like for her to continue the job of shredding and sorting or whatever it is she is doing because that works very well for her recovery.

 8/14/08

James E. Gee, M.D.

JEG/mlm

BMR

38

mlm

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_  
FOLLOW UP ☒

### PATIENT INFORMATION

Time in: 1547 Time out: 1630 Date of Injury: 7-22-08 Today's Date: 8-13-08  
Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

**Back and Lower Extremity**

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Upper Extremity**

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

**Work level: Lifting/Pushing/Pulling**

|            |                                                   |                |
|------------|---------------------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible               | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq             | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq             | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq             | - 100 lbs. max |
| Very Heavy | <input checked="" type="checkbox"/> over 100 lbs. |                |

**Activity and hour restrictions (if applicable)**  
☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

### Other Restrictions or Clarifications:

please continue same work

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 3 weeks Date: Sept. 3 Time: 4:30

Patient Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: [Signature] James Gee, MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

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PATIENT SIGNATURE: Emma Hamilton

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton

Date: September 3, 2008

She is making steady progress. I am concerned about the strength that she demonstrates with dorsiflexion of the wrist. I examined closely some of the dorsal tendons. I think all is intact but there is one concern.

She needs to work on strengthening and I advised her of that. She will continue to wear the splint at work and I will see her next week.

I am seeing her a little earlier than I normally would see her but she is apparently having some situational work problems that are forcing her to do more than I want her to do. I don't know how else to limit her activities but I am going to try to do that and follow her more closely to make sure all is well.

I may send her to therapy according to the progress she makes in the next week.

 9-4-08  
James E. Gee, M.D.

JEG/mlm

56080063

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 HAMILTON, EMMA  
 249-17-0683  
 803-481-942  
 09/03/08

PATIENT LABEL

**WORK STATUS REPORT**

INITIAL VISIT

FOLLOW UP ☒**PATIENT INFORMATION**

Time in: 10:25 Time out: 4:50 Date of Injury: 7-22-08 Today's Date: 9-3-08  
 Employer: Color. Fi. Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5454

Frank M. 603-334-8090

**DIAGNOSIS**

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
 2. Same cpt \_\_\_\_\_  
 3. \_\_\_\_\_ cpt \_\_\_\_\_

**TREATMENT**

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

**WORK STATUS**

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

**Back and Lower Extremity**

None Occ. Often Regularly  
 Sitting ☐ ☐ ☐ ☐  
 Walking or standing ☐ ☐ ☐ ☐  
 Bend/squat/twist/crawl ☐ ☐ ☐ ☐  
 Climb/work on heights ☐ ☐ ☐ ☐

**Upper Extremity**

Grasp/pinch ☐ ☐ ☒ ☐  
 Reach above shoulder ☐ ☐ ☒ ☐  
 Reach beyond forearm limits ☐ ☐ ☒ ☐  
 Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

**Work level: Lifting/Pushing/Pulling**

Sedentary ☒ Negligible - 10 lbs. max  
 Light ☐ 10 lbs. freq - 20 lbs. max  
 Medium ☐ 25 lbs. freq - 50 lbs. max  
 Heavy ☐ 50 lbs. freq - 100 lbs. max  
 Very Heavy ☐ over 100 lbs.

**Activity and hour restrictions (if applicable)**

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

**Other Restrictions or Clarifications:**

to @ wrist. No heavy lifting, or strain  
wear splint at all times  
Do not perform jobs if can not  
be done with splint

**FOLLOW UP**

Return Appointment: ☐ No ☒ Yes one week Date 9-10 Time 4:30

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gao, MD

Eric Byrd, MD

**INFORMATION RELEASE & ACKNOWLEDGEMENT**

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- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: \_\_\_\_\_

43281

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

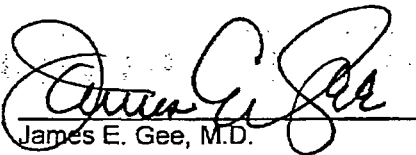
Emma Hamilton

Date: September 10, 2008

This patient is doing extremely well and has recovered really nicely from a very significant roller type injury but she is very frustrated and very concerned and anxious about the long time that it is taking to regain full use of this hand.

I have advised her in the past that it is going to be a very long, long course and I am not sure that she is going to feel as though she has complete function of this hand. There is a possibility that there is a minor tendon injury. There are other possibilities also.

At this time, there is nothing more to do than to rehabilitate this hand and wrist. I am going to see if occupational therapy will help her and maybe speed up her recovery. She will return here in three weeks.

 9/11/08  
James E. Gee, M.D.

JEG/mlm

42

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP ☒

### PATIENT INFORMATION

Time in: 1620 Time out: 4:48 Date of Injury: 7-22-08 Today's Date: 9-10-08  
Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

**Back and Lower Extremity**

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Upper Extremity**

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | ____ L Arm               | ____ R Arm               | ____ Both                |                          |

**Work level: Lifting/Pushing/Pulling**

|            |                          |               |                |
|------------|--------------------------|---------------|----------------|
| Sedentary  | <input type="checkbox"/> | Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> | 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> | 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> | 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> | over 100 lbs. |                |

**Activity and hour restrictions (if applicable)**  
☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 3 weeks Date 10-1 Time 3:45

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: James Gee, MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

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- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: Emma R. Hamilton



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250 W. Wesmark Blvd., Sumter, SC 29150  
Phone: (803) 774 - 8842 FAX: (803) 774 - 5283

PATIENT LABEL

## REHABILITATION PRESCRIPTION

NAME: Emma Hamilton

DATE: 9-10-08

DIAGNOSIS: \_\_\_\_\_

### PROCEDURES

|                                             |                                             |                                             |                                           |
|---------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Pre-Placement Eval | <input type="checkbox"/> Complete FCE       | <input type="checkbox"/> Limited FCE      |
| <input type="checkbox"/> Wound Care         | <input type="checkbox"/> Whirlpool          | <input type="checkbox"/> Debridement        | <input type="checkbox"/> Dressing Changes |
| <input type="checkbox"/> Home Program       | <input type="checkbox"/> Patient Education  | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Gait Training    |
| <input type="checkbox"/> Splint Fabrication | <input type="checkbox"/> Strengthening      | <input type="checkbox"/> CV-Conditioning    | <input type="checkbox"/> Work Hardening   |
| <input type="checkbox"/> Other: _____       |                                             |                                             |                                           |

### MODALITIES

☐ May substitute other appropriate modalities

|                                          |                                       |                                                    |                                              |
|------------------------------------------|---------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Moist Heat      | <input type="checkbox"/> Traction     | <input type="checkbox"/> Ultrasound                | <input type="checkbox"/> Fluidotherapy       |
| <input type="checkbox"/> Cryotherapy     | <input type="checkbox"/> TENS Unit    | <input type="checkbox"/> Phonophoresis             | <input type="checkbox"/> Cerv. Traction Unit |
| <input type="checkbox"/> Electric Stim   | <input type="checkbox"/> Whirlpool    | <input type="checkbox"/> Iontophoresis with: _____ |                                              |
| <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Other: _____ |                                                    |                                              |

### GOALS

|                                        |                                                          |                                                    |
|----------------------------------------|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Independent Exercise Program    | <input type="checkbox"/> Return to Normal Function |
| <input type="checkbox"/> Increase ROM  | <input type="checkbox"/> Increase Strength and Endurance |                                                    |
| <input type="checkbox"/> Other: _____  |                                                          |                                                    |

### COMMENTS

Patien had a very significant ~~trauma~~ roller type (crush) injury on 7-22-08. She's done great with Rom & recovery but she's concerned & wants some help & assistance with Rom. Use all modalities

Frequency: 3x weekly for 6 weeks Physician Signature: as you see fit

### SCHEDULING

(TO BE COMPLETED BY PHYSICAL THERAPY DEPARTMENT)

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Signature (acknowledging appointment): \_\_\_\_\_

Once appointment scheduled and acknowledged, fax to Tuomey Industrial Medicine 803.774.5283

WHITE COPY - PHYSICAL THERAPY

YELLOW COPY - PATIENT

PINK COPY - PHYSICIAN

36764 Rev. 06/30/2008

NOTE - may have minor injury to tendons but needs 44  
p. 3 8037745282 66 Tuomey IM Aug 15 08 10:49a

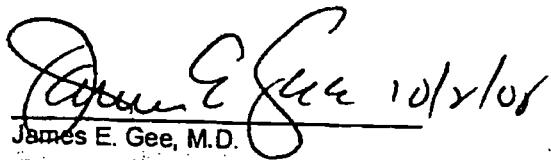
43281

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: October 1, 2008

She is very pleased with her progress and I think therapy was very worthwhile. We will continue the same approach and I will see her in three weeks.

 10/2/08  
James E. Gee, M.D.

JEG/mlm

21-0080377



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PATIENT LABEL

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-942  
249-17-0683 10/01/08

## WORK STATUS REPORT

INITIAL VISIT ☐  
FOLLOW UP ☒

## PATIENT INFORMATION

Time in: 1450 Time out: 1535 Date of Injury: 07-22-08 Today's Date: 10-01-08  
Employer: Colon Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

## DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt  
2. Compression injury R hand cpt  
3. 9 wires cpt

## TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

## WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

## Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## Upper Extremity

|                             | None                     | Occ.                                | Often                               | Regularly                |
|-----------------------------|--------------------------|-------------------------------------|-------------------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |

Restrictions apply to ☐ L Arm ☒ R Arm ☐ Both

## Work level: Lifting/Pushing/Pulling

|            |                                     |               |                |
|------------|-------------------------------------|---------------|----------------|
| Sedentary  | <input checked="" type="checkbox"/> | Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/>            | 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/>            | 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/>            | 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/>            | over 100 lbs. |                |

## Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

## Other Restrictions or Clarifications:

use splint at all times

## FOLLOW UP

Return Appointment: ☐ No ☒ Yes 3 weeks Date: Oct-22 Time: 10:45 AM

Patient Referred to: Dr. [Signature] Phone: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: [Signature] James Gee, MD Eric Byrd, MD

## INFORMATION RELEASE &amp; ACKNOWLEDGEMENT

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PATIENT SIGNATURE: Emma R. Hamilton

**FAKED**  
10/01/08

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

## PROGRESS NOTE

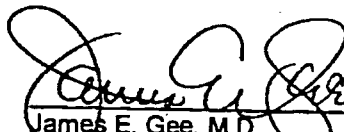
Emma Hamilton  
Date: October 22, 2008

Ms. Hamilton really loves her physical therapy and is really pleased with the progress she has made. She never seemed to quite have the confidence that she could make this improvement "on her own" and so therapy has really been a positive thing for her. The therapist apparently has suggested a work hardening program to get her back to her job. He indicates that this is done in Florence.

I really think that her strength will come with time. She is beginning to get some neurogenic type sensation and I feel the nerve regeneration is well on its way or maybe even near completion.

I am going to get nerve conduction studies just to see the status of the nerves (it has been three months to the day).

I suggested that she go to therapy here in Sumter for a home program to help strengthen. That along with time will get her back into her regular job. I will see her in follow-up and review the nerve conduction studies when they are available.

  
James E. Gee, M.D. 10/23/08  
JEG/mlm DVR



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2600 80968

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA  
249-17-0683  
803-481-9425  
10/22/08

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT

FOLLOW UP ☒

### PATIENT INFORMATION

Time in: 1033 Time out: 1125 Date of Injury: 07-22-08 Today's Date: 10-22-08  
Employer: Coker- Jr. Employer's Phone: \_\_\_\_\_ Employer's Fax: 7755654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Same diagnosis cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

None Occ. Often Regularly  
Sitting ☐ ☐ ☐ ☐  
Walking or standing ☐ ☐ ☐ ☐  
Bend/squat/twist/crawl ☐ ☐ ☐ ☐  
Climb/work on heights ☐ ☐ ☐ ☐

#### Upper Extremity

Grasp/pinch ☐ ☐ ☐ ☐  
Reach above shoulder ☐ ☐ ☐ ☐  
Reach beyond forearm limits ☐ ☐ ☐ ☐  
Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

#### Work level: Lifting/Pushing/Pulling

Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.

#### Activity and hour restrictions (If applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

Continue same work

NCS are requested

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 3 week Date 11-12 Time 10:00

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: James Geo, MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

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PATIENT SIGNATURE: Emma Hamilton

## REHABILITATION PRESCRIPTION

NAME: E Hamilton DATE: 10/22/08

DIAGNOSIS: roller type injury @ hand on 7/22/08

### PROCEDURES

|                                             |                                             |                                             |                                           |
|---------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Pre-Placement Eval | <input type="checkbox"/> Complete FCE       | <input type="checkbox"/> Limited FCE      |
| <input type="checkbox"/> Wound Care         | <input type="checkbox"/> Whirlpool          | <input type="checkbox"/> Debridement        | <input type="checkbox"/> Dressing Changes |
| <input type="checkbox"/> Home Program       | <input type="checkbox"/> Patient Education  | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Gait Training    |
| <input type="checkbox"/> Splint Fabrication | <input type="checkbox"/> Strengthening      | <input type="checkbox"/> CV-Conditioning    | <input type="checkbox"/> Work Hardening   |
| <input type="checkbox"/> Other: _____       |                                             |                                             |                                           |

### MODALITIES

☐ May substitute other appropriate modalities

|                                          |                                       |                                                    |                                              |
|------------------------------------------|---------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Moist Heat      | <input type="checkbox"/> Traction     | <input type="checkbox"/> Ultrasound                | <input type="checkbox"/> Fluidotherapy       |
| <input type="checkbox"/> Cryotherapy     | <input type="checkbox"/> TENS Unit    | <input type="checkbox"/> Phonophoresis             | <input type="checkbox"/> Cerv. Traction Unit |
| <input type="checkbox"/> Electric Stim   | <input type="checkbox"/> Whirlpool    | <input type="checkbox"/> Iontophoresis with: _____ |                                              |
| <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Other: _____ |                                                    |                                              |

### GOALS

|                                        |                                                          |                                                    |
|----------------------------------------|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Independent Exercise Program    | <input type="checkbox"/> Return to Normal Function |
| <input type="checkbox"/> Increase ROM  | <input type="checkbox"/> Increase Strength and Endurance |                                                    |
| <input type="checkbox"/> Other: _____  |                                                          |                                                    |

### COMMENTS

Please set up home program. She  
does not want to go to Home.  
She can & will be a good worker  
at home. Thanks for good job with her

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Physician Signature: [Signature]

### SCHEDULING

(TO BE COMPLETED BY PHYSICAL THERAPY DEPARTMENT)

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Signature (acknowledging appointment): \_\_\_\_\_

Once appointment scheduled and acknowledged, fax to Tuomey Industrial Medicine 803.774.5283

WHITE COPY - PHYSICAL THERAPY

YELLOW COPY - PATIENT

PINK COPY - PHYSICIAN



TUOMEY  
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INDUSTRIAL MEDICINE AND WELLNESS

250 W. Mark Blvd., Building #2  
Sumter, South Carolina 29150

TEL: (803)774-8642 • FAX: (803)774-5282

### REFERRAL NOTE

DATE: 10.22.08

PATIENT NAME: E. Hamlet SSN 249-17-0683 DOB 12-4-64

REFERRAL TO: Dr. M. White - Sumter neurology & pain management  
312 Broad St  
Sumter, SC 29150 PHONE: 803 774-7246

DATE/TIME: \_\_\_\_\_

REFERRAL TYPE  
☐ CONSULT  
☒ EVALUATION

☒ PROCEDURE NCS  
☐ OTHER

DIAGNOSIS Roller type injury (R) - 7-22-08

#### REASON FOR REFERRAL

☐ FAILURE TO RESPOND TO CONSERVATIVE TREATMENT  
☐ REQUIRES ONGOING CARE AND MANAGEMENT  
☐ REQUIRES SPECIALIZED SERVICES OR PROCEDURES

nerves are improving -

NOTES

Hamlet

Eric Byrd, MD

James Gee, MD

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: November 12, 2008

The patient is extremely anxious and seems to be ~~getting worse and worse~~ with regards to wanting something done more quickly.

I tried to discuss the situation with her, advising her that she has done well with regards to this significant injury and it is just going to take time, that she doesn't need any surgical procedure even if it is a small tear of the radial tendon. I don't believe she needs a shot of steroids right now.

After a very, very long discussion, I suggested that we try Sterapred DS for 12 days, ~~get an MRI~~ (she wants an MRI anyway) and just give it more time. Her splint will be optional at work.

I did ask her if she considered getting an independent medical evaluation. She does not seem to be interested in that, possibly because she doesn't want to pay but I am not sure exactly the reason.

I will see her again in three weeks.

\_\_\_\_\_  
James E. Gee, M.D.

JEG/mlm

*unsigned  
copy  
see*

2E3290 80889

2E3290 80489



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 IM0175676 F 12/04/64 43281  
 HAMILTON, EMMA 803-481-9421  
 249-17-8683 11/12/08

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP ☒

## PATIENT INFORMATION

 Time in: 0950 Time out: 10:20 Date of Injury: 7-22-08 Today's Date: 11-12-08

 Employer: Coler Ai Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

## DIAGNOSIS

 Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
 2. same diagnosis cpt \_\_\_\_\_  
 3. \_\_\_\_\_ cpt \_\_\_\_\_

## TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

## WORK STATUS

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

## Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## Upper Extremity

|                             | None                               | Occ.                     | Often                    | Regularly                |
|-----------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | _____ L Arm _____ R Arm _____ Both |                          |                          |                          |

## Work level: Lifting/Pushing/Pulling

| Sedentary  | <input type="checkbox"/> | Negligible - 10 lbs. max    |
|------------|--------------------------|-----------------------------|
| Light      | <input type="checkbox"/> | 10 lbs. freq - 20 lbs. max  |
| Medium     | <input type="checkbox"/> | 25 lbs. freq - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> | 50 lbs. freq - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> | over 100 lbs.               |

## Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

## Other Restrictions or Clarifications:

Continue same workSplint is optionalMRI requested

## FOLLOW UP

Return Appointment: ☐ No ☒ Yes3 weeksDate 12-3 Time 10:30

Patient Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

## INFORMATION RELEASE &amp; ACKNOWLEDGEMENT

- 1.) By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: Emma R. Hamilton

MRI OUTPATIENT ORDER REQUEST

Date: 11/15/08

Patient Name: Emma Danielson

DOB: 12/04/64

Age: \_\_\_\_\_

Sex: M ☐ F ☒

Weight: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_

MRI Head

- ☐ Brain
- ☐ IAC
- ☐ Orbits
- ☐ Pituitary
- ☐ MRA Circle of Willis
- ☐ MRA Carotid arteries/Vertebral

MRI Hips

- ☐ Left
- ☐ Right

MRI Shoulder

- ☐ Left
- ☐ Right
- ☐ With Saline Injection

MRI Spine

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar/ Sacral Spine

MRI Elbow

- ☐ Left
- ☐ Right

MRI Neck

- ☐ Soft Tissue

MRI Wrist

- ☐ Left
- ☒ Right

MRI Abdomen

- ☐ General
- ☐ MRCP/Pancreas
- ☐ Liver
- ☐ Renal/Adrenal
- ☐ MRA Renal Arteries

MRI Hand

- ☐ Left
- ☐ Right

MRI Knee

- ☐ Left
- ☐ Right

MRI Pelvis

- ☐ General
- ☐ Prostate (endorectal)

MRI Foot

- ☐ Left
- ☐ Right

MRI Ankle

- ☐ Left
- ☐ Right

Other: Compartment injury

① wrist 3 1/2 months ago  
still painful  
possible tear of tendon

Bring this form with you to your appointment.

without it, there could be a delay or cancellation of your exam.

Physician Signature: \_\_\_\_\_

41126 Rev. 11/16/2002

43281

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: December 3, 2008

We had another very, very long discussion. Much of it was the same.

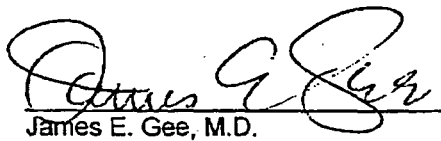
I reiterated with her that the nerve conduction studies seem to be normal and the MRI seems to be normal except for the fact that she has had some trauma.

I advised her that I feel she will improve with time and I do not feel there is a "quick fix." I discussed reflex dystrophy with her and suggested that she be seen again by the neurologist just to see if he thinks that this could possibly be part of the problem. She certainly doesn't have the classical presentation.

I do not believe that she needs to see another specialist at this time to consider any type of aggressive therapy. I think she just needs time.

Apparently one of the problems that she is facing is a limit on how long they will keep her job available for her. She states until January. We will just do the best we can.

Addendum Note: I am again, as mentioned above, requesting authorization for follow-up neurological evaluation.

 12/4/08  
James E. Gee, M.D.

JEG/mlm

12/4/08 Called Ms. Mohl Re: work restrictions and  
left a message. 

300... 0438

IM0173676 F 12/04/04 43281  
HAMILTON, EMMA 803-481-9425  
249-17-0683 12/03/08

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 1025 Time out: 11:09 Date of Injury: 7-22-08 Today's Date: 12-3-08  
Employer: Color-It Employer's Phone: \_\_\_\_\_ Employer's Fax: \_\_\_\_\_

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

| Back and Lower Extremity                                 | None                     | Occ.                     | Often                    | Regularly                | Work level: Lifting/Pushing/Pulling                         |
|----------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------------------------------|
| Sitting                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sedentary <input type="checkbox"/> Negligible - 10 lbs. max |
| Walking or standing                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Light <input type="checkbox"/> 10 lbs. freq - 20 lbs. max   |
| Bend/squat/twist/crawl                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medium <input type="checkbox"/> 25 lbs. freq - 50 lbs. max  |
| Climb/work on heights                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heavy <input type="checkbox"/> 50 lbs. freq - 100 lbs. max  |
| Upper Extremity                                          |                          |                          |                          |                          | Very Heavy <input type="checkbox"/> over 100 lbs.           |
| Grasp/pinch                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Activity and hour restrictions (if applicable)              |
| Reach above shoulder                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Not to operate hazardous machinery |
| Reach beyond forearm limits                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Not to drive car/truck/forklift    |
| Restrictions apply to _____ L Arm _____ R Arm _____ Both |                          |                          |                          |                          | To work no more than _____ hrs. per day                     |

Other Restrictions or Clarifications: \_\_\_\_\_

use splint for 2 weeks

Please, please, have her write us  
- she will get better, but time is  
only way. There is no "quick fix".  
Please understand

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 3 weeks Date 12-24 Time 11:00

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: James Gee, MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

- 1.) By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE Emma R. Hamilton 55

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: December 24, 2008

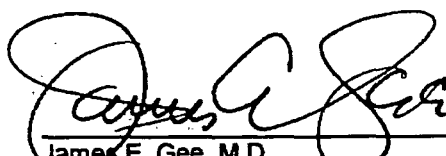
Ms. Hamilton has "made my day" by telling me that she is doing better and using her arm more.

The examination is about the same. All function is intact but certainly not back to normal as we have mentioned many times.

I want to continue to simply follow her and have her gradually increase her activities. I prescribed a 2 pound barbell so that she can perform strengthening exercises at home and not have to go to physical therapy. I have asked her to be patient and she seems to be much less anxious today. All of that is very good and encouraging.

There is a note in the chart that an independent medical examination is going to be established. That note was 12/10. I do not know why that has not been accomplished but I did advise the patient. In view of that, we are not pursuing (it has not been authorized because of the pending independent medical evaluation) the follow-up with the neurologist at this point.

In anticipation that the patient will see someone in the next several weeks, I am establishing her an appointment for four weeks. I advised her I really don't need to see her again until she has had the independent medical evaluation.

 12/31/08  
James E. Gee, M.D.  
JEG/mlm DNR



TUOMEY

MEDICAL PROFESSIONALS, INC.

INDUSTRIAL MEDICINE AND WELLNESS

250 W. Wesmark Blvd., Sumter, SC 29150  
Phone: (803) 774-8842 FAX: (803) 774-5283

28000

73

IM0175676 F 12/04/64 43281

HAMILTON, EMMA

803-481-9425

249-17-0683

12/24/08

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 9:47 Time out: 11:35 Date of Injury: 7-22-08 Today's Date: 12-24-08  
Employer: Color Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

Back and Lower Extremity None Occ. Often Regularly

Sitting ☐ ☐ ☐ ☐  
Walking or standing ☐ ☐ ☐ ☐  
Bend/squat/twist/crawl ☐ ☐ ☐ ☐  
Climb/work on heights ☐ ☐ ☐ ☐

Upper Extremity

Grasp/pinch ☐ ☐ ☐ ☐  
Reach above shoulder ☐ ☐ ☐ ☐  
Reach beyond forearm limits ☐ ☐ ☐ ☐  
Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

Work level: Lifting/Pushing/Pulling

Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.

Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery

☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

Continue same. Thanks for your  
cooperation

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 4 weeks Date 1-28 Time 2:00

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

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- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: \_\_\_\_\_

2A036090357

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

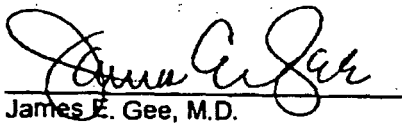
PROGRESS NOTE

Emma Hamilton  
Date: January 28, 2009

She is about the same. She has not had the independent medical examination. Everything with this office is more or less on hold until we get that opinion to see if workman's comp is going to go in another direction, etc., etc.

I explained this to the patient. We will call and see if we can get an update. The patient states she does not know of an appointment.

Addendum Note: We did call. Apparently, the patient has an appointment for February 11th. We will see her in follow-up in four weeks if she is still being treated in this clinic.

 1/29/09  
James E. Gee, M.D.

JEG/mlm

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP ✓

### PATIENT INFORMATION

Time In: 1346 Time out: 2:51 Date of Injury: 7-22-08 Today's Date: 1-28-09  
Employer: Colo-Ji Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5254

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Strain cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

| Back and Lower Extremity | None                     | Occ.                     | Often                    | Regularly                |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Upper Extremity             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | ____ L Arm               | ____ R Arm               | ____ Both                |                          |

Work level: Lifting/Pushing/Pulling  
Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.

Activity and hour restrictions (if applicable)  
☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 4 weeks Date \_\_\_\_\_ Time \_\_\_\_\_  
Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date 1-25 Time 12:30  
PHYSICIAN'S SIGNATURE: James Gee MD Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

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- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: Emma Hamilton

21063090750

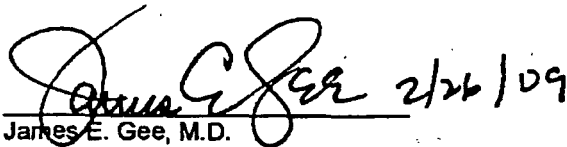
Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: February 25, 2009

Ms. Hamilton is doing fairly well. She has good days and bad days. She has seen Dr. Green but we don't have a record. He sent her to physical therapy (that has been tried previously for about six weeks).

She is "laid off" so work is not an important issue at this time so we will just give her time, let her start her therapy, and have her return here in four weeks. I hope I will have a note from Dr. Green by that time.

 2/26/09  
James E. Gee, M.D.

JEG/mlm



TUOMEY

21003090750

MEDICAL PROFESSIONALS, INC.  
INDUSTRIAL MEDICINE AND WELLNESS  
250 W. Wesmark Blvd., Sumter, SC 29150  
Phone: (803) 774 - 8842 FAX: (803) 774 - 5283

PATIENT LABEL

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-9425  
249-17-0687 02/25/09

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

## PATIENT INFORMATION

Time in: 1214 Time out: 1235 Date of Injury: 7-22-08 Today's Date: 2-25-09  
Employer: Colo. J. Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

## DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

## TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

## WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

Back and Lower Extremity None Occ. Often Regularly  
Sitting ☐ ☐ ☐ ☐  
Walking or standing ☐ ☐ ☐ ☐  
Bend/squat/twist/crawl ☐ ☐ ☐ ☐  
Climb/work on heights ☐ ☐ ☐ ☐  
Upper Extremity  
Grasp/pinch ☐ ☐ ☐ ☐  
Reach above shoulder ☐ ☐ ☐ ☐  
Reach beyond forearm limits ☐ ☐ ☐ ☐  
Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

Work level: Lifting/Pushing/Pulling  
Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.

Activity and hour restrictions (if applicable)  
☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

## FOLLOW UP

Return Appointment: ☐ No ☒ Yes 4 weeks Date 03-25-09 Time 1pm

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Geb, MD

Eric Byrd, MD

## INFORMATION RELEASE &amp; ACKNOWLEDGEMENT

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- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

PATIENT SIGNATURE: \_\_\_\_\_

Emma R. Hamilton

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



## Physician's Statement

Claimant's Name: Emma Hamilton

Employer's Name: Martin Color-Fi, Inc.

Physician's Name: James Gee

Insurance Carrier: Liberty Mutual Insurance Company

Practice/Clinic: \_\_\_\_\_

SCWCC File No: 0810330

Preparer's Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 7/22/2008

Date of first office visit: 7-23-08 Date of last visit: 3-25-09

Diagnosis or nature of Injury or illness: Roller injury - compression - (P) hand

Body part(s) injured: \_\_\_\_\_ Body part(s) affected: \_\_\_\_\_

Date of Maximum Medical Improvement: to be determined - 2/25/09

Based on the AMA Guidelines, the claimant has sustained a \_\_\_\_\_ % medical impairment to \_\_\_\_\_ injured body part(s) and a \_\_\_\_\_ % medical impairment to \_\_\_\_\_ other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

PIP not performed by me. Dr. Green is a "hand specialist" and I defer to his examination.

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Restricted work through Feb - plant "laid off"  
Pt. scheduled to be seen 5-26-09.

James Gee  
Treating Physician, James Gee, M.D.

5/7/09  
Date

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

#### PROGRESS NOTE

Emma Hamilton

Date: May 27, 2009

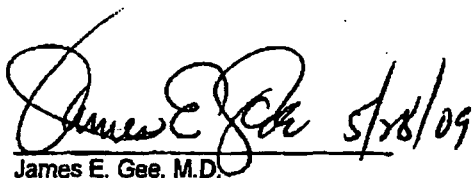
Her chief complaint continues to be weakness. The examination is the same.

She and I had a very, very long discussion. I advised her as follows:

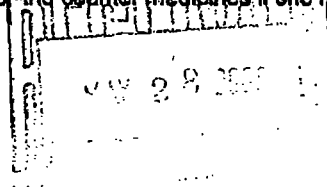
1. She has been evaluated by three physicians, a neurologist, an orthopedic surgeon, and a hand specialist. She has had nerve conduction studies, x-rays, and an MRI. None of these studies show significant damage to any structures of the wrist and arm.
2. Despite the above studies, the patient had a very significant crush-type injury to the right hand and wrist. As I told her from the initial visit, it takes a long time for this problem to improve and then to regain function and normal strength.
3. At some point between February 25, 2009 and March 25, 2009, I felt she reached maximum medical benefits as far as active orthopedic care was concerned. It was difficult to state an exact date since the patient was not working at that time and I had to review these records and make determination from retrospective point of view. I did feel and still feel that this type of problem can improve for up to one year so I have recommended that permanent impairment rating be done at that point in time (July 2009). I did, however, feel that a period of observation was necessary to see if the patient was able to strengthen the hand and arm. She had received physical therapy and I outlined a program with her to strengthen the arm. I thought she could do this without further formal therapy.
4. On today's visit, I find that the patient has not strengthened the arm as much as I would like and therefore I am suggesting as Dr. Green did previously that the patient enter the work hardening program prior to the final examination (PIR).
5. I advised the patient that I agree with Dr. Green that she does have a degree of permanent impairment. I agree with Dr. Green that it will not be a large impairment but she should have that examination prior to her complete discharge.

**SUMMARY:** I advised the patient it is "up to you," and if you work hard, you will do well; therefore, I have made referral and asked the patient to return to see me in about four weeks to monitor her progress.

**Addendum Note:** The patient does not need any other medications at this time. We have tried all appropriate medications and I have suggested that she use over-the-counter medicines if she has discomfort.

  
James E. Gee, M.D.

JEG/mlm  
c: Mr. McElveen



Dr. Gee 96

63

TUOMEY MEDICAL PROFESSIONALS, INC.  
INDUSTRIAL MEDICINE AND WELLNESS  
250 West Wesmark Boulevard, Sumter, South Carolina 29150

FACSIMILE TRANSMITTAL SHEET

TO: Rasha FROM: Marilyn  
COMPANY: Liberty Mutual DATE: 11/23/09  
FAX NUMBER: 1-803-422-6896 TOTAL NO. OF PAGES INCLUDING COVER: 1  
PHONE NUMBER: 1-800-532-7706 SENDER'S PHONE NUMBER: (803) 774 - 8842  
RE: Emma Hamilton SENDER'S FAX NUMBER: (803) 774 - 5283

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

11/10/09 Spoke with Rasha and she states could not find a place that does  
workhardening program.  
11/12/09 10:40 am Left a message on Emma's cell phone about Work Hardening Program  
11/18/09 3:15 pm Left a message on voicemail of her cell phone about Work Hardening Program,  
and asked to return my call. Also spoke with Tony and asked him to  
have Emma to call the office in reference to work hardening program.  
11/23/09 9:30 AM Left message on home number and cell phone number to return my call.  
Emma called the office today, and told her that a workhardening program is located  
at McLeod Hospital in Florence. Emma has personal concerns that my handler  
from making these appointments. CONFIDENTIALITY NOTICE  
Emma states she will call me on tomorrow morning.

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CLARENDON MEMORIAL HOSPITAL  
10 HOSPITAL STREET  
MANNING, SC 29102

RADIOLOGY REPORT

|               |                 |            |              |                |
|---------------|-----------------|------------|--------------|----------------|
| Patient name: | HAMILTON EMMA R |            | Acct #:      | 1043841        |
| Age:          | 43              | Sex:       | F            | Admit Phy:     |
| Birthdate:    | 12/04/1964      | Stay type: | O/P          | GEE JAMES E MD |
| Admit date:   | 11/26/08        | Room:      |              | Ordering Phy:  |
| Disch date:   | 11/26/08        | Phone:     | 803/481/9425 | GEE JAMES E MD |
|               |                 |            |              | Med Rec #:     |
|               |                 |            |              | 186564         |
|               |                 |            |              | X-Ray #:       |

\*\*\*Unsigned transcriptions are preliminary reports and do not represent a medical or legal document\*\*\*  
MRI UPR JOINT RT WO CON 73221RT COMPLETE:11/26/08 14:12 RTH 5024  
(B)BACKGROUND: COMPRESSION INJURY

HISTORY: right wrist pain/swelling

MRI OF THE RIGHT WRIST:

MRI of the right wrist was performed with multiple sagittal, axial, and coronal images using the standard pulse sequences.

MRI demonstrates increased signal and subtle sclerosis along the ulnar aspect of the lunate bone. The finding could reflect changes related to previous direct trauma with healing versus ulnar abutment syndrome. There are small subchondral cystic degenerative changes along the lunate.

Otherwise, the remainder of the carpal bones appear grossly intact. The flexor and extensor tendons appear intact. Mild degenerative changes along the triangular fibrocartilage are noted, with no discrete tear demonstrated.

The intrinsic ligaments appear intact. There is no evidence of carpal row offset. Minimal degenerative changes at the dorsal aspect of the scapholunate ligament are noted.

IMPRESSION: MRI of the right wrist demonstrates subtle sclerosis with increased signal and small subchondral cystic degenerative changes along the ulnar aspect of the lunate bone as discussed above.

No evidence of retracted tendon or ligament injury at the right wrist.

Dictated by: MEF  
Transcribed by: KJM  
Date: 11/26/08 19:05  
Signed: 11/26/08 19:33

Electronically Reviewed and signed by: MICHAEL E. FAULSTICH, MD, Ph.D.  
Diplomate ACR

Reports and Images can be viewed on the internet at <https://pacs.clarendonhealth.com> Please call 803-435-3121 to gain access.

Copy for: GEE JAMES E MD via fax  
Copy for: 048 MEDICAL RECORDS (HIM)

**MIDLANDS****orthopaedics, p.a.**

Robert M. Peelle, Jr, MD\*J. Talley Parron, MD\*Robert M. DaSilva, MD  
 James A. O'Leary, MD\*Michael R. Ugino, MD\*Michael S. Green, MD  
 M. David Redmond, MD\*William C. James, MD\*Robert D. Santrock, MD

Frederick C. Piehl, MD\*Thomas P. Gross, MD\*Coleman D. Fowble, MD\*Thomas A. Arnsey, MD

1910 Blanding Street \* Columbia, SC 29201 \* 1013 Lake Murray Boulevard \* Irmo, SC 29063  
 (803)256.4107 \* www.midlandsortho.com

**Initial Exam****NAME:** Hamilton, Emma**DATE:** 02/11/09**EMPLOYER:****ACCOUNT:** 2028160**DOB:** 12/04/1964 **AGE:** 44 years old**OCCUPATION:** No data for occupation**CC:** Rt hand and wrist pain**DATE OF INJURY/ONSET/SURGERY:** 7/22/08

**HPI:** Pt wrist and hand was caught in rollers in a machine at work. Pt was in a splint. Pt went to phy. therapy for 18 visits. Pt still has numbness, tingling and pain as well a decrease in strength. Apparently the patient has wanted to go back to work full duty prior to this time for her prior physician said that she wasn't ready. She states that she still feels weakness and feels that therapy would be helpful. She says her hand feels tight in that she has some decreased strength.

**PAST MED HX:** 01. Acid Reflux  
 03. Asthma

**SURGICAL HISTORY:** No Surgery Reported**FAMILY HISTORY:** Family History Reviewed

**SOCIAL HISTORY:** 04. Alcohol-Occasional  
 06. Children-Yes  
 07. Marital Status-Divorced  
 17. Tobacco-cigarettes >1 PPD  
 25. Work History-Unemployed  
 26. Right-Hand Dominance

**ALLERGIES:** STEROIDS  
 Sulfa

**MEDICATION(s):** Darvocet-N  
 Ibuprofen

**REVIEW OF SYSTEMS:**

General, neuro, psychiatric, respiratory, cardiovascular, GI, GU, blood and lymph, EENT, musculoskeletal, skin and endocrine are normal except for what is noted: Height

**Weight**

01. Any significant weight change

05. Frequent hay fever symptoms

06. Seasonal/year round allergies

20. Eczema

21. Frequent heartburn or indigestion

43. Anesthesia -- no previous problems

**PHYSICAL EXAM:****Vital Signs:** No data for Vitals**Appearance:** no acute distress**Psychiatric:** awake, alert, and oriented x3 Mood and affect were appropriate**Skin:** warm and dry, no new lesions or rashes Clean, dry, no lesions, no rashes**Neuro:** alert & oriented x3

Report Date: February 24. 2009 Patient: Hamilton, Emma DOS: 02/11/09

**FOCUSED EXAM:** Patient ambulated without difficulties. The skin is intact. She does have some soft tissue thickening and slight swelling of the dorsal aspect of her hand. Range of motion of her wrist at greater than 80° the volar flexion, greater than 80° of dorsi flexion, ulnar deviation 35°, radial deviation 25 to 30°, full supination and full pronation. She has full flexion and extension of her fingers. However up on being asked to flex her fingers she went through some non-physiologic contortions. Her flexion cascade was voluntarily altered in her attempts to show an inability to do so. However she is normal flexion and extension increases of her digits. They are not swollen. They are not stiff. Hand intrinsic are normal in function. We did not do grip strength or pinch strength today. Neurologic status and circulatory status are both normal. She essentially has a normal hand exam. Two-point discrimination is 5 mm throughout. A negative Phalen's test and a negative Tinel's are present.

**RADIOGRAPHS:****PROCEDURE:**

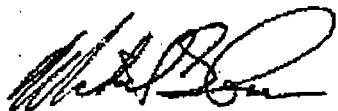
**ASSESSMENT:** -Status post roller injury right hand  
-Resolved peri-tendonous and peri-articular fibrosis

**PLAN:** Of the patient's exam today is essentially normal. She may have some strength issues that may respond to a supervised work hardening/BTE rehabilitation program. She can work unrestricted activities at this time. She has reached maximal medical benefits with regards to motion but may need some strengthening. She is discharged from the office.

**PRESCRIPTIONS:** No data for Prescription

**PRE-EXAMINATION:****WORK STATUS:**

( ) Full Time ( ) Part Time ( ) Restrictions ( ) Out of Work ( ) Non-Applicable



Michael S. Green, M.D.

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



# Physician's Statement

Claimant's Name: Anna Hamilton Employer's Name: Forrest Fibers, Inc.  
Physician's Name: Dr. Michael Allen Insurance Carrier: Liberty Mutual  
Practice/Clinic: Midland Orthopedics, PA SCWCC File No: \_\_\_\_\_  
Preparer's Name: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 07-22-08

Date of first office visit: 02-11-09 Date of last visit: 02-11-09

Diagnosis or nature of injury or illness: T19.44 pain in foot, hand

Body part(s) injured: Right Hand, wrist Body part(s) affected: \_\_\_\_\_

Date of Maximum Medical Improvement: 02-11-09

Based on the AMA Guidelines, the claimant has sustained a 2 % medical impairment to Hand injured body part(s) and a \_\_\_\_\_ % medical impairment to \_\_\_\_\_ other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician

Date

2028160

South Carolina Workers' Compensation Commission  
1612 Marion Street P.O. Box 171F  
Columbia, South Carolina 29202-1715  
(803) 737-5723  
www.WCC.SC.gov



## Physician's Statement

Claimant's Name: Emma Hamilton  
Physician's Name: \_\_\_\_\_  
Practice/Clinic: \_\_\_\_\_  
Preparer's Name: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_

Employer's Name: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
SCWC File No: \_\_\_\_\_

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 7/2/08

Date of first office visit: 2/11/09 Date of last visit: 2/11/09

Diagnosis or nature of injury or illness: 3/4 protractor injury Rt. hand/resolved peritendinous

Body part(s) injured: Rt. hand Body part(s) affected: periarticular fibrosis

Date of Maximum Medical Improvement: 2/11/09

Based on the AMA Guidelines, the claimant has sustained a \_\_\_\_\_ % medical impairment to \_\_\_\_\_ injured body part(s) and a \_\_\_\_\_ % medical impairment to \_\_\_\_\_ other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician

Date

**Moore Orthopaedics**  
104 Saluda Pointe Drive  
Lexington, South Carolina 29072  
(803) 227-8124 Phone / (803) 227-8224 Fax

06/30/2010

EMMA HAMILTON 256804

Lexington Office

**HISTORY:**

Emma Hamilton is a 45-year-old right hand dominant female here for an independent evaluation of her right hand. The patient previously worked as a color specialist at Color-Fi Corporation and sustained an on the job injury on July 22, 2008, when she reportedly caught her hand in a roller at work. She reported the immediate onset of sharp pain in the hand, which she did not have previously. She initially went to the emergency department where she was splinted and given pain medication and x-rays were taken. She then presented the following day to Dr. Gee who found the patient to have a roller type crush injury to the hand with no signs of compartment syndrome or vascular compromise. She was treated with analgesics and later with therapy. The patient has not yet returned to work since the time of her injury. She states that her hand continues to hurt and is made better with heat and rubbing it out and made worse with using it too much. She did undergo an extensive course of therapy including work hardening, which she states she felt was helpful in her recovery. She states that she was interested in working light-duties while she was recovering, but that no light-duties were available to her. She initially complained of some new onset tingling in her hand after the crush injury and this was evaluated with a nerve conduction study by Dr. Marshall White on November 3, 2008, which showed no signs of abnormalities in the right upper extremity. She also underwent imaging of her right hand with an MRI scan on November 26, 2008, which showed no signs of fracture in the hand or wrist. She did have some subchondral cystic degenerative changes in the ulnar aspect of the lunate bone.

**PAST MEDICAL HISTORY:**

The patient information sheet was reviewed and signed. She has a history of depression and asthma. She does smoke. She denies alcohol use. She is divorced.

**PHYSICAL EXAMINATION:**

She is in minimal distress. There are no signs of bruising or swelling noted about the right hand compared to the left. There is full range of motion of her fingers and wrist. There is no carpal instability. She is nontender over the lunate and nontender over the ulna. There is a negative Finkelstein's test. There is variable strength testing measurements with static and dynamic testing. There is a normal objective sensory examination of the median and ulnar nerve distributions. There is negative Tinel's at the elbow, negative Tinel's at the wrist. There are no signs of crepitus or carpal instability with wrist range of motion.

**IMPRESSION:**

STATUS-POST ROLLER INJURY TO RIGHT HAND  
WHICH APPEARS TO BE RESOLVED FROM AN  
OBJECTIVE STANDPOINT

Continued

**Moore Orthopaedics**  
104 Saluda Pointe Drive  
Lexington, South Carolina 29072  
(803) 227-8124 Phone / (803) 227-8224 Fax

06/30/2010

EMMA HAMILTON 256804

Lexington Office

**Continued****PLAN:**

I see no signs of ongoing swelling or loss of mobility. Her nerve studies were normal. I do not believe the cystic changes in her lunate were likely related to the injury, but rather represent likely pre-existing chronic changes, as she is not clinically painful in this area of her wrist. At this point in time, I see no contraindication to return to work without restriction. I see no evidence of permanent partial impairment to the right hand or wrist. I believe her treatment to date has been appropriate for her work related crush injury. I do not believe any further treatment or testing is medically necessary. Follow up with me is p.r.n.

David B. Fulton, M.D.

**CC List:**

DBF:ats47

DD: 06/30/2010 DT: 07/01/2010 09:38:18

47903

This document was electronically authenticated by David B. Fulton, M.D. on 07/08/2010  
10:22:43.

STATE OF SOUTH CAROLINA  
BEFORE THE WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO. 0810330

Emma Hamilton, Employee,

Claimant,

vs.

Martin Color-Fi, Inc., Employer,

Liberty Insurance Corporation, Carrier,

Defendants.

**APA SUBMISSIONS**

HEARING BEFORE THE HONORABLE G. BRYAN LYNDON  
December 15, 2010 at 1:30 P.M.

|        |                                                                                                                                                                   |                  |                        |
|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------|
| Tab 6  | Tuomey Industrial Medicine & Wellness<br>Dr. James Gee                                                                                                            | 7/23/08-2/25/10  | Pages 73-109           |
| Tab 7  | Cornell Therapy Associates                                                                                                                                        | 9/18/08-10/23/08 | Pages 110-130          |
| Tab 8  | Sumter Neurology and Pain Management<br>Dr. Marshall White                                                                                                        | 11/03/08         | Pages 131-132          |
| Tab 9  | Progressive Physical Therapy                                                                                                                                      | 6/19/09-10/28/09 | Pages 133-156          |
| Tab 10 | McLeod Health<br>John P. Zelenka, OTR/L                                                                                                                           | 12/31/09-1/26/10 | Pages 157- 241         |
| Tab 11 | Kingstree Surgical Associates<br>Dr. Blake Moore                                                                                                                  | 6/01/09-9/04/10  | Pages 242-250          |
| Tab 12 | Exhibits:<br>A) Martin Color-Fi Accident Investigation Report;<br><br>B) Martin Color-Fi E-mail;<br><br>C) Martin Color-Fi Employee Attendance Councelling Sheet. |                  | A1<br><br>B1<br><br>C1 |

**South Carolina Workers' Compensation Commission**

P.O. Box 1715 c 1612 Marion Street  
Columbia, South Carolina 29202-1715  
(803) 737-5700

WCC File # 0810330  
Carrier File # WC550-614499  
Carrier Code #  
Employer FEIN

Emma Hamilton  
Claimant's Name

Martin Color-Fi, Inc.  
Employer's Name

2227 Bobwhite Drive Sumter, SC 29154  
Address City, State Zip

320 Neeley Street Sumter, SC 29150  
Address City, State Zip

(803) 481-9425

Home Phone #

Work Phone #

Liberty Insurance Corporation  
Insurance Carrier

Joseph T. McElveen, Jr.

P.O. Box 2038, Sumter, SC 29151-2038

(803) 775-1263

Preparer's Name

Address

Phone #

A claim for workers' compensation benefits is made based on the following grounds: ☒ Injury ☐ Illness ☐ Repetitive Trauma

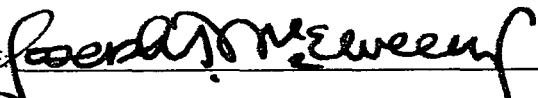
1. Compensation Rate: \$344.35
2. AWW \$516.51
- Date of Injury: July 22, 2008
3. Type of injury and body part(s): Crush injury to right arm (hand and wrist).
4. Facts in Controversy: Admitted claim.
5. Legal issues involved: (a) Has Claimant reached maximum medical improvement?  
(b) If not, what further medical treatment should she receive?  
(c) If so, what is the level of her permanent impairment?  
(d) What future medical treatment should be ordered?  
(e) Should payment of any disability award be made in a lump sum and alternatively stated in terms of Claimant's life expectancy to reflect the permanent nature of her disability?
6. Unusual problems: (a) Claimant feels that she essentially has received no real treatment for her problems. Dr. Blake Moore was concerned that Claimant's MRI was generally ignored. He saw this MRI as showing the possibility of "ulnar abutment syndrome" or "avascular necrosis". The MRI mentions "subchondral cystic degeneration along the lunate bone", which is consistent with the diagnoses Dr. Moore mentions. Yet, neither the treating doctor, nor the independent medical examination (IME) doctors chosen by the Defendants mention any of these problems. See Dr. Moore's reports, Claimant's APA, pp. 242. Claimant does not believe that she is at MMI and that she needs more treatment as mentioned by Dr. Moore.  
(b) One IME doctor, Dr. Green, submitted two Forms 14B, without explanation. One said the right hand had a 2% impairment rating. The one dated the next day said 1%. This occurrence emphasizes the point that Dr. Green, as an IME doctor, did not consider Claimant to be a patient, as does the fact that he found Claimant at MMI and released her to full duty, despite the fact that he said Claimant needed "strengthening". Dr. Green makes no mention of the MRI. (The functional capacity evaluation (FCE) had not been done at the time of the Green appointment.) Claimant submits that the Green impairment rating should be disregarded.  
(c) Another IME doctor, Dr. Fulton, opined that Claimant has no impairment of her injured right arm. Dr. Fulton, who, like Dr. Green, did not form a patient-physician relationship with Claimant, dismissed the problems found on the MRI and did not mention the FCE, completed five months before his examination.  
(d) The report of Dr. Blake Moore is by far the most thorough and calls for additional testing and treatment.  
(e) The FCE from McLeod Work Recovery Center documents that Claimant can no longer perform her former job. That job required the medium-to-heavy physical demand category, but she can now perform only at the light strength level. Her limitations result primarily from limitations on the use of her right hand (page 5). Note that grip strength of her dominant hand was almost one-third less than in her non-dominant hand. She also showed right arm fatigue on the Repetitive Movement Screening Test (page 10). She showed pain behaviors related to her right arm on lifting (pages 10-11). The examiner said that Claimant applied "full physical effort". He also noted that Claimant appeared to under report her discomfort on the FCE and during work hardening. He felt she was motivated to return to work. The FCE was ignored by the IME doctors and the authorized treating doctor, who deferred the impairment rating to Dr. Green, the IME doctor.  
(f) Claimant submits that the most reasonable information for a disability determination is found in Dr. Moore's reports, if the Commissioner finds Claimant to be at MMI. Dr. Moore explains that the AMA Guides, 6<sup>th</sup> Ed. do not allow consideration of all impairment in giving a rating. For instance, he assesses a DRE rating of 7% to the upper extremity due to the abnormal bone architecture of the lunate. He also finds a 5% upper extremity impairment due to loss of range of motion and a 20% upper extremity impairment as a result of strength loss. The fifth edition of the Guides would have considered the strength loss; the sixth edition does not. Claimant submits that the loss of range of motion and the loss of strength must be considered in assessing permanent disability under the Workers' Compensation Act.

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.

7. Witnesses (designate if expert): \*Claimant, Emma Hamilton
8. Exhibits: A) Martin Color-Fi Accident Investigation Report; B) Martin Color-Fi E-mail; C) Martin Color-Fi Employee Attendance Councelling Sheet.
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance): See Notice of Witnesses and Written Documents.
10. Name, address, and specialty, if any, of the treating physician: Dr. James Gee, Tuomey Industrial Medicine and Wellness, 250 W. Wesmark Blvd., Building 2, Sumter, SC 29150.
11. Impairment rating(s); body part(s); physician and date of opinion: (a) 7% upper extremity based upon DRE (diagnosis-related estimate); 20% upper extremity due to loss of strength; and 5% due to loss of range of motion, Dr. Blake H. Moore 6/01/09; b) 2% right hand 3/31/09, 1% right hand 4/01/09, Dr. Michael Green (Per IME Visit); c) 0% impairment Dr. David Fulton 6/30/10.
12. I am amending my Form 50/51 in the following manner: N/A

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

SIGNATURE



Email: [jmcelveen@bryanlaw.com](mailto:jmcelveen@bryanlaw.com)

DATE OF HEARING: December 15, 2010

TIME OF HEARING: 1:30 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.

## WORK STATUS REPORT

INITIAL VISIT ☒  
FOLLOW UP ☐

### PATIENT INFORMATION

Time in: 11:20 Time out: 12:10 Date of Injury: 7-22-08 Today's Date: 7-23-08  
Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. trallett cruste cpt \_\_\_\_\_  
2. \_\_\_\_\_ cpt \_\_\_\_\_  
3. to @ hand & wrist cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☒ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☒ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☒ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                           | Occ.                           | Often                         | Regularly                |
|-----------------------------|--------------------------------|--------------------------------|-------------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/>       | <input type="checkbox"/>       | <input type="checkbox"/>      | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/>       | <input type="checkbox"/>       | <input type="checkbox"/>      | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/>       | <input type="checkbox"/>       | <input type="checkbox"/>      | <input type="checkbox"/> |
| Restrictions apply to       | <input type="checkbox"/> L Arm | <input type="checkbox"/> R Arm | <input type="checkbox"/> Both |                          |

#### Work level: Lifting/Pushing/Pulling

|            |                                        |                |
|------------|----------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs. |                |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

no work until I see a doctor

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes Thursday Date: 07-24 Time: 3:30pm

Patient Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: James Gee, MD Eric Byrd, MD

73

### INFORMATION RELEASE & ACKNOWLEDGEMENT

- By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

97

PATIENT SIGNATURE: Emma R. Hamilton

**TUOMEY**

MEDICAL PROFESSIONALS, INC.

**INDUSTRIAL MEDICINE AND WELLNESS**

250 W. Wesmark Blvd., Sumter, SC 29150

Phone: (803) 774 - 8842 FAX: (803) 774 - 5283

 IM0175676 F 12/04/64 43281  
 HAMILTON, EMMA  
 249-17-0683  
 803-481-9425  
 07/30/08

PATIENT LABEL

**MEDICAL ASSESSMENT****ASSESSMENT**

Date of Injury: \_\_\_\_\_

BP \_\_\_\_ / \_\_\_\_ / \_\_\_\_ T \_\_\_\_ P \_\_\_\_ RR \_\_\_\_

Vision R 20/ \_\_\_\_ L 20/ \_\_\_\_ Corr. \_\_\_\_ UnCorr. \_\_\_\_

Improvement: Same \_\_\_\_ Worse \_\_\_\_ Better \_\_\_\_

**MEDICATIONS:** \_\_\_\_\_**ALLERGIES:** \_\_\_\_\_**NURSING ASSESSMENT:** \_\_\_\_\_

better -

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

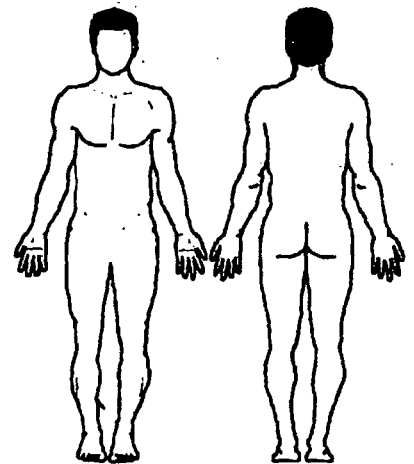
**MEDICAL EVALUATION:** Above Noted \_\_\_\_ History reviewed and noted \_\_\_\_**INITIAL:** \_\_\_\_\_

7-30-08

Good progress

same  
inside vs out

J. Med



dictated by [signature]

[signature]

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

36444 Rev: 04/17/2008

**TUOMEY**  
 MEDICAL PROFESSIONALS, INC.  
 INDUSTRIAL MEDICINE AND WELLNESS  
 250 W. Westmark Blvd., Sumter, SC 29150  
 Phone: (803) 774 - 8842 FAX: (803) 774 - 5283

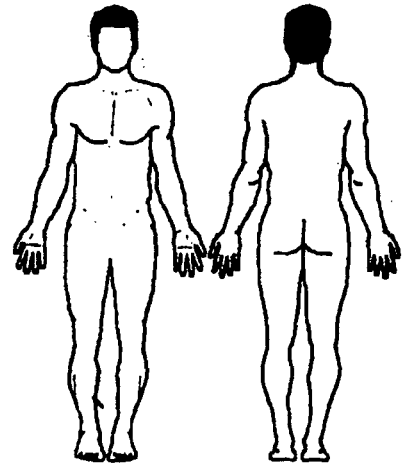
IM0175676 F 12/04/64 43281  
 HAMILTON, EMMA 803-481-9425  
 249-17-0603 08/13/08

PATIENT LABEL

**MEDICAL ASSESSMENT****ASSESSMENT**Date of Injury: 7-22-08BP    /    /    T    P    RR   Vision R 20/    L 20/    Corr.    UnCorr.   Improvement: Same ☒ Worse    Better   but better than original injuryMEDICATIONS: Dawocet, IbuprofenALLERGIES: Sulfa

**NURSING ASSESSMENT:** Fla (D) hand injury. States today, pinky  
stiff, outer hand feels like a burning. Top of hand has  
Knott. palm discolored & painful on thumb joint.

**MEDICAL EVALUATION:** Above Noted    History reviewed and noted   

INITIAL: DM8/13/08

9  
13  
22

new splint  
Zuccer

dictated w/ leew

PHYSICIAN'S SIGNATURE: [Signature]

36444 Rev: 04/17/2008

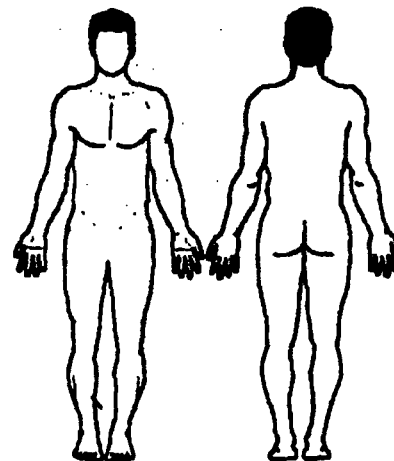
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 INDUSTRIAL MEDICINE AND WELLNESS  
 250 W. Westmark Blvd., Sumter, SC 29150  
 Phone: (803) 774-8842 FAX: (803) 774-5283

IM0175676 F 12/04/64 43281  
 HAMILTON, EMMA 803-481-9425  
 243-17-0683 09/03/08

PATIENT LABEL

**MEDICAL ASSESSMENT****ASSESSMENT**Date of Injury: 7-22-08BP 1 / 1 / 1 T 1 P 18 RR 18Vision R 20/ 1 L 20/ 1 Corr. 1 UnCorr. 1Improvement: Same 1 Worse 1 Better 1MEDICATIONS: IbuprofenALLERGIES: Sulfa

NURSING ASSESSMENT: Flu (R) hand injury, states hand  
has weakness, pain, slight swelling, feeling cold  
& feels like tight glove.

MEDICAL EVALUATION: Above Noted 1 History reviewed and noted 1INITIAL: Em

9-2-08  
work on me?  
exercise - 0.5? - radial  
for me:  
work doing  
"chief"  
as the

dictated in lieu  
[Signature]

PHYSICIAN'S SIGNATURE: [Signature]

36444 Rev: 04/17/2008

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IM0175676 F 12/04/84 43281

HAMILTON, EMMA

803-481-9425

249-17-0663

05/10/08

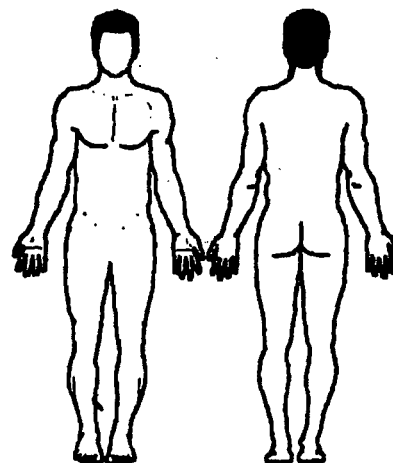
PATIENT LABE

**MEDICAL ASSESSMENT****ASSESSMENT**Date of Injury: 7-22-08BP 1 / 1 / 1 T 1 P 1 RR 18Vision R 20/    L 20/    Corr.    UnCorr.   Improvement: Same    Worse    Better ✓MEDICATIONS: ibuprofenALLERGIES: Seizure**NURSING ASSESSMENT:**

Flu (R) hand injury. % hand weakness  
using 3lb wt. but hand feel tight & %  
thumb pain & in palm

Cell # 83 795-8269INITIAL: DMMEDICAL EVALUATION: Above Noted    History reviewed and noted   

O.T.



PHYSICIAN'S SIGNATURE: \_\_\_\_\_

36444 Rev: 04/17/2008

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PATIENT LABEL

IM0175676 F 12/04/64 43281  
 HAMILTON, EMMA 803-481-54  
 249-17-0687 10/01/09

## MEDICAL ASSESSMENT

### ASSESSMENT

Date of Injury: 7/22/08

BP 100/80 / 1 T 88 RR 18

Vision R 20/ 20 L 20/ 20 Corr. UnCorr.

Improvement: Same Worse Better

### MEDICATIONS:

TBLL, Darvocet - PRN

### ALLERGIES:

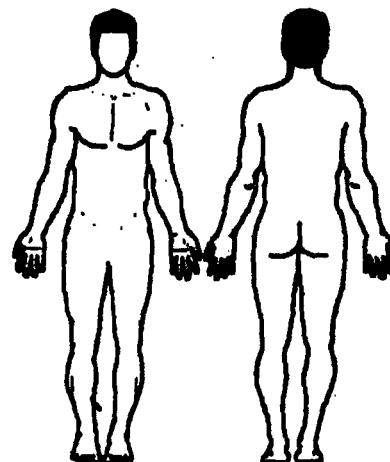
Sulfa

### NURSING ASSESSMENT:

3:07pm Follow Up on Rt. hand injury.  
Pt states hand is getting stronger, but no pain in the joint  
of thumb and wrist, index finger knuckle. No swelling, and  
hand aches at night.

MEDICAL EVALUATION: Above Noted History reviewed and noted

INITIAL: MA



10-1-08

butler

Zimmer

dictated in lines

PHYSICIAN'S SIGNATURE: [Signature]

38444 Rev: 04/17/2008

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**INDUSTRIAL MEDICINE AND WELLNESS**  
 880 W. Westmark Blvd., Dunbar, SC 29540  
 Phone: (803) 774-8842 FAX: (803) 774-8823

INCL 1756/16 P 12 24/09 43261  
 HAMILTON, ENHA 803-481-942  
 249-17-0683 10/22/00

PATIENT LABEL

# MEDICAL ASSESSMENT

## ASSESSMENT

Date of Injury: 7-22-08

BP 1 / 1 T 1 P 18

Vision R 20/    L 20/    Corr.    UnCorr.   

Improvement: Same    Worse    Better   

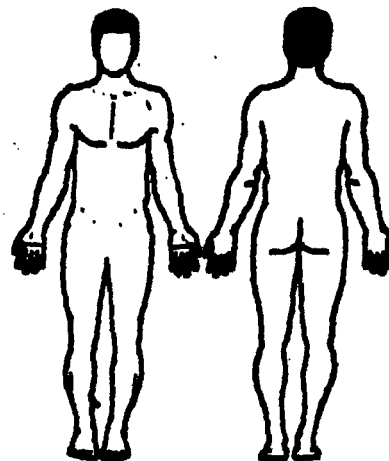
MEDICATIONS: Thyroxine, Lanoxin, EPR

ALLERGIES: Sulfa

NURSING ASSESSMENT: Flu @ hand injury, pt states OT  
has helped a lot & therapy rehab is ending  
states her hand feels better & therapy

MEDICAL EVALUATION: Above Noted    History reviewed and noted   

INITIAL: DM



10-22-08

NCS

dictated by her

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

38444 Rev. 04/17/2008

43281

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: November 12, 2008

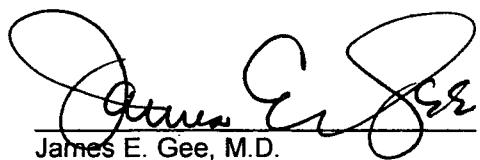
The patient is extremely anxious and seems to be getting worse and worse with regards to wanting something done more quickly.

I tried to discuss the situation with her, advising her that she has done well with regards to this significant injury and it is just going to take time, that she doesn't need any surgical procedure even if it is a small tear of the radial tendon. I don't believe she needs a shot of steroids right now.

After a very, very long discussion, I suggested that we try Sterapred DS for 12 days, get an MRI (she wants an MRI anyway) and just give it more time. Her splint will be optional at work.

I did ask her if she considered getting an independent medical evaluation. She does not seem to be interested in that, possibly because she doesn't want to pay but I am not sure exactly the reason.

I will see her again in three weeks.

 11/19/08  
James E. Gee, M.D.

JEG/mlm

pm



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IM0175676 F 12/04/64 43281  
HAMILTON, EMMA  
249-17-0583  
803-481-94  
11/12/08

PATIENT LABEL

## MEDICAL ASSESSMENT

## ASSESSMENT

Date of Injury: 7-22-08

BP 118/90 T P RR

Vision R 20/ L 20/ Corr. UnCorr.

Improvement: Same Worse Better

## MEDICATIONS:

Advil 800

~~Tace 800~~

## ALLERGIES:

Sulfa

NURSING ASSESSMENT: 9:50 AM Follow Up on R hand. H states hand  
hurts and water pain 7/10.

MEDICAL EVALUATION: Above Noted History reviewed and noted

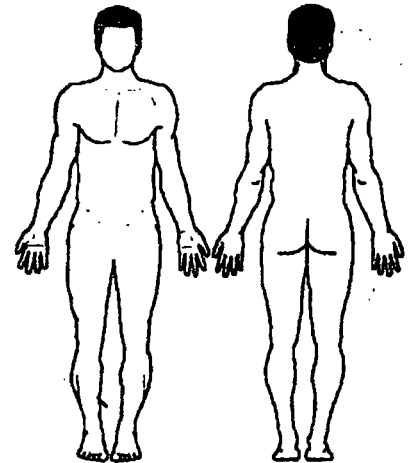
INITIAL: MA

7-22-08

111

9  
31  
30  
31  
104

32 mm Hg



NAT

Nessarapara

dictated m'leu  
[Signature]

PHYSICIAN'S SIGNATURE:

36444 Rev: 04/17/2008



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IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-94  
249-17-0683 12/03/06

PATIENT LABEL

# MEDICAL ASSESSMENT

## ASSESSMENT

Date of Injury: 7/22/08

BP 130/80 T 96 RR

Vision R 20/ L 20/ Corr. UnCorr.

Improvement: Same Worse Better

## MEDICATIONS:

ERASMA

paracetamol PRN

## ALLERGIES:

NURSING ASSESSMENT: 10:30 A.M. Follow Up on R hand / MRI Results.  
Pt state hand hurts, arm hurts. Rates pain 3/10

MEDICAL EVALUATION: Above Noted History reviewed and noted

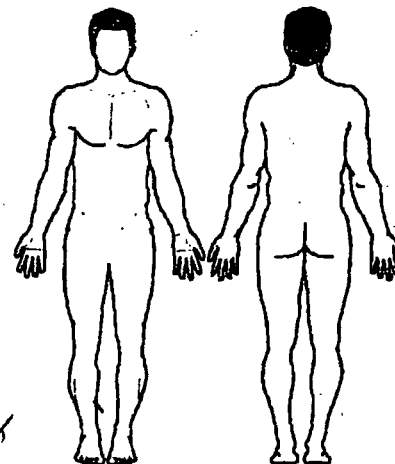
INITIAL:

MA

7/3/08  
Hand

not on  
med on

6 months



Staged  
5th day

ER - Paralytic  
Xanthax

Skipped DS

mother 800

Doc

Neurologist

Reflex deep tendon

distal in line

PHYSICIAN'S SIGNATURE:

36444 Rev: 04/17/2008

**REFERRAL NOTE**

DATE: 12-3-08

PATIENT NAME: E. Hamilton SSN 249-17-0683 DOB 12-4-64

REFERRAL TO: Dr. Marshall White  
Sumter Neurology & Pain Management  
312 Broad St Sumter, SC PHONE: 803-774-7246

DATE/TIME: \_\_\_\_\_

**REFERRAL TYPE**

☒ CONSULT ☐ PROCEDURE  
☐ EVALUATION ☐ OTHER

DIAGNOSIS \_\_\_\_\_

**REASON FOR REFERRAL**

☐ FAILURE TO RESPOND TO CONSERVATIVE TREATMENT  
☐ REQUIRES ONGOING CARE AND MANAGEMENT  
☐ REQUIRES SPECIALIZED SERVICES OR PROCEDURES

NOTES Follow up - Roller type injury -

you performed MCS - etc

Still painful, etc. Don't believe there  
is true s. reflex dystrophy but would like your  
opinion. Would Neuroton or similar be  
of any value? Thanks

  
Eric Byrd, MD

James Gee, MD

12/4/08 Called and left a message 9:05  
(434-4000)  

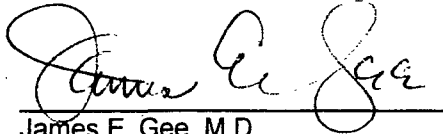

Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

43281

PROGRESS NOTE

Emma Hamilton  
Date: March 25, 2009

Everything is about the same. She really indicates that she is slowly but surely improving and that's about all I can really hope for right now. I will continue to follow her and see her again in a couple of months.

 3/26/09  
James E. Gee, M.D.

JEG/mlm



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PATIENT LABEL

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA  
249-17-0683  
03/25/09

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_  
FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 1248 Time out: 1310 Date of Injury: 7-22-08 Today's Date: 3-25-09  
Employer: Cole J. Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5653

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | _____ L Arm              | _____ R Arm              | _____ Both               |                          |

#### Work level: Lifting/Pushing/Pulling

|            |                                        |                |
|------------|----------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs. |                |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 2 months

Patient Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

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- I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

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PATIENT SIGNATURE: \_\_\_\_\_

Emma R. Hamilton



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Sumter, South Carolina 29150

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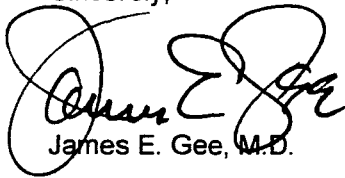
May 27, 2009

RE: Emma Hamilton

Dear Mr. McElveen:

Enclosed is a copy of my impressions after visiting with Ms. Hamilton on May 27, 2009. I hope this answers your questions. Please let me know if there are any questions not answered by this report.

Sincerely,



James E. Gee, M.D.

JEG/mlm  
Enclosure

413481

PAT: \_\_\_\_\_

## WORK STATUS REPORT

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 11:07 Time out: 11:55 Date of Injury: 7-22-08 Today's Date: 5-27-09  
Employer: Color Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Adm cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                               | Occ.                     | Often                    | Regularly                |
|-----------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | _____ L Arm _____ R Arm _____ Both |                          |                          |                          |

#### Work level: Lifting/Pushing/Pulling

|            |                                        |                |
|------------|----------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs. |                |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes one month Date 6-24 Time 2:30

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gae, MD

Eric Byrd, MD

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PATIENT SIGNATURE: \_\_\_\_\_

43281

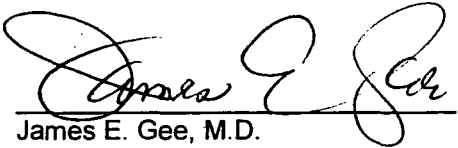
Tuomey Industrial Medicine and Wellness  
See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

Emma Hamilton  
Date: July 1, 2009

I think she is making progress. Apparently, therapy felt they should "work-up to" the work hardening program and so she has had more physical therapy. She seems to be more confident than I have seen her in some time and I think she is making progress.

I am requesting that she indeed be in the therapy program and that she "work-up to" and complete the work hardening program. She will return to see me in several weeks.

 7/2/09  
James E. Gee, M.D.

JEG/mlm



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IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-9425  
249-17-0683 07/01/09

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 1510 Time out: 1550 Date of Injury: 7-22-08 Today's Date: 7-1-09  
Employer: Colo. Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Sam cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Work level: Lifting/Pushing/Pulling

|            |                                        |                |
|------------|----------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs. |                |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

no change

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 4-6 weeks Date Aug 12 Time 3:00pm

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

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PATIENT SIGNATURE: \_\_\_\_\_

Emma R. Hamilton



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PATIENT LABEL

## REHABILITATION PRESCRIPTION

NAME: Emma Hunter

DATE: 7/1/09

DIAGNOSIS: \_\_\_\_\_

### PROCEDURES

|                                             |                                             |                                             |                                           |
|---------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Pre-Placement Eval | <input type="checkbox"/> Complete FCE       | <input type="checkbox"/> Limited FCE      |
| <input type="checkbox"/> Wound Care         | <input type="checkbox"/> Whirlpool          | <input type="checkbox"/> Debridement        | <input type="checkbox"/> Dressing Changes |
| <input type="checkbox"/> Home Program       | <input type="checkbox"/> Patient Education  | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Gait Training    |
| <input type="checkbox"/> Splint Fabrication | <input type="checkbox"/> Strengthening      | <input type="checkbox"/> CV-Conditioning    | <input type="checkbox"/> Work Hardening   |
| <input type="checkbox"/> Other: _____       |                                             |                                             |                                           |

### MODALITIES

☐ May substitute other appropriate modalities

|                                          |                                       |                                                    |                                              |
|------------------------------------------|---------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Moist Heat      | <input type="checkbox"/> Traction     | <input type="checkbox"/> Ultrasound                | <input type="checkbox"/> Fluidotherapy       |
| <input type="checkbox"/> Cryotherapy     | <input type="checkbox"/> TENS Unit    | <input type="checkbox"/> Phonophoresis             | <input type="checkbox"/> Cerv. Traction Unit |
| <input type="checkbox"/> Electric Stim   | <input type="checkbox"/> Whirlpool    | <input type="checkbox"/> Iontophoresis with: _____ |                                              |
| <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Other: _____ |                                                    |                                              |

### GOALS

|                                        |                                                          |                                                    |
|----------------------------------------|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Independent Exercise Program    | <input type="checkbox"/> Return to Normal Function |
| <input type="checkbox"/> Increase ROM  | <input type="checkbox"/> Increase Strength and Endurance |                                                    |
| <input type="checkbox"/> Other: _____  |                                                          |                                                    |

### COMMENTS

Please "work up" to full  
work hardening program & complete same

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_ Physician Signature: Charles J. [Signature]

### SCHEDULING

(TO BE COMPLETED BY PHYSICAL THERAPY DEPARTMENT)

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Signature (acknowledging appointment): \_\_\_\_\_

Once appointment scheduled and acknowledged, fax to Tuomey Industrial Medicine 803.774.5283

WHITE COPY - PHYSICAL THERAPY

YELLOW COPY - PATIENT

PINK COPY - PHYSICIAN

43281

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

PROGRESS NOTE

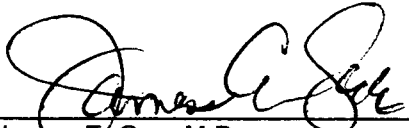
Emma Hamilton

Date: August 12, 2009

She is making steady progress. I think for the most part it is just because of time and use since she apparently has not had recent therapy.

It appears that the request of July 1st was not authorized for a fairly long period of time and because of that when she returned to therapy they could not see her because 30 days had elapsed and she needed a new prescription.

At any rate, I would like for her to complete the work hardening programs. I am returning her to physical therapy (if authorized) for six weeks and she will work toward the work hardening program. I will see her again in follow-up.

 8/13/09  
James E. Gee, M.D.

JEG/mlm

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_  
FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 3:00 Time out: 3:20 Date of Injury: 7-22-08 Today's Date: 8-12-09  
Employer: Color Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                               | Occ.                     | Often                    | Regularly                |
|-----------------------------|------------------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | _____ L Arm _____ R Arm _____ Both |                          |                          |                          |

#### Work level: Lifting/Pushing/Pulling

| Sedentary  | <input type="checkbox"/> | Negligible - 10 lbs. max    |
|------------|--------------------------|-----------------------------|
| Light      | <input type="checkbox"/> | 10 lbs. freq - 20 lbs. max  |
| Medium     | <input type="checkbox"/> | 25 lbs. freq - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> | 50 lbs. freq - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> | over 100 lbs.               |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

no change

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 8 weeks Date 10-14 Time 10:00

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

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### INFORMATION RELEASE & ACKNOWLEDGEMENT

- By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

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PATIENT SIGNATURE: \_\_\_\_\_

Emma R. Hamilton



TUOMEY

MEDICAL PROFESSIONALS, INC.

INDUSTRIAL MEDICINE AND WELLNESS

250 W. Wesmark Blvd., Sumter, SC 29150  
Phone: (803) 774 - 8842 FAX: (803) 774 - 5283

PATIENT LABEL

## REHABILITATION PRESCRIPTION

NAME:

*E. Hamilton*

DATE:

*8/12/09*

DIAGNOSIS:

### PROCEDURES

|                                             |                                             |                                             |                                           |
|---------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Pre-Placement Eval | <input type="checkbox"/> Complete FCE       | <input type="checkbox"/> Limited FCE      |
| <input type="checkbox"/> Wound Care         | <input type="checkbox"/> Whirlpool          | <input type="checkbox"/> Debridement        | <input type="checkbox"/> Dressing Changes |
| <input type="checkbox"/> Home Program       | <input type="checkbox"/> Patient Education  | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Gait Training    |
| <input type="checkbox"/> Splint Fabrication | <input type="checkbox"/> Strengthening      | <input type="checkbox"/> CV-Conditioning    | <input type="checkbox"/> Work Hardening   |
| <input type="checkbox"/> Other: _____       |                                             |                                             |                                           |

### MODALITIES

☐ May substitute other appropriate modalities

|                                          |                                       |                                                    |                                              |
|------------------------------------------|---------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Moist Heat      | <input type="checkbox"/> Traction     | <input type="checkbox"/> Ultrasound                | <input type="checkbox"/> Fluidotherapy       |
| <input type="checkbox"/> Cryotherapy     | <input type="checkbox"/> TENS Unit    | <input type="checkbox"/> Phonophoresis             | <input type="checkbox"/> Cerv. Traction Unit |
| <input type="checkbox"/> Electric Stim   | <input type="checkbox"/> Whirlpool    | <input type="checkbox"/> Iontophoresis with: _____ |                                              |
| <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Other: _____ |                                                    |                                              |

### GOALS

|                                        |                                                          |                                                    |
|----------------------------------------|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Independent Exercise Program    | <input type="checkbox"/> Return to Normal Function |
| <input type="checkbox"/> Increase ROM  | <input type="checkbox"/> Increase Strength and Endurance |                                                    |
| <input type="checkbox"/> Other: _____  |                                                          |                                                    |

### COMMENTS

*Work Hardening*

*I requested July 1st for extended D.T. but not authorized for awhile - 30 day limit requires new prescription - This is it. Thanks*

Frequency: \_\_\_\_\_ Duration: *black* Physician Signature: *[Signature]*

### SCHEDULING

(TO BE COMPLETED BY PHYSICAL THERAPY DEPARTMENT)

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Signature (acknowledging appointment): \_\_\_\_\_

Once appointment scheduled and acknowledged, fax to Tuomey Industrial Medicine 803.774.5283

WHITE COPY - PHYSICAL THERAPY

YELLOW COPY - PATIENT

PINK COPY - PHYSICIAN

## REHABILITATION PRESCRIPTION

NAME: E. Hamilton

DATE: 9-17-09

DIAGNOSIS: \_\_\_\_\_

### PROCEDURES

|                                             |                                             |                                             |                                           |
|---------------------------------------------|---------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Pre-Placement Eval | <input type="checkbox"/> Complete FCE       | <input type="checkbox"/> Limited FCE      |
| <input type="checkbox"/> Wound Care         | <input type="checkbox"/> Whirlpool          | <input type="checkbox"/> Debridement        | <input type="checkbox"/> Dressing Changes |
| <input type="checkbox"/> Home Program       | <input type="checkbox"/> Patient Education  | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Gait Training    |
| <input type="checkbox"/> Splint Fabrication | <input type="checkbox"/> Strengthening      | <input type="checkbox"/> CV-Conditioning    | <input type="checkbox"/> Work Hardening   |
| Other: _____                                |                                             |                                             |                                           |

### MODALITIES

☐ May substitute other appropriate modalities

|                                          |                                    |                                                    |                                              |
|------------------------------------------|------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Moist Heat      | <input type="checkbox"/> Traction  | <input type="checkbox"/> Ultrasound                | <input type="checkbox"/> Fluidotherapy       |
| <input type="checkbox"/> Cryotherapy     | <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Phonophoresis             | <input type="checkbox"/> Cerv. Traction Unit |
| <input type="checkbox"/> Electric Stim   | <input type="checkbox"/> Whirlpool | <input type="checkbox"/> Iontophoresis with: _____ |                                              |
| <input type="checkbox"/> Aquatic Therapy | Other: _____                       |                                                    |                                              |

### GOALS

|                                        |                                                          |                                                    |
|----------------------------------------|----------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Decrease Pain | <input type="checkbox"/> Independent Exercise Program    | <input type="checkbox"/> Return to Normal Function |
| <input type="checkbox"/> Increase ROM  | <input type="checkbox"/> Increase Strength and Endurance |                                                    |
| Other: _____                           |                                                          |                                                    |

### COMMENTS

Work hardening program as requested

Thanks

Frequency: \_\_\_\_\_

Duration: up to 6 weeks

Physician Signature: Dr. J. J. [Signature]

### SCHEDULING

(TO BE COMPLETED BY PHYSICAL THERAPY DEPARTMENT)

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Signature (acknowledging appointment): \_\_\_\_\_

Once appointment scheduled and acknowledged, fax to Tuomey Industrial Medicine 803.774.5283

Dear Dr. Gee,

We are unable to find a facility that can set up work hardening Ms. Hamilton. Can you make any suggestions? We also need an updated script if you still continue to recommend work hardening.

We appreciate if you would complete the attached form 14b and return it to me.

Thank you for your assistance,

**Rasha Youssef | Liberty Mutual Middle Market WC Claims | Technical Claims Specialist**

Box 49000 Charlotte, NC 28277

800.532.7706 x 24398 | 603-422-6896

817324398

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

#### PROGRESS NOTE

Emma Hamilton

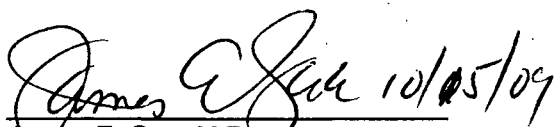
Date: October 14, 2009

She is continuing with therapy but there continues to be some confusion on the direction. She apparently has not progressed or been sent to work hardening yet. It may have to do with the number of visits that she has completed.

I advised her that I think she should try to return to some type of work at this point.

She has seen Dr. Green and he didn't offer any other treatment and I don't have any other treatment other than physical therapy and just trying to "work through" this problem as best she can. At the same time, I realize she has not worked in about 15 months and certainly she can't be as productive as she was immediately. Therefore, I have some restrictions on her work and I hope that the workplace will work with her as she tries to get back into her routine.

In summary, we will continue therapy and try to get her through the work hardening program. We will try to return to work and progress at the workplace and I will see her again in about six weeks or she will call if she has problems.

  
James E. Gee, M.D.

JEG/mlm





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INDUSTRIAL MEDICINE AND WELLNESS

250 W. Wesmark Blvd., Sumter, SC 29150  
Phone: (803) 774 - 8842 FAX: (803) 774 - 5283

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA  
249-17-0683  
803-481-9425  
10/14/09

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 0953 Time out: 10:45 Date of Injury: 7-22-08 Today's Date: 10-14-09  
Employer: Color J. Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Same cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☒ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                               | Regularly                           |
|------------------------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |

#### Work level: Lifting/Pushing/Pulling

|            |                                                  |                |
|------------|--------------------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible              | - 10 lbs. max  |
| Light      | <input checked="" type="checkbox"/> 10 lbs. freq | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq            | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq            | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs.           |                |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                               | Regularly                |
|-----------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Restrictions apply to \_\_\_\_\_ L Arm ☒ R Arm \_\_\_\_\_ Both \_\_\_\_\_

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

Continue P.T. & work  
hardening program while she tries  
to work

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 6 week Date 11-25 Time 9:30

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Erie Byrd, MD

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### INFORMATION RELEASE & ACKNOWLEDGEMENT

- By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

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PATIENT SIGNATURE

Emma R. Hamilton

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



# Physician's Statement

Claimant's Name: Emma Hamilton  
Physician's Name: Dr. James Gree  
Practice/Clinic: Imw  
Preparer's Name: \_\_\_\_\_  
Phone: (803) 773 - 8842

Employer's Name: Color Fi  
Insurance Carrier: Liberty Mutual  
SCWCC File No: WC550-614499

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 7/22/08

Date of first office visit: 7/23/09 Date of last visit: 10/14/09

Diagnosis or nature of injury or illness: Compression injury @ hand/wrist

Body part(s) injured: \_\_\_\_\_ Body part(s) affected: \_\_\_\_\_

Date of Maximum Medical Improvement: No

Based on the **AMA Guidelines**, the claimant has sustained a \_\_\_\_\_ % medical impairment to \_\_\_\_\_ injured body part(s) and a \_\_\_\_\_ % medical impairment to not one yet other affected body part(s)

\_\_\_\_ The claimant is able to return to work without restriction.

\_\_\_\_ The claimant is able to return to work with the following restrictions:

terminated  
\_\_\_\_ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

\_\_\_\_ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

\_\_\_\_ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Is going to work Handing Program

[Signature]  
Treating Physician

Nov 11, 2009  
Date

98

*Rescheduled*  
*Rescheduled*  
*h*

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: \_\_\_\_\_ Time out: \_\_\_\_\_ Date of Injury: 7-22-08 Today's Date: 11-25-09  
Employer: Coler Ji Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5054

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. \_\_\_\_\_ cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: NO SHOW

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | _____ L Arm              | _____ R Arm              | _____ Both               |                          |

#### Work level: Lifting/Pushing/Pulling

|            |                                        |                |
|------------|----------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs. |                |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

### FOLLOW UP

Return Appointment: ☐ No ☐ Yes \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ James Gee, MD \_\_\_\_\_ Eric Byrd, MD

### INFORMATION RELEASE & ACKNOWLEDGEMENT

- 1.) By signing, I authorize attending physician and/or the Industrial Medicine and Wellness program to release above information and other information acquired in the course of examination or treatment to my employer or its representative, or to a consulting physician or health care provider.
- 2.) I acknowledge the above information and instructions, and acknowledge that any restrictions are effective at the date or time shown above and apply to both work and off work activities.

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

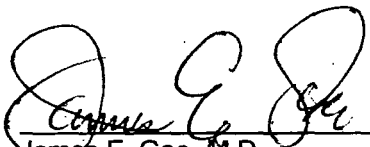
PROGRESS NOTE

Emma Hamilton

Date: December 2, 2009

She is being followed for a compression type injury to the right hand, forearm and wrist.

She seems to have the best attitude that I have seen in quite some time. She seems to be pleased that she has now begun the work hardening program. I asked her about the course and the outline. As is usually the case, they will increase her activities and probably have her up to 4 hours fairly soon. The target date for her return to work is January 14<sup>th</sup>. She advises me that the workplace has told her that she needs to be "100%" to return. I will see her in five weeks.

  
James E. Gee, M.D. 12/3/09

JEG/mlm

PATIENT LABEL

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-  
249-17-0683 12/02/1

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 0950 Time out: 1030 Date of Injury: 7-22-08 Today's Date: 12-2-09  
Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Sam cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                                | Often                    | Regularly                |
|------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | ___ L Arm                | ___ R Arm                | ___ Both                 |                          |

#### Work level: Lifting/Pushing/Pulling

|            |                                                      |
|------------|------------------------------------------------------|
| Sedentary  | <input type="checkbox"/> Negligible - 10 lbs. max    |
| Light      | <input type="checkbox"/> 10 lbs. freq - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs.               |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift

To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

Plan: return to Regular work  
Jan 14.

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes 5 weeks Date: Jan. 6, 2010 Time: 10:00 AM

Patient Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

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PATIENT SIGNATURE: \_\_\_\_\_

Emma R. Hamilton

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

#### PROGRESS NOTE

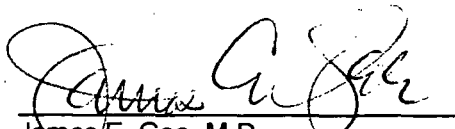
Emma Hamilton

Date: December 23, 2009

The patient is seen today because she is having some difficulty with the work hardening program. I have talked with John Zelinka. Our conversation prompted me to review the MRI and some of the past records.

I think the main point at this time is the patient is 18 months post-injury. She is really interested in continuing the work hardening program and she needs to work through the fatigue and some discomfort that she has to see if she can complete the program. I don't believe January 14<sup>th</sup> is going to be a realistic time for her to return to work but we will continue to work with her in every way that we can. There is some indication that the job may not be available anyway.

The plan as follows would be continue the work hardening program, and if she cannot complete the program or if she becomes too painful, she will have to return to see Dr. Moore to see if he wants to be more aggressive. I absolutely recommend a continued nonsurgical approach at this time. I think that's her best choice to improve. I will see her as we discussed prior to her tentative return to work date.

  
James E. Gee, M.D.  
JEG/mlm  
DNR

12/30/09

PATIENT LABEL

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-942  
249-17-0683 12/23/09

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 1455 Time out: 3124 Date of Injury: 7-22-08 Today's Date: 12-23-09  
Employer: Color-Fi Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5454

### DIAGNOSIS

Diagnoses: 1. same cpt \_\_\_\_\_  
2. \_\_\_\_\_ cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

None Occ. Often Regularly

Sitting ☐ ☐ ☐ ☐  
Walking or standing ☐ ☐ ☐ ☐  
Bend/squat/twist/crawl ☐ ☐ ☐ ☐  
Climb/work on heights ☐ ☐ ☐ ☐

#### Upper Extremity

Grasp/pinch ☐ ☐ ☐ ☐  
Reach above shoulder ☐ ☐ ☐ ☐  
Reach beyond forearm limits ☐ ☐ ☐ ☐  
Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

#### Work level: Lifting/Pushing/Pulling

Sedentary ☐ Negligible - 10 lbs. max  
Light ☐ 10 lbs. freq - 20 lbs. max  
Medium ☐ 25 lbs. freq - 50 lbs. max  
Heavy ☐ 50 lbs. freq - 100 lbs. max  
Very Heavy ☐ over 100 lbs.

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

### FOLLOW UP

Return Appointment: ☐ No ☒ Yes Keep same Date \_\_\_\_\_ Time \_\_\_\_\_

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ James Goss, MD \_\_\_\_\_ Eric Byrd, MD

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PATIENT SIGNATURE: Emma R. Hamilton

PATIENT LABEL

IM0175676 F 12/04/64 43281  
HAMILTON, EMMA 803-481-94  
249-17-0683 01/06/10

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: \_\_\_\_\_ Time out: \_\_\_\_\_ Date of Injury: 7-22-08 Today's Date: 1-6-10  
Employer: Color-J Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. \_\_\_\_\_ cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

*No Show*

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restrictions apply to       | _____ L Arm              | _____ R Arm              | _____ Both               |                          |

#### Work level: Lifting/Pushing/Pulling

|            |                                        |                |
|------------|----------------------------------------|----------------|
| Sedentary  | <input type="checkbox"/> Negligible    | - 10 lbs. max  |
| Light      | <input type="checkbox"/> 10 lbs. freq  | - 20 lbs. max  |
| Medium     | <input type="checkbox"/> 25 lbs. freq  | - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> 50 lbs. freq  | - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> over 100 lbs. |                |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

#### Other Restrictions or Clarifications:

*1, no - 10*  
*Apparently missed this app.*  
*work had day stopped*

### FOLLOW UP

Return Appointment: ☐ No ☐ Yes \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ James Gee, MD \_\_\_\_\_ Eric Byrd, MD

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Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

#### PROGRESS NOTE

Emma Hamilton / 8

Date: February 18, 2010

I am not exactly sure what has really transpired with this patient. I have been in a secondary role recently.

In quick summary, this patient was referred to Dr. Green, a hand specialist, who indicated that she had reached maximum medical benefits and eventually Dr. Green gave her an impairment rating. I believe, but I am not sure, that the patient was then referred to another physician (Dr. Moore) by her attorney.

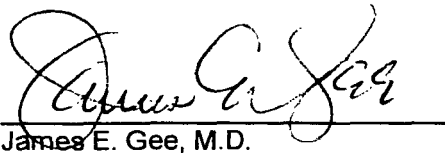
Subsequently, I have referred the patient to the work hardening program which I believe was initially suggested by Dr. Green, the specialist. The patient has been discharged from the work hardening program for apparent fear on the therapist's part that the program was not in her best interest. I have read the records and this is my interpretation of the notes.

I know nothing to do at this time but to refer the patient back to the specialist. I spoke with her and suggested that she be returned to see Dr. Green. Later in the conversation, I think it became clear that she would prefer to be seen by Dr. Moore.

I have asked the patient to bring the copy of Dr. Moore's note and records for my review so I can include those in the information that I have prior to this referral.

I have stated on many occasions that there is nothing that we can offer at this point in time and it has to be in the hands of a specialist. She, of course, can come to this clinic on a p.r.n. basis but I am not establishing a follow-up appointment.

This patient is very aggravated today and her attitude is not nice or pleasant. I have not seen this attitude in this patient in quite some time. I realize her frustration but we are just going to have to do the best we can with getting her motivated and in the right direction. I have advised her to be very, very cautious in making future decisions about aggressive treatment for her wrist. It is my opinion that she needs to be very thoroughly reevaluated before further aggressive treatment is initiated. I think the first thing that needs to be done is get another MRI of her wrist and maybe get more than one opinion as well as seeing if anything has changed since the previous MRI.

 2/24/10  
James E. Gee, M.D.

JEG/mlm

PATIENT LABEL

## MEDICAL ASSESSMENT

### ASSESSMENT

Date of Injury: 7/22/09

BP 124/88 / T P RR

Vision R 20/ L 20/ Corr. UnCorr.

Improvement: Same Worse Better

MEDICATIONS: Teniposide 800mg

ALLERGIES: Wife, Steroids

**NURSING ASSESSMENT:** 3p Follow-up (R) hand/arm. Pt. states she was told in work hardening, that she was doing more damage than good. Pt. states she feels that her (R) hand/arm is stronger. Still does have occasional discomfort. Pt. rates current discomfort level a 1/5.

**MEDICAL EVALUATION:** Above Noted History reviewed and noted

INITIAL: PJ

2/8/12

~~Dr. Moore~~  
Dr. Moore

I did not examine

Patient today just  
tried to make decision

Patient's attitude  
is bad today -

I think lawyer referral

has caused some confusion for  
everyone - if indeed that is the  
case -

Michael W. Liba

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

PATIENT LABEL

## WORK STATUS REPORT

INITIAL VISIT \_\_\_\_\_

FOLLOW UP \_\_\_\_\_

### PATIENT INFORMATION

Time in: 1452 Time out: 1540 Date of Injury: 7-22-08 Today's Date: 2-18-10  
Employer: Color-It Employer's Phone: \_\_\_\_\_ Employer's Fax: 775-5654

### DIAGNOSIS

Diagnoses: 1. \_\_\_\_\_ cpt \_\_\_\_\_  
2. Spine cpt \_\_\_\_\_  
3. \_\_\_\_\_ cpt \_\_\_\_\_

### TREATMENT

☐ Minor first aid ☐ Anti-inflammatory meds ☐ Physical Therapy ☐ Antibiotics  
☐ Over the counter meds ☐ Muscle relaxants ☐ Sutures/Wound care ☐ Bloodborne pathogen protocol  
☐ Tetanus ☐ Scheduled pain meds ☐ Splint/Cast/Boot/Sling/Crutches ☐ Other: \_\_\_\_\_

### WORK STATUS

☐ No restrictions ☐ Restriction ☐ No work Restrictions Effective: ☐ Today ☐ Next Shift: \_\_\_\_\_

#### Back and Lower Extremity

|                        | None                     | Occ.                     | Often                    | Regularly                |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sitting                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking or standing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend/squat/twist/crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb/work on heights  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Upper Extremity

|                             | None                     | Occ.                     | Often                    | Regularly                |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Grasp/pinch                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach beyond forearm limits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Restrictions apply to \_\_\_\_\_ L Arm \_\_\_\_\_ R Arm \_\_\_\_\_ Both

#### Work level: Lifting/Pushing/Pulling

| Sedentary  | <input type="checkbox"/> | Negligible - 10 lbs. max    |
|------------|--------------------------|-----------------------------|
| Light      | <input type="checkbox"/> | 10 lbs. freq - 20 lbs. max  |
| Medium     | <input type="checkbox"/> | 25 lbs. freq - 50 lbs. max  |
| Heavy      | <input type="checkbox"/> | 50 lbs. freq - 100 lbs. max |
| Very Heavy | <input type="checkbox"/> | over 100 lbs.               |

#### Activity and hour restrictions (if applicable)

☐ Not to operate hazardous machinery  
☐ Not to drive car/truck/forklift  
To work no more than \_\_\_\_\_ hrs. per day

Other Restrictions or Clarifications: \_\_\_\_\_

Referral

### FOLLOW UP

Return Appointment: ☒ No ☐ Yes \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient Referred to: \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

James Gee, MD

Eric Byrd, MD

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PATIENT SIGNATURE: \_\_\_\_\_

Emma R. Hamilton

Tuomey Industrial Medicine and Wellness

See Assessment and Medical Evaluation for this date for additional information

CHART NOTE

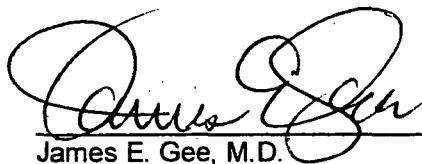
Emma R. Hamilton

Date: February 25, 2010

I have reviewed the record from Blake H. Moore of the Kingstree Surgical Associates. Ms. Hamilton had mentioned to me that she saw him in consultation. I did not have records. My assumption that this referral was by the attorney seems to be correct. It also seems to be that the patient was seen by Dr. Moore for an "independent medical review" and I don't really believe that Dr. Moore is a hand specialist and I do not see that he made definite recommendations as to how this patient should be further treated. It seems that his primary emphasis was offering a second opinion (Dr. Michael Green offered the first) concerning this patient's impairment.

If I have completely understood the nature, purpose, and conclusions of the patient's one time visit to Dr. Moore, it would appear to me that this patient needs to see a hand specialist rather than Dr. Moore for further treatment. EVALUATION  
If, however, Dr. Moore does special work with wrist type injuries or if he agrees to further treat this patient, then referral back to Dr. Moore is certainly an option. 8

If, however, Dr. Moore does not further treat the patient, I would again recommend that the patient be seen by a hand specialist. If she chooses not to return to Dr. Green, then another hand specialist certainly could be chosen. I believe that the insurance carrier will make that referral and so I have tried to make this point clear on my referral note.

 3/3/10  
James E. Gee, M.D.

JEG/mlm

H3281

**REFERRAL NOTE**

DATE: Feb. 25, 2010

PATIENT NAME: Curtis Hamilton SSN \_\_\_\_\_ DOB \_\_\_\_\_

REFERRAL TO: Hank Specialist - Patient has seen  
Dr. Green but wants to see Dr. Blake Moore -  
I don't believe he is a ~~hand~~ specialist

DATE/TIME: \_\_\_\_\_

**REFERRAL TYPE**

☒ CONSULT \_\_\_\_\_ PROCEDURE \_\_\_\_\_  
☐ EVALUATION \_\_\_\_\_ OTHER \_\_\_\_\_

DIAGNOSIS Compression injury wrist

**REASON FOR REFERRAL**

☐ FAILURE TO RESPOND TO CONSERVATIVE TREATMENT  
☐ • REQUIRES ONGOING CARE AND MANAGEMENT  
☐ REQUIRES SPECIALIZED SERVICES OR PROCEDURES

NOTES Patient continues to have sx which  
seem to be unusual and not totally  
explained by stroke, course, etc. May  
need another MRI, etc

Eric Byrd, MD

James Gee  
James Gee, MD

Clinical NotesPatient Name Summa Hamilton

Pain 0 1 2 3 4 5 6 7 8 9 10

Description map @ hand

|                                       |                                  |                                  |
|---------------------------------------|----------------------------------|----------------------------------|
| Evaluation <u>1</u>                   | Ultrasound <u>    </u>           | Self-care/ADL Tng <u>    </u>    |
| Re-evaluation <u>    </u>             | E-stim <u>    </u>               | Physical test/report <u>    </u> |
| Therapeutic Exercise <u>1</u>         | Phonophoresis <u>    </u>        | Strapping: shld <u>    </u>      |
| Manual/Myofascial Therapy <u>1</u>    | Paraffin bath <u>1</u>           | elbow/wrist <u>    </u>          |
| Moist Heat/Ice <u>    </u>            | Contrast bath <u>    </u>        | hand/finger <u>    </u>          |
| Massage Therapy <u>    </u>           | Neuromuscular re-ed <u>    </u>  | Other: <u>    </u>               |
| Orthotic fit and training <u>    </u> | Iontophoresis <u>    </u>        |                                  |
| Orthotic adjustment <u>    </u>       | Therapeutic activity <u>    </u> |                                  |

Therapeutic Exercise:Passive:     Active assisted:     Active: See belowResistive:     Stretching:     Patient Education: Barriers to education: NoneHome exercises: Type: Tendon gliding exercisesChanges/updates: (none)Patient response: Pt demo @Comments: OT assessed pt for OT tx.See eval for details and goals fortx. OT provided paraffin bath to @ hand/forearm.OT instructed pt on AEP tendon glidingexercises and pt demo @. OT provided manualstretching @ hand. Pt will benefit from OT to learn andrestore @ hand functionTherapist Signature: Edward C. [Signature] Date: 9-18-08

**CORNELL THERAPY ASSOCIATE (Independent Contractor)**

Initial Evaluation ☒ (2 IDs ☐ ) Re-Evaluation ☐

Patient's Name: Emma Hamilton

Referring Physician: Dr Gee

Date of Birth/Age: 12/4/64

Today's Date: 8-18-08

Diagnosis: (R) hand crush injury,  
pain

Date of Injury: 7-22-08

**PAST MEDICAL HISTORY:**

Nothing remarkable

ALLERGY: YES NO

LATEX ALLERGY: YES NO

sulfate

**LIVING SITUATION/OCCUPATION:**

Lives w/ family / color specialist

**CHIEF COMPLAINT:**

Pain, loss of function (R) hand

**COGNITIVE SKILLS**

Alert / Oriented  
Attention Span  
Memory  
Problem Solving  
Safety Awareness  
Follow Directions

Intact

**VISUAL/PERCEPTUAL SKILLS**

Depth Perception  
Visual Tracking  
Unilateral Neglect  
Visual Field Cut  
Dysmetria

Intact

**SENSORY AWARENESS**

Light/ Deep Pressure  
Sharp/Dull  
Hot/Cold  
Stereognosis

generally intact however extreme sensitivity is apparent over dorsolateral (R) thumb

**EDEMA**

None Moderate  
Minimal Severe

(R) CMC1  
dorsal hand

Pt reports edema was much worse until last week.

**PAIN**

Pt reports various types (0-10 scale) and levels of pain: shooting, aching, sharp, dull, sensitivity,

Name: Emma Hamilton / From 3-9 of 10

Emma Hamilton  
9-18-08

|                  | RIGHT |       |         | LEFT |      |         |
|------------------|-------|-------|---------|------|------|---------|
|                  | PROM  | AROM  | STRNGTH | PROM | AROM | STRNGTH |
| <b>SHOULDERS</b> |       |       |         |      |      |         |
| Flex (0-180)     | WNL   | WNL   | WNL     |      |      |         |
| Ext (0-60)       |       |       |         |      |      |         |
| Abd (0-180)      |       |       |         |      |      |         |
| Int. Rot (0-70)  |       |       |         |      |      |         |
| Ext. Rot (0-90)  |       |       |         |      |      |         |
| <b>ELBOWS</b>    |       |       |         |      |      |         |
| Flex (0-150)     |       |       |         |      |      |         |
| Ext (0-0)        |       |       |         |      |      |         |
| Supin (0-80)     |       |       |         |      |      |         |
| Pron (0-80)      |       |       |         |      |      |         |
| <b>WRISTS</b>    |       |       |         |      |      |         |
| Flex (0-80)      | WNL   | WNL   |         |      |      |         |
| Ext (0-70)       | 0-53° | 0-43° |         |      |      |         |
| RadDev (0-25)    | 0-18° | 0-18° |         |      |      |         |
| Uln Dev (0-35)   | 0-10° | 0-10° |         |      |      |         |
| <b>HANDS</b>     |       |       |         |      |      |         |
|                  | MP    | PIP   | DIP     | MP   | PIP  | DIP     |
| Index            | 0-77° | WNL   | WNL     |      |      |         |
| Middle           | 0-75  |       |         |      |      |         |
| Ring             | 0-77  |       |         |      |      |         |
| Small            | 0-83  |       |         |      |      |         |
|                  | MP    | IP    |         | MP   | IP   |         |
| Thumb            | WNL   | WNL   |         |      |      |         |

Emma Hamilton  
9-18-08

### GRIP STRENGTH

|              | R. Hand | L. Hand |
|--------------|---------|---------|
| First Trial  | 45#     | 75#     |
| Second Trial |         |         |
| Third Trial  |         |         |
| Average      |         |         |

### PINCH STRENGTH

|             | R. Hand | L. Hand |
|-------------|---------|---------|
| Tip-to tip  | 4#      | 12#     |
| Lateral     | 10#     | 15#     |
| 3 jaw chuck | 13#     | 15#     |

HAND DOMINANCE: R or L

### COORDINATION

Gross Motor Intact

Fine Motor Degraded (R) Intact (L)

### FUNCTIONAL TRANSFERS

Supine to sit  
Sit to stand  
In/out of tub  
In/out of shower  
On/off toilet

(I)

### ADL'S

UE Dressing  
LE Dressing  
Grooming  
Home Mgmt

(A) as needed 2<sup>nd</sup> to (R) hand injury.

### COMMENT SECTION:

Pt stated her injury to (R) hand occurred at work when her hand was caught in machinery and "folded" longitudinally severely compromising carpal/radial wrist

### TREATMENT PLAN

1. Ther ex
2. Paraffin bath
3. RICE
4. Phonophoresis/US
5. Therapeutic taping

6. Manual tx
7. ~~tx~~
8. E-stim
9. Splinting as needed
- 10.

function, and IF/thumb joints.

9-18-08

Name: Summa Han / Tan

**LONG TERM GOAL(S)** weeks

- ① AROM @ wrist extension will ↑ to 60°
- ② Pain @ hand will ↓ to 3/10 or less @ exercise
- ③ R hand grip strength will ↑ to 60#
- ④ R hand tip-to-tip pinch strength will ↑ to 10#

**SHORT TERM GOALS:** 3 weeks

- ① AROM @ wrist extension will ↑ to 50°
- ② Pain @ hand will ↓ to 5/10 or less @ exercise
- ③ R hand grip strength will ↑ to 50#
- ④ R hand tip-to-tip pinch strength will ↑ to 6#

**Frequency/ Duration**

3 weeks 6 weeks per MD

Occupational Therapist's Signature: Echamuel Anell MTR

I certify that I have examined the above named patient. Occupational Therapy is necessary and service will be furnished while under my care. The treatment plan has been established and will be reviewed every 30 days, or more often, if the patient's condition warrants it.

ATTENDING PHYSICIAN: \_\_\_\_\_

DATE:

Dr. Gee

Clinical NotesPatient Name Emma Hamilton

Pain 0 1 2 3 4 5 6 7 8 9 10

Description pt reports chronic hurt in tx.

|                                    |                        |                      |
|------------------------------------|------------------------|----------------------|
| Evaluation                         | Ultrasound             | Self-care/ADL Tng    |
| Re-evaluation                      | E-stim                 | Physical test/report |
| Therapeutic Exercise <u>2</u>      | Phonophoresis <u>1</u> | Strapping: shld      |
| Manual/Myofascial Therapy <u>1</u> | Paraffin bath <u>1</u> | elbow/wrist          |
| Moist Heat/Ice <u>1</u>            | Contrast bath          | hand/finger          |
| Massage Therapy                    | Neuromuscular re-ed    | Other:               |
| Orthotic fit and training          | Iontophoresis          |                      |
| Orthotic adjustment                | Therapeutic activity   |                      |

Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Exer = AROM flexion/extension; ulnar/radial deviation  
Full ROM exer = power web (R) hand flexion/extension  
exer = yellow therapy = small hand gripping

Resistive: and reverse

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: Add AROM exer, power web, exerChanges/updates: AddPatient response: PT deny

Comments: OT provided paraffin to R hand x 10 min.  
Phonophoresis to dorsal/lateral wrist joint 10.  
Ther ex as listed above. Tnc to (R) wrist/hand  
x 8 min. PT tolerated tx better today = ↓  
anxiety

Therapist Signature: Sharon Grier CST Date: 9-19-08

Clinical NotesPatient Name Emma Hamilton

Pain 0 1 2 3 4 5 6 7 8 9 10

Description pt reported pain exacerbated, "claylike" lower limb.Evaluation Ultrasound Self-care/ADL TngRe-evaluation E-stim Physical test/reportTherapeutic Exercise 1 Phonophoresis Strapping: shldManual/Myofascial Therapy 1 Paraffin bath elbow/wrist 1Moist Heat/Ice 1 Contrast bath hand/fingerMassage Therapy Neuromuscular re-ed Other:Orthotic fit and training IontophoresisOrthotic adjustment Therapeutic activityTherapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Chnd digits / wrist extension exer, FMS exer& playing cards x 8 min

Resistive: \_\_\_\_\_

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: Continue 2-3 timesChanges/updates: nonePatient response: pt compliant

Comments: OT provided phonophoresis to R. hand wrist  
at 1.0 dorsal wrist, summit 1.0 volar wrist. Manual finger  
and soft tissue mobilization R hand  
& wrist. Ther exer as listed above. Ice to R hand/wrist  
x 10 min. Therapeutic taping R wrist to & provide use.

Therapist Signature: Edw Giveth Date: 9-23-08

Clinical NotesPatient Name Emma Hamilton

Pain 0-1-2-3-4-5-6-7-8-9-10

Description Pain

|                                    |                        |                      |
|------------------------------------|------------------------|----------------------|
| Evaluation                         | Ultrasound             | Self-care/ADL Tng    |
| Re-evaluation                      | E-stim                 | Physical test/report |
| Therapeutic Exercise <u>2</u>      | Phonophoresis <u>1</u> | Strapping: shld      |
| Manual/Myofascial Therapy <u>1</u> | Paraffin bath <u>1</u> | elbow/wrist          |
| Moist Heat/Ice                     | Contrast bath          | hand/finger          |
| Massage Therapy                    | Neuromuscular re-ed    | Other:               |
| Orthotic fit and training          | Iontophoresis          |                      |
| Orthotic adjustment                | Therapeutic activity   |                      |
| <u>Therapeutic Exercise:</u>       |                        |                      |

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: flex/extend wrist, ulnar/radial deviation;  
gripping, exerted webbed tool, digit extension  
 Resistive: rubber band resistance, exercise yellow therapy  
 Stretching: exert hammer @ wrist extension

Patient Education: Barriers to education: NoneHome exercises: Type: ContinueChanges/updates: NonePatient response: Compliant

Comments: OT provided phonophoresis to (R) lateral wrist/  
lateral wrist pain at 1-2. Manual stretching/soft tissue  
mobilization @ wrist/hand region. Ther ex as listed  
above. Pt progressing slowly w/ strength/endurance  
using @ hand. @ wrist paraffin bath x 10 min

Therapist Signature: Emma Hamilton Date: 9-25-08

Clinical NotesPatient Name Sanna HamiltonDescription Pain 0 1 2 3 4 5 6 7 8 9 10

|                               |                        |                      |
|-------------------------------|------------------------|----------------------|
| Evaluation                    | Ultrasound             | Self-care/ADL Tng    |
| Re-evaluation                 | E-stim                 | Physical test/report |
| Therapeutic Exercise <u>1</u> | Phonophoresis <u>1</u> | Strapping: shld      |
| Manual/Myofascial Therapy     | Paraffin bath          | elbow/wrist          |
| Moist Heat/Ice <u>1</u>       | Contrast bath          | hand/finger          |
| Massage Therapy               | Neuromuscular re-ed    | Other:               |
| Orthotic fit and training     | Iontophoresis          |                      |
| Orthotic adjustment           | Therapeutic activity   |                      |

Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Wrist extension c 3 lbs x 25; flexion c 3 lbsResistive: x 25; Ext x 10 min c therapy.

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: EnduraChanges/updates: NonePatient response: Compliant

Comments: 2 grip measured at 55#, 2 tip to tip pinch  
measured at 10#. Treated pt and provided  
a written report for MD. Phonophoresis to volar  
Wrist/hand 10 min at 1.0. Ther ex as listed above.  
Pt is seeing volantes modest but clear  
progress c to. Tcc to Wrist/hand x 10 min

Therapist Signature: Sharon Keworth Date: 10-1-08

## PROGRESS NOTE

|                     |           |
|---------------------|-----------|
| Name: Emma Hamilton | Client #: |
|---------------------|-----------|

| Date    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10-1-08 | <p>OT has seen pt 6x including eval on 9-18-08. Pt's pain remains an issue localized over first dorsal compartment, volar wrist, and IF MP mainly. Pain remains variable w/ pt stating it is @ 2 of 10 w/ use, but is higher at times, and aches.</p> <p>Strength has increased w/ R grip increasing from 45# to 55#, and R tip-to-tip pinch increasing from 4# to 10#.</p> <p>Endurance has improved from poor to fair w/ extended uses, though pt displays discomfort as activity proceeds.</p> <p>AROM R wrist extension has ↑ from 43° to 51°; Flexion AROM has been wNL. Radial deviation AROM has improved from 18° to wNL.</p> <p>Recommend continue OT to ↓ pain, restore strength and endurance w/ R hand use.</p> <p>Edward Camello, OT</p> |
| 10-1-08 | <p>Continue please</p> <p>Dr Gee</p> <p>Thank you for this referral</p> <p>10-1-08</p> <p>Nice job</p> <p>Thanks</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

Clinical NotesPatient Name Emma HamiltonPain 0 1 2 3 4 5 6 7 8 9 10

Description R hand  
 Evaluation \_\_\_\_\_ Ultrasound \_\_\_\_\_ Self-care/ADL Tng \_\_\_\_\_  
 Re-evaluation \_\_\_\_\_ E-stim 1 \_\_\_\_\_ Physical test/report \_\_\_\_\_  
 Therapeutic Exercise 2 \_\_\_\_\_ Phonophoresis 1 \_\_\_\_\_ Strapping: shld \_\_\_\_\_  
 Manual/Myofascial Therapy \_\_\_\_\_ Paraffin bath 1 \_\_\_\_\_ elbow/wrist \_\_\_\_\_  
 Moist Heat/Ice \_\_\_\_\_ Contrast bath \_\_\_\_\_ hand/finger \_\_\_\_\_  
 Massage Therapy \_\_\_\_\_ Neuromuscular re-ed \_\_\_\_\_ Other: \_\_\_\_\_  
 Orthotic fit and training \_\_\_\_\_ Iontophoresis \_\_\_\_\_  
 Orthotic adjustment \_\_\_\_\_ Therapeutic activity \_\_\_\_\_

Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Tendons being exercised; R wrist + flexion/extension  
exer; squeezing soft + ball; pronation/supination  
 Resistive: 3 lbs/2 lbs. FMS lower = quarter; pinch  
over clothes pin.  
 Stretching: \_\_\_\_\_

Patient Education: Barriers to education: None

Home exercises: Type: Add clothes pin pinch, FMS exer  
 Changes/updates: Add  
 Patient response: Compliant

Comments: OT provided a paraffin bath to R hand/wrist  
x 10 min. E-stim x 15 min as stretching and exercises  
R wrist/hand as listed above. PT provided up  
dated HEP. Slow but steady progress.

Therapist Signature: Edmund Connel DTR Date: 10-3-08

Clinical NotesPatient Name Emma Hamilton

Pain 0 1 2 3 4 5 6 7 8 9 10  
 Description pt stated she feels "cramping" but no pain  
 Evaluation Ultrasound Self-care/ADL Tng  
 Re-evaluation E-stim Physical test/report  
 Therapeutic Exercise 2 Phonophoresis 1 Strapping: shld  
 Manual/Myofascial Therapy 1 Paraffin bath 1 elbow/wrist  
 Moist Heat/Ice 1 Contrast bath hand/finger  
 Massage Therapy Neuromuscular re-ed Other:  
 Orthotic fit and training Iontophoresis  
 Orthotic adjustment Therapeutic activity  
Therapeutic Exercise: E-stim unattended 1

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Exer = yellow Theraputty x 10min exer = green  
 Resistive: putty, exer = gripper x 25; exer = digi-extend,  
exer = red Theraputty wrist x 10min.

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: Exer now = green TheraputtyChanges/updates: AddPatient response: up limit

Comments: OT provided paraffin bath to (R) hand/wrist  
x 8min. Manual stretching (R) wrist. Phonophoresis  
to dorsal/ulnar (R) wrist x 8min at 1.0. Ther ex  
as listed above. E-stim = 12e x 10 min.  
(R) hand/wrist.

Therapist Signature: Shun Kuro OTR Date: 10-7-08

Clinical NotesPatient Name Emma Hamilton

Pain 0 1 2 3 4 5 6 7 8 9 10

Description "just a little nerve type pain"

Evaluation Ultrasound Self-care/ADL Tng     

Re-evaluation E-stim Physical test/report     

Therapeutic Exercise 2 Phonophoresis 1 Strapping: shld     

Manual/Myofascial Therapy 1 Paraffin bath 1 elbow/wrist     

Moist Heat/Ice      Contrast bath      hand/finger     

Massage Therapy      Neuromuscular re-ed      Other:     

Orthotic fit and training      Iontophoresis     

Orthotic adjustment      Therapeutic activity     

Therapeutic Exercise: E-stim method 1

Passive:     Active assisted:     

Active: RTS exer c 10-20 lbs rowing; FR/ER of shld x several

Resistive: legs working weight bearing of wrist. Exer c 3 lbs (R)

wrist extension x 9, Flexion x 2, exer c gripper (2B, 1R) x 30;

Stretching: exer c 10-12, @ wrist ulnar/radial deviation c 2 lbs x 21

Patient Education: Barriers to education: NoneHome exercises: Type: ContinueChanges/updates: NonePatient response: Complained

Comments: OT provided paraffin bath to (R) hand/wrist

x 8 min. Manual stretching (R) hand/wrist. Phonophoresis

to dorsolateral (R) wrist/hand 5 min at 1.0. Then exer

tested above. E-stim to (R) wrist c 10 min.

pt tolerating exercise

Therapist Signature: Edwin Cornell OR Date: 10-9-08

Clinical NotesPatient Name Emma Hamilton

Pain 0 1 2 3 4 5 6 7 8 9 10

Description Quadrant/hand

|                                       |                                  |                                  |
|---------------------------------------|----------------------------------|----------------------------------|
| Evaluation <u>    </u>                | Ultrasound <u>1</u>              | Self-care/ADL Tng <u>    </u>    |
| Re-evaluation <u>    </u>             | E-stim <u>1</u>                  | Physical test/report <u>    </u> |
| Therapeutic Exercise <u>2</u>         | Phonophoresis <u>    </u>        | Strapping: shld <u>    </u>      |
| Manual/Myofascial Therapy <u>1</u>    | Paraffin bath <u>1</u>           | elbow/wrist <u>    </u>          |
| Moist Heat/Ice <u>1</u>               | Contrast bath <u>    </u>        | hand/finger <u>    </u>          |
| Massage Therapy <u>    </u>           | Neuromuscular re-ed <u>    </u>  | Other: <u>    </u>               |
| Orthotic fit and training <u>    </u> | Iontophoresis <u>    </u>        |                                  |
| Orthotic adjustment <u>    </u>       | Therapeutic activity <u>    </u> |                                  |

Therapeutic Exercise:Passive:     Active assisted: Quadrant, wristActive: Exer AROM wrist flex/ext; exer 2 flex bng  
gripper, digi extensor, weight bearing onResistive: Quadrant/handStretching:     Patient Education: Barriers to education: NoneHome exercises: Type: Add flexor exer and weight bearingChanges/updates: AddPatient response: Comp hands

Comments: OT provided paraffin bath to Quadrant/hand  
x 8 min Manual stretching Quadrant/hand. Then  
ex listed above. Phonophoresis to dorsal hand (R)  
wrist/hand x 8 min at 1.0 E-stim 2 Quadrant exer  
x 15 min Ice to Quadrant/hand x 8 min.

Therapist Signature: Splendore C. M. D. PT Date: 10-10-21

Clinical NotesPatient Name Emma Hamilton

Pain 0-1-2-3-4-5-6-7-8-9-10

Description R hand

|                               |                        |                      |
|-------------------------------|------------------------|----------------------|
| Evaluation                    | Ultrasound             | Self-care/ADL Tng    |
| Re-evaluation                 | E-stim <u>1</u>        | Physical test/report |
| Therapeutic Exercise <u>2</u> | Phonophoresis <u>1</u> | Strapping: shld      |
| Manual/Myofascial Therapy     | Paraffin bath          | elbow/wrist          |
| Moist Heat/Ice <u>1</u>       | Contrast bath          | hand/finger          |
| Massage Therapy               | Neuromuscular re-ed    | Other:               |
| Orthotic fit and training     | Iontophoresis          |                      |
| Orthotic adjustment           | Therapeutic activity   |                      |

Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Exer @ wrist - e gripper, drop - extend, etc.Resistive: wrist extension e 5 lbs x 15; wrist flexion e thru bar x 15, open e gripper then a pretty x 10 min e e-stim.

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: CatnineChanges/updates: NonePatient response: CompliantComments: OT provided phonophoresis to dorsal/helareswrist x 2 min at 1.0. Ther ex as listed above.Ice R hand x 2 min.Therapist Signature: Sharon Newton Date: 10-14-08

Clinical NotesPatient Name Emma HamiltonPain 0—1—2—3—4—5—6—7—8—9—10Description this A.M. @ hand

|                                    |                        |                      |
|------------------------------------|------------------------|----------------------|
| Evaluation                         | Ultrasound             | Self-care/ADL Tng    |
| Re-evaluation                      | E-stim                 | Physical test/report |
| Therapeutic Exercise <u>2</u>      | Phonophoresis <u>1</u> | Strapping: shld      |
| Manual/Myofascial Therapy <u>1</u> | Paraffin bath <u>1</u> | elbow/wrist          |
| Moist Heat/Ice                     | Contrast bath          | hand/finger          |
| Massage Therapy                    | Neuromuscular re-ed    | Other:               |
| Orthotic fit and training          | Iontophoresis          |                      |
| Orthotic adjustment                | Therapeutic activity   |                      |

Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: During extension x 15 reps;  
over R hand w/ gripper, above 2 dig: extended exercises,Resistive: 2nd & thumbbar

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: Continue after tomorrow's tx, rest today,Changes/updates: NonePatient response: Pt compliant

Comments: Pt over R wrist on scapula, biceps curl  
30 lbs x 7; rowing = 30 lbs x 15; hand 2 R/E R 2nd 20 lbs  
x 15. Please please to R wrist a wrist / R wrist 1 min  
at 1.0. Ther use as listed above Paraffin bath  
to R hand x 8 min. Pt frustrated because pain  
continues even though progress in strength is evident.

Therapist Signature: Steve Condit Date: 10/16/08

Clinical NotesPatient Name Emma HamiltonPain 0 1 2 3 4 5 6 7 8 9 10

Description base of R thumb  
 Evaluation \_\_\_\_\_ Ultrasound \_\_\_\_\_ Self-care/ADL Tng \_\_\_\_\_  
 Re-evaluation \_\_\_\_\_ E-stim 1 Physical test/report \_\_\_\_\_  
 Therapeutic Exercise 1 Phonophoresis 1 Strapping: shld \_\_\_\_\_  
 Manual/Myofascial Therapy 1 Paraffin bath 1 elbow/wrist \_\_\_\_\_  
 Moist Heat/Ice 1 Contrast bath \_\_\_\_\_ hand/finger \_\_\_\_\_  
 Massage Therapy \_\_\_\_\_ Neuromuscular re-ed \_\_\_\_\_ Other: \_\_\_\_\_  
 Orthotic fit and training \_\_\_\_\_ Iontophoresis \_\_\_\_\_  
 Orthotic adjustment \_\_\_\_\_ Therapeutic activity \_\_\_\_\_  
Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Rowing @ 120 lbs x 25; horse PR @ 20 lbs x 15;Resistive: horiz PR @ 10 lbs x 15; biceps curl @ 30 lbs x 20;Stretching: Exer @ green therapyPatient Education: Barriers to education: NoneHome exercises: Type: Continue w/ weight bearingChanges/updates: NonePatient response: CompliantComments: Paraffin bath to R hand/wrist x 8 min.

OT provided phono waves to dorsal/lateral R wrist/hand  
8 min at 1.2 c Manual stretching, soft tissue mobili-  
zation x 10 min. Ther ex as listed above @ 1 c-stim  
and 1 c-stim. Ice to R wrist/hand x 8 min.  
Pt still limited by weakness/pain.

Therapist Signature: Edward Cull OTR Date: 10/17/08

Clinical NotesPatient Name Simone Hamilton

Pain 0-1-2-3-4-5-6-7-8-9-10

Description Exercise (R) hand  
 Evaluation \_\_\_\_\_ Ultrasound \_\_\_\_\_ Self-care/ADL Tng \_\_\_\_\_  
 Re-evaluation 1 E-stim \_\_\_\_\_ Physical test/report \_\_\_\_\_  
 Therapeutic Exercise 1 Phonophoresis \_\_\_\_\_ Strapping: shld \_\_\_\_\_  
 Manual/Myofascial Therapy 1 Paraffin bath 1 elbow/wrist \_\_\_\_\_  
 Moist Heat/Ice \_\_\_\_\_ Contrast bath \_\_\_\_\_ hand/finger \_\_\_\_\_  
 Massage Therapy \_\_\_\_\_ Neuromuscular re-ed \_\_\_\_\_ Other: \_\_\_\_\_  
 Orthotic fit and training \_\_\_\_\_ Iontophoresis \_\_\_\_\_  
 Orthotic adjustment \_\_\_\_\_ Therapeutic activity \_\_\_\_\_

Therapeutic Exercise:

Passive: \_\_\_\_\_

Active assisted: \_\_\_\_\_

Active: Exer @ Buret flexor pollicis longus 2-3 lbs.Resistive: Exer @ Buret supinator, digital extensor

Stretching: \_\_\_\_\_

Patient Education: Barriers to education: NoneHome exercises: Type: ContinueChanges/updates: NonePatient response: Compliant

Comments: OT reevaluated pt for progress & tx.  
See reeval for details. OT provided paraffin  
bath to @ hand. OT provided manual tx to @  
hand & wrist. Ther ex @ hand as listed  
above.

Therapist Signature: Shirley Gullack Date: 10/24/08

**Sumter Neurology  
and Pain Management  
312 Broad Street  
803-774-7246**

Patient: Hamilton, Emma  
Sex: Female  
Age: 43  
Weight: lbs  
I.D.#: 5597  
Ref. M.D.: Gee, MD

Physician: Marshall A. White, MD  
Test Date: 11/03/08

**History/Comments:**

43 y.o. female patient with an injury sustained to the right hand July 22, 2008 while at work. This accident involving a roller/crush injury. The patient states that she was placed in a splint. She works for Color Fi, Inc as a color specialist. The workers compensation insurance would like to have a NCS/EMG performed on both hands to rule out other potential contributing factors to her symptoms, i.e. peripheral neuropathy, etc. Medical Hx is otherwise negative.

**Motor Nerve Study**

**Left Median Nerve**

| Rec Site: APB | Lat (ms) | Norm Lat | Amp (mV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|---------------|----------|----------|----------|----------|------------|-----------|
| Stim Site     |          |          |          |          |            |           |
| Wrist         | 3.2      | <4.5     | 7.2      | >3       | 45.1       | >48       |
| Elbow         | 6.9      |          | 7.3      |          | 45.1       | ok        |

**Right Median Nerve**

| Rec Site: APB | Lat (ms) | Norm Lat | Amp (mV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|---------------|----------|----------|----------|----------|------------|-----------|
| Stim Site     |          |          |          |          |            |           |
| Wrist         | 3.5      | <4.5     | 3.2      | >3       | 45.3       | >48       |
| Elbow         | 7.5      |          | 3.1      |          | 45.3       | ok        |

**Left Ulnar Nerve**

| Rec Site: ADM | Lat (ms) | Norm Lat | Amp (mV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|---------------|----------|----------|----------|----------|------------|-----------|
| Stim Site     |          |          |          |          |            |           |
| Wrist         | 3.2      | <3.6     | 10.5     | >5       | 72.0       | >48       |
| B.Elbow       | 5.7      |          | 9.6      |          | 72.0       |           |
| A.Elbow       | 6.8      |          | 8.8      |          | 77.1       |           |

**Right Ulnar Nerve**

| Rec Site: ADM | Lat (ms) | Norm Lat | Amp (mV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|---------------|----------|----------|----------|----------|------------|-----------|
| Stim Site     |          |          |          |          |            |           |
| Wrist         | 3.3      | <3.6     | 8.1      | >5       | 65.8       | >48       |
| B.Elbow       | 6.1      |          | 8.7      |          | 65.8       |           |
| A.Elbow       | 7.2      |          | 9.0      |          | 92.3       |           |

page 2

Patient: Hamilton, Emma  
I.D.#: 5597

Test Date: 11/03/08

Sensory Nerve Study**Left Median Nerve**

| Rec Site: Wrist | Lat (ms) | Norm Lat | Amp (uV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|-----------------|----------|----------|----------|----------|------------|-----------|
| Stim Site Wrist | 1.1      | <2.3     | 46.3     | >40      |            |           |

**Right Median Nerve**

| Rec Site: Wrist | Lat (ms) | Norm Lat | Amp (uV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|-----------------|----------|----------|----------|----------|------------|-----------|
| Stim Site Wrist | 1.5      | <2.3     | 43.7     | >40      |            |           |

**Left Ulnar Nerve**

| Rec Site: Wrist | Lat (ms) | Norm Lat | Amp (uV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|-----------------|----------|----------|----------|----------|------------|-----------|
| Stim Site Wrist | 1.2      | <2.2     | 33.3     | >11      |            |           |

**Right Ulnar Nerve**

| Rec Site: Wrist | Lat (ms) | Norm Lat | Amp (uV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|-----------------|----------|----------|----------|----------|------------|-----------|
| Stim Site Wrist | 1.4      | <2.2     | 21.7     | >11      |            |           |

**Left Radial Nerve**

| Rec Site: Wrist | Lat (ms) | Norm Lat | Amp (uV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|-----------------|----------|----------|----------|----------|------------|-----------|
| Stim Site Index | 1.6      |          | 33.3     |          |            |           |

**Right Radial Nerve**

| Rec Site: Wrist | Lat (ms) | Norm Lat | Amp (uV) | Norm Amp | C.V. (m/s) | Norm C.V. |
|-----------------|----------|----------|----------|----------|------------|-----------|
| Stim Site Index | 1.8      |          | 26.3     |          |            |           |

Imp: essentially normal b. l. hand  
upper extremity NCS.

Waukesha, WI

Time In: / Time Out:

| EXAM ROOM TIME                  |          |         | CHECKOUT TIME        | TICKET NO. |
|---------------------------------|----------|---------|----------------------|------------|
| ACCOUNT NUMBER                  | DATE     | TIME    |                      |            |
| ** NEW **<br>25245              | 06/19/09 | 11:00am | PT SUMTER, 10455322  | 45430      |
| NAME & ADDRESS<br>EMMA HAMILTON |          |         | INSURANCE BALANCE    |            |
| DOB:                            |          |         | ACCOUNT BALANCE      |            |
| GENDER:                         |          |         | CURRENT CHARGES 240- |            |
| IBG:                            |          |         | AMOUNT PAID          |            |
| FCL:                            |          |         | NEW BALANCE 240-     |            |
| CELL:                           |          |         | CASH CHECK M.O. C.C. |            |
| WRK:                            |          |         |                      |            |
| INSURED: EMMA HAMILTON          |          |         | RELATION:            |            |
| INS:                            |          |         |                      |            |
| REASON: NEW PATIENT/EVAL        |          |         |                      |            |

| PROCEDURES                                                              | CPT      | FEE |                                                                                                    |
|-------------------------------------------------------------------------|----------|-----|----------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Evaluation                          | 97001    | 91- | S = please see eval form for details.                                                              |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |     |                                                                                                    |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |     |                                                                                                    |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |     |                                                                                                    |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |     |                                                                                                    |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |     |                                                                                                    |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |     |                                                                                                    |
| <input type="checkbox"/> Strength                                       | STRENGTH |     |                                                                                                    |
| <input type="checkbox"/> SFCP                                           | SFCP     |     |                                                                                                    |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |     |                                                                                                    |
| <input type="checkbox"/> Whirlpool                                      | 97022    |     |                                                                                                    |
| <input type="checkbox"/> Ultrasound, 15 mins.                           | 97035    |     |                                                                                                    |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |     |                                                                                                    |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |     |                                                                                                    |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.      | 97110    | 76- |                                                                                                    |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |     |                                                                                                    |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24- |                                                                                                    |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |     |                                                                                                    |
| <input type="checkbox"/> Manual Therapy                                 | 97140    |     | A = HEP in full injury to shoulder 7/24 has had no Rx of therapy via 10/08 - P = possible per PDC. |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |     |                                                                                                    |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |     |                                                                                                    |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |     |                                                                                                    |
| <input checked="" type="checkbox"/> Self Care Training, 15 mins.        | 97535    | 43- |                                                                                                    |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |     |                                                                                                    |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |     |                                                                                                    |
| <input type="checkbox"/> Other / Supplies                               | 99070    |     |                                                                                                    |
|                                                                         |          |     |                                                                                                    |
|                                                                         |          |     |                                                                                                    |

Visit Number: \_\_\_\_\_ of \_\_\_\_\_

Staff: \_\_\_\_\_

Therapist's Signature: William E. G...

**RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS**

I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_  
Date

8037745283

Industrial Medicine

27:45

07-17-2009

3/4

0002/0003

Sumter  
2475 Broad Street  
Sumter, SC 29150  
803-934-8470 Phone 803-934-8457 Fax

## To M.D.:

- ☐ Faxed  
☐ Mailed  
☐ Given to Patient  
☐ Filed in DCCB chart

## PHYSICAL THERAPY ELBOW/HAND/WRIST EVALUATION

Patient: Emma Hamilton Date: 6/19/09  
DOB: 12/4/1964  
Physician: Dr. Gee Therapist: Bill Cooper  
Diagnosis: Charley's  
Mechanism of Injury: Car accident - hit car  
Date of Onset: July 2008

History: pt. hit car in 7/08 - hit car & got out but car was still moving. She was hit by the car & she was in the car for 10 minutes. She was hit by the car & she was in the car for 10 minutes. She was hit by the car & she was in the car for 10 minutes.

PMHx:

| Joint      | 0°   | 90° | 180° | 60° | 90° | 180° |
|------------|------|-----|------|-----|-----|------|
| Elbow Flex | 143° | ↓   | ↓    | ↓   | ↓   | ↓    |
| Elbow Ext  | 76°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| Wrist Flex | 82°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| Wrist Ext  | 75°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| MCP Flex   | 76°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| MCP Ext    | 22°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| PIP Flex   | 36°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| PIP Ext    | 0°   | ↓   | ↓    | ↓   | ↓   | ↓    |
| DIP Flex   | 30°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| DIP Ext    | 60°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| MP Flex    | 30°  | ↓   | ↓    | ↓   | ↓   | ↓    |
| MP Ext     | 30°  | ↓   | ↓    | ↓   | ↓   | ↓    |

## Special Tests:

Elbow: WallWrist: Wrist extension with thumb outHand: Pin

G

Pin

## Cervical Spine Provoking Moments:

Spurling's Test:

Upper Limb Tension Tests:

Palpation: Head to Neck, more swelling at right side of neckSensation: NoneSwelling: NoneAppearance: NoneOther Finding: pt. fatigued - 2-3 mg of sleep pills per day

Grip Strength: 18.35 L 26.75 R  
Pinch Strength: 18.16 L 20.87 R  
6.5 kg 11.4 kg

[PPT - F008 - (02-09)]

8037745283

Industrial Medicine

00393454

Progressive Physical

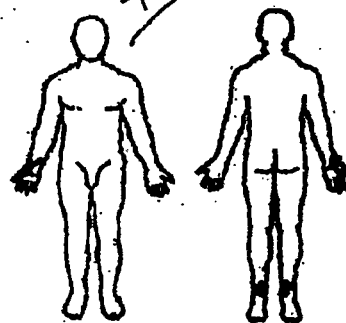
26:48

07-17-2009

2/4

0003/0003

Occupation / Work Status: not working  
 Demands of Job / Lifestyle: active life and things  
 Meds: NA  
 X-Ray / MRI: all in 11/08  
 When Worse: PP + one of @ back/neck  
 When Better: rest, manual therapy



Pain Rating: Current        Worse        Constant / Periodic        Dull / Sharp       

## Summary of Significant Findings:

1. ROM: to wrist act @
2. Strength: to back/neck
3. Posture: DM
4. Radicular Symptoms: umbilical pain @ back/neck
5. Special Tests: 0
6. Tenderness: to back/neck
7. Swelling / Appearance: none / white
8. Joint Play: to back/neck
9. Gait: DM
10. Other: 0

## Assessment:

Pt is unable to perform a single leg stand in a functional manner - he is in a lot of pain. Pt says change to knee + some of the pain is in the hip area - he is not sure if it is in the hip or the knee. Pt is not sure if it is in the hip or the knee.

## Goals:

- ☒ Decrease pain to: Current 1/10 Worse 1/10 to allow greater functional mobility
- ☒ Increase Strength of to back/neck to improve function / ADLs
- ☒ Increase ROM of to back/neck to improve function / ADLs
- ☒ Pt will be independent & compliant with HEP
- ☒ Pt will demonstrate / understand correct posture & body mechanics to promote healing & function, and prevent re-injury
- ☒ Pt will demonstrate proper technique and posture w/ the following activities: It will be able to use single leg -

## Plan of Care:

- Modalities may include: ☒ MENS / IFC / HVPC w/ moist heat/ice ☐ Iontophoresis ☒ US ☐ Phonophoresis
- ☐ Soft Tissue Massage
  - ☒ Manual Therapy hand to back
  - ☒ Therapeutic Exercise to back/neck
  - ☐ Education
  - ☐ Posture awareness / correction
  - ☒ Functional Activities activity
  - ☐ Other

Frequency & Duration 5 / week for 4 weeks

Rehab Potential: Poor Fair Good

Patient understands & agrees with the plan of care: Yes ☒ No ☐

Vocational Readjustment: social / vocational services needed? Yes ☐ No ☒ If Yes, please comment:

## Additional Comments:

Please Sign and date below

Physician/Nurse Practitioner

Date

Therapist

Date

FAXED

JUL 01 2009

JUL 17 2009  
FAXED

[PPT - F013 - (02-09)]

Time In: / Time Out:

| FROM ROOM TIME | ACCOUNT NUMBER | DATE     | TIME    | CHECKOUT TIME       | TICKET NO. |
|----------------|----------------|----------|---------|---------------------|------------|
|                | 25247          | 06/22/09 | 12:30pm | PT SUMTER, 1C455803 | 45494      |

|                         |        |                            |                          |
|-------------------------|--------|----------------------------|--------------------------|
| NAME & ADDRESS          | MONDAY | DOB: 12/04/1964 (44 years) | INSURANCE BALANCE \$0.00 |
| HAMILTON, EMMA          |        | GENDER: F                  | ACCOUNT BALANCE \$0.00   |
| 2227 BOBWHITE DR        |        | IBG:                       | CURRENT CHARGES 135-     |
| SUMTER, SC 29154        |        | FCL: 6                     | AMOUNT PAID              |
| 803-481-9425            |        | CELL:                      | NEW BALANCE 375-         |
| WRK:                    |        | RELATION: OTHER            | CASH CHECK M.O. C.C.     |
| INSURED: HAMILTON, EMMA |        | COPAY:                     |                          |
| INS: WC/MEDRISK         |        |                            |                          |
| REASON: FOLLOW UP       |        |                            |                          |
| NICKNAME:               |        |                            |                          |

| PROCEDURES                                                                  | CPT      | FEE        | Subjective:                                                                                                                                                                            |
|-----------------------------------------------------------------------------|----------|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                         | 97001    |            | Pain Level (0-10) <u>2</u>                                                                                                                                                             |
| <input type="checkbox"/> OT Evaluation                                      | 97002    |            | <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change                                                                               |
| <input type="checkbox"/> Functional Capacity Evaluation                     | 97750    |            | <i>Pt stated severe pain after Eval</i>                                                                                                                                                |
| <input type="checkbox"/> Physical Performance Test                          | 97750.1  |            | Objective:                                                                                                                                                                             |
| <input type="checkbox"/> Work Hardening, 2 hours                            | 97545    |            | <input checked="" type="checkbox"/> MFC <input type="checkbox"/> HI-Volt <input type="checkbox"/> Micro <input type="checkbox"/> NMES                                                  |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                       | 97546    |            | <input type="checkbox"/> Ultrasound 1/3 Mhz <u>      </u> W/cm <sup>2</sup> <u>      </u> min.                                                                                         |
| <input type="checkbox"/> Acc. Sports Ach. Program                           | ASAP     |            | <input checked="" type="checkbox"/> Moist Heat Pack <input type="checkbox"/> Ice Pack                                                                                                  |
| <input type="checkbox"/> Length                                             | STRENGTH |            | <input checked="" type="checkbox"/> Therapeutic Exercise per Flow Sheet                                                                                                                |
| <input type="checkbox"/> SFCP                                               | SFCP     |            | <input checked="" type="checkbox"/> Manual Therapy <u>Ther-X Demo</u>                                                                                                                  |
| <input type="checkbox"/> Paraffin Bath                                      | 97018    |            | <input type="checkbox"/> Functional Activities                                                                                                                                         |
| <input type="checkbox"/> Whirlpool                                          | 97022    |            | Assessment:                                                                                                                                                                            |
| <input type="checkbox"/> Ultrasound, 15 mins.                               | 97035    |            | Tolerance <input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor                                                                         |
| <input type="checkbox"/> Iontophoresis, 15 mins.                            | 97033    |            | Plan:                                                                                                                                                                                  |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                          | 97026    |            | <input checked="" type="checkbox"/> Continue Plan of Care                                                                                                                              |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. <u>2</u> | 97110    | <u>76-</u> | Visit Number: <u>      </u> of <u>      </u>                                                                                                                                           |
| <input type="checkbox"/> Functional Activities, 15 mins.                    | 97530    |            | Staff: <u>      </u>                                                                                                                                                                   |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins.     | 97032    | <u>24-</u> | Therapist's Signature: <u>William E. G...</u>                                                                                                                                          |
| <input type="checkbox"/> Massage, 15 mins.                                  | 97124    |            | RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS                                                                                                                              |
| <input checked="" type="checkbox"/> Manual Therapy                          | 97140    | <u>35-</u> | I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above. |
| <input type="checkbox"/> Mechanical Traction                                | 97012    |            | Patient or Authorized Person's Signature                                                                                                                                               |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.                   | 97112    |            | Date                                                                                                                                                                                   |
| <input type="checkbox"/> Gait Training, 15 mins.                            | 97116    |            | 136                                                                                                                                                                                    |
| <input type="checkbox"/> Self Care Training, 15 mins.                       | 97535    |            |                                                                                                                                                                                        |
| <input type="checkbox"/> TENS Set Up                                        | 64550    |            |                                                                                                                                                                                        |
| <input type="checkbox"/> ROM Measure & Report                               | 95851    |            |                                                                                                                                                                                        |
| <input type="checkbox"/> Other / Supplies                                   | 99070    |            |                                                                                                                                                                                        |

Time In: / Time Out:

| EXAM ROOM TIME                         |          |         | CHECKOUT TIME              | TICKET NO. |
|----------------------------------------|----------|---------|----------------------------|------------|
| COUNT NUMBER                           | DATE     | TIME    |                            |            |
| 25247                                  | 06/23/09 | 12:00pm | PT SUMTER,                 | 1C45563    |
| NAME & ADDRESS                         |          |         | TUESDAY                    |            |
| HAMILTON, EMMA                         |          |         | DOB: 12/04/1964 (44 years) |            |
| 2227 BOBWHITE DR                       |          |         | GENDER: F                  |            |
| SUMTER, SC 29154                       |          |         | IBG:                       |            |
| 803-481-9425                           |          |         | FCL: 6                     |            |
| WRK:                                   |          |         | CELL:                      |            |
| INSURED: HAMILTON, EMMA                |          |         | RELATION: OTHER            |            |
| INS: WC/MEDRISK                        |          |         |                            |            |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |          |         |                            |            |
| NICKNAME:                              |          |         | COPAY:                     |            |
|                                        |          |         | INSURANCE BALANCE \$240.00 |            |
|                                        |          |         | ACCOUNT BALANCE \$240.00   |            |
|                                        |          |         | CURRENT CHARGES 173-       |            |
|                                        |          |         | AMOUNT PAID                |            |
|                                        |          |         | NEW BALANCE 548-           |            |
|                                        |          |         | CASH                       | CHECK      |
|                                        |          |         | NO                         | C.C.       |

| PROCEDURES                                                              | CPT      | FEE  |  |
|-------------------------------------------------------------------------|----------|------|--|
| Evaluation                                                              | 97001    |      |  |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |      |  |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |      |  |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |      |  |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |      |  |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |      |  |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |      |  |
| <input type="checkbox"/> Strength                                       | STRENGTH |      |  |
| <input type="checkbox"/> SFCP                                           | SFCP     |      |  |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |      |  |
| <input type="checkbox"/> Whirlpool                                      | 97022    |      |  |
| <input type="checkbox"/> Ultrasound, 15 mins.                           | 97035    |      |  |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |      |  |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |      |  |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. 3    | 97110    | 114- |  |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |      |  |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24-  |  |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |      |  |
| <input checked="" type="checkbox"/> Manual Therapy                      | 97140    | 35-  |  |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |      |  |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |      |  |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |      |  |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |      |  |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |      |  |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |      |  |
| <input type="checkbox"/> Other / Supplies                               | 99070    |      |  |

**Subjective:**  
Pain Level (0-10) 1  
☐ Increased ☒ Decreased ☐ No Change

**Objective:**  
☒ SFC ☐ Hi-Volt ☐ Micro ☐ NMES  
☐ Ultrasound 1/3 Mhz W/cm<sup>2</sup> min.  
☐ Moist Heat Pack ☐ Ice Pack  
☒ Therapeutic Exercise per Flow Sheet  
☒ Manual Therapy ST Massage  
☐ Functional Activities

**Assessment:**  
Tolerance ☒ Good ☐ Fair ☐ Poor

**Plan:**  
☒ Continue Plan of Care

Visit Number: 0 of PTA

Staff: William E. G...

Therapist's Signature: William E. G...

**RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS**  
I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.

Patient or Authorized Person's Signature \_\_\_\_\_

Date \_\_\_\_\_

Time In: / Time Out:

| EXAM ROOM TIME                         |          |         | CHECKOUT TIME              | TICKET NO. |
|----------------------------------------|----------|---------|----------------------------|------------|
| COUNT NUMBER                           | DATE     | TIME    |                            |            |
| 25247                                  | 06/24/09 | 01:00pm | PT SUMTER,                 | 1045630    |
| NAME & ADDRESS                         |          |         | WEDNESDAY                  |            |
| HAMILTON, EMMA                         |          |         | DOB: 12/04/1964 (44 years) |            |
| 2227 BOBWHITE DR                       |          |         | GENDER: F                  |            |
| SUMTER, SC 29154                       |          |         | IBG:                       |            |
| 803-481-9425                           |          |         | FCL: 6                     |            |
| WRK:                                   |          |         | CELL:                      |            |
| INSURED: HAMILTON, EMMA                |          |         | RELATION: OTHER            |            |
| INS: WC/MEDRISK                        |          |         |                            |            |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |          |         |                            |            |
| NICKNAME:                              |          |         | COPAY:                     |            |
|                                        |          |         | INSURANCE BALANCE \$375.00 |            |
|                                        |          |         | ACCOUNT BALANCE \$375.00   |            |
|                                        |          |         | CURRENT CHARGES 154-       |            |
|                                        |          |         | AMOUNT PAID                |            |
|                                        |          |         | NEW BALANCE 702-           |            |
|                                        |          |         | CASH                       | CHECK      |
|                                        |          |         | M.O.                       | C.C.       |

| PROCEDURES                                                                  | CPT      | FEE  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------|----------|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                         | 97001    |      | Subjective:<br>Pain Level (0-10) <u>3</u><br><input checked="" type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change                                                                                                                                                                                                                                                                                                                                                                  |
| <input type="checkbox"/> OT Evaluation                                      | 97002    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Functional Capacity Evaluation                     | 97750    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Physical Performance Test                          | 97750.1  |      | Objective:<br><input checked="" type="checkbox"/> TENS <input type="checkbox"/> Hi-Volt <input type="checkbox"/> Micro <input type="checkbox"/> NMES<br><input checked="" type="checkbox"/> Ultrasound <u>1.3</u> Mhz <u>1.3</u> W/cm <sup>2</sup> <u>1</u> min.<br><input checked="" type="checkbox"/> Moist Heat Pack <input type="checkbox"/> Ice Pack<br><input checked="" type="checkbox"/> Therapeutic Exercise per Flow Sheet<br><input type="checkbox"/> Manual Therapy<br><input type="checkbox"/> Functional Activities |
| <input type="checkbox"/> Work Hardening, 2 hours                            | 97545    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                       | 97546    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Acc. Sports Ach. Program                           | ASAP     |      | Assessment:<br>Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor                                                                                                                                                                                                                                                                                                                                                                                                     |
| <input type="checkbox"/> Strength                                           | STRENGTH |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> SFCP                                               | SFCP     |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Paraffin Bath                                      | 97018    |      | Plan:<br><input checked="" type="checkbox"/> Continue Plan of Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Whirlpool                                          | 97022    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input checked="" type="checkbox"/> Ultrasound, 15 mins.                    | 97035    | 16-  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Iontophoresis, 15 mins.                            | 97033    |      | Visit Number: <u>0</u> of <u>PTA</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                          | 97026    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. <u>3</u> | 97110    | 114- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Functional Activities, 15 mins.                    | 97530    |      | Therapist's Signature: <u>William E. G...</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins.     | 97032    | 24-  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Massage, 15 mins.                                  | 97124    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Manual Therapy                                     | 97140    |      | RELEASE OF MEDICAL INFORMATION and<br>ASSIGNMENT OF BENEFITS<br>I hereby authorize the release of medical information necessary to<br>process this claim and authorize payment of medical benefits to PPT or<br>their designee for services described above.                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> Mechanical Traction                                | 97012    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.                   | 97112    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Gait Training, 15 mins.                            | 97116    |      | Patient or Authorized Person's Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <input type="checkbox"/> Self Care Training, 15 mins.                       | 97535    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> TENS Set Up                                        | 64550    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> ROM Measure & Report                               | 95851    |      | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <input type="checkbox"/> Other / Supplies                                   | 99070    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                             |          |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

Time In: / Time Out:

| COUNT NUMBER | DATE     | TIME    | CHECKOUT TIME       | TICKET NO. |
|--------------|----------|---------|---------------------|------------|
| 25247        | 06/25/09 | 03:05pm | PT SUMTER, 10457750 | 45703      |

NAME & ADDRESS: HAMILTON, EMMA  
2227 BOBWHITE DR  
SUMTER, SC 29154  
803-481-9425  
WRK:  
INSURED: HAMILTON, EMMA  
INS: WC/MEDRISK  
REASON: \*DEMAND\*  
NICKNAME:

THURSDAY

DOB: 12/04/1964 (44 years)  
GENDER: F  
IBG:  
FCL: 6  
CELL:  
RELATION: OTHER  
COPAY:

INSURANCE BALANCE \$548.00  
ACCOUNT BALANCE \$548.00  
CURRENT CHARGES 211-  
AMOUNT PAID  
NEW BALANCE 913-  
CASH CHECK M.O. C.C.

| PROCEDURES                                                              | CPT      | FEE  |
|-------------------------------------------------------------------------|----------|------|
| <input checked="" type="checkbox"/> Evaluation                          | 97001    |      |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |      |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |      |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |      |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |      |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |      |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |      |
| <input type="checkbox"/> Length                                         | STRENGTH |      |
| <input type="checkbox"/> SFCP                                           | SFCP     |      |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |      |
| <input type="checkbox"/> Whirlpool                                      | 97022    |      |
| <input type="checkbox"/> Ultrasound, 15 mins.                           | 97035    |      |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |      |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |      |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.      | 97110    | 152- |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |      |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24-  |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |      |
| <input checked="" type="checkbox"/> Manual Therapy                      | 97140    | 35-  |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |      |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |      |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |      |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |      |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |      |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |      |
| <input type="checkbox"/> Other / Supplies                               | 99070    |      |

Subjective:  
Pain Level (0-10) 3  
☐ Increased ☐ Decreased ☒ No Change

Objective:  
☒ NIFC ☐ Hi-Volt ☐ Micro ☐ NMES  
☒ Ultrasound 1.5 Mhz 1.4 W/cm<sup>2</sup> 6 min.  
☒ Moist Heat Pack ☐ Ice Pack  
☒ Therapeutic Exercise per Flow Sheet  
☒ Manual Therapy *Hand/Ankle/Wrist*  
☒ Functional Activities *Walking/standing*  
☒ *Walking* *1 x 25 min* *1 x 10 to 15 min*  
☒ *Walking* *1 x 10 to 15 min*  
Assessment:  
Tolerance ☒ Good ☐ Fair ☐ Poor  
*Hand/Ankle/Wrist* *1 x 25 min* *1 x 10 to 15 min*  
Plan:  
☒ Continue Plan of Care *↑ functional status*

Visit Number: \_\_\_\_\_ of \_\_\_\_\_

Staff: \_\_\_\_\_

Therapist's Signature: *William F. G...*

RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS  
I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.

Patient or Authorized Person's Signature \_\_\_\_\_

Date \_\_\_\_\_

Time In: / Time Out:

| ACCOUNT NUMBER | DATE     | TIME    | CHECKOUT TIME       | TICKET NO. |
|----------------|----------|---------|---------------------|------------|
| 25247          | 06/26/09 | 02:30pm | PT SUMTER, 10458214 | 1045765    |

|                                        |  |        |                            |                            |
|----------------------------------------|--|--------|----------------------------|----------------------------|
| NAME & ADDRESS                         |  | FRIDAY | DOB: 12/04/1964 (44 years) | INSURANCE BALANCE \$702.00 |
| HAMILTON, EMMA                         |  |        | GENDER: F                  | ACCOUNT BALANCE \$702.00   |
| 2227 BOBWHITE DR                       |  |        | IBG:                       | CURRENT CHARGES 249-       |
| SUMTER, SC 29154                       |  |        | FCL: 6                     | AMOUNT PAID                |
| 803-481-9425                           |  |        | CELL:                      | NEW BALANCE 1162-          |
| WRK:                                   |  |        | RELATION: OTHER            | CASH                       |
| INSURED: HAMILTON, EMMA                |  |        |                            | CHECK                      |
| INS: WC/MEDRISK                        |  |        |                            | N.O.                       |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |  |        |                            | C.C.                       |
| NICKNAME:                              |  |        | COPAY:                     |                            |

| PROCEDURES                                                              | CPT      | FEE | Subjective:                                                                                                         |
|-------------------------------------------------------------------------|----------|-----|---------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                     | 97001    |     | Pain Level (0-10) <u>3</u>                                                                                          |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |     | <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input checked="" type="checkbox"/> No Change |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |     | <i>pt sore but feels progress</i>                                                                                   |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |     |                                                                                                                     |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |     |                                                                                                                     |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |     |                                                                                                                     |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |     |                                                                                                                     |
| <input type="checkbox"/> Strength                                       | STRENGTH |     |                                                                                                                     |
| <input type="checkbox"/> SFCP                                           | SFCP     |     |                                                                                                                     |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |     |                                                                                                                     |
| <input type="checkbox"/> Whirlpool                                      | 97022    |     |                                                                                                                     |
| <input type="checkbox"/> Ultrasound, 15 mins.                           | 97035    |     |                                                                                                                     |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |     |                                                                                                                     |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |     |                                                                                                                     |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.      | 97110    | 90- |                                                                                                                     |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |     |                                                                                                                     |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24- |                                                                                                                     |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |     |                                                                                                                     |
| <input checked="" type="checkbox"/> Manual Therapy                      | 97140    | 35- |                                                                                                                     |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |     |                                                                                                                     |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |     |                                                                                                                     |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |     |                                                                                                                     |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |     |                                                                                                                     |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |     |                                                                                                                     |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |     |                                                                                                                     |
| <input type="checkbox"/> Other / Supplies                               | 99070    |     |                                                                                                                     |

|                                                                                                                                                                                                                                                            |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| Objective:                                                                                                                                                                                                                                                 | <i>pt sore but feels progress</i> |
| Subjective:                                                                                                                                                                                                                                                | <i>pt sore but feels progress</i> |
| Assessment:                                                                                                                                                                                                                                                | <i>pt sore but feels progress</i> |
| Plan:                                                                                                                                                                                                                                                      | <i>Continue Plan of Care</i>      |
| Visit Number:                                                                                                                                                                                                                                              | _____ of _____                    |
| Staff:                                                                                                                                                                                                                                                     | _____                             |
| Therapist's Signature:                                                                                                                                                                                                                                     | <i>William E. G...</i>            |
| <b>RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS</b><br>I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above. |                                   |
| Patient or Authorized Person's Signature                                                                                                                                                                                                                   |                                   |
| Date                                                                                                                                                                                                                                                       |                                   |

Time In: / Time Out:

| EXAM ROOM TIME                         |          |         | CHECKOUT TIME              | TICKET NO. |
|----------------------------------------|----------|---------|----------------------------|------------|
| COUNT NUMBER                           | DATE     | TIME    |                            |            |
| 25247                                  | 06/29/09 | 02:00pm | PT SUMTER,                 | 1C45816    |
| NAME & ADDRESS                         |          |         | MONDAY                     |            |
| HAMILTON, EMMA                         |          |         | DOB: 12/04/1964 (44 years) |            |
| 2227 BOBWHITE DR                       |          |         | GENDER: F                  |            |
| SUMTER, SC 29154                       |          |         | IBG:                       |            |
| 803-481-9425                           |          |         | FCL: 6                     |            |
| WRK:                                   |          |         | CELL:                      |            |
| INSURED: HAMILTON, EMMA                |          |         | RELATION: OTHER            |            |
| INS: WC/MEDRISK                        |          |         |                            |            |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |          |         |                            |            |
| NICKNAME:                              |          |         | COPAY:                     |            |
|                                        |          |         | INSURANCE BALANCE \$913.00 |            |
|                                        |          |         | ACCOUNT BALANCE \$913.00   |            |
|                                        |          |         | CURRENT CHARGES 239        |            |
|                                        |          |         | AMOUNT PAID                |            |
|                                        |          |         | NEW BALANCE 1401-          |            |
|                                        |          |         | CASH CHECK I.D. C.C.       |            |

| PROCEDURES                                                                  | CPT      | FEE  |                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------|----------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                         | 97001    |      | <b>Subjective:</b><br>Pain Level (0-10) <u>3</u><br><input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input checked="" type="checkbox"/> No Change<br><i>pt states she is making progress</i>                                                                                                             |
| <input type="checkbox"/> OT Evaluation                                      | 97002    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Functional Capacity Evaluation                     | 97750    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Physical Performance Test                          | 97750.1  |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Work Hardening, 2 hours                            | 97545    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                       | 97546    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Acc. Sports Ach. Program                           | ASAP     |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Strength                                           | STRENGTH |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> SFCP                                               | SFCP     |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Paraffin Bath                                      | 97018    |      |                                                                                                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> Ultrasound, 15 mins.                    | 97035    | 16-  |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Iontophoresis, 15 mins.                            | 97033    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                          | 97026    |      |                                                                                                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. <u>4</u> | 97110    | 152- |                                                                                                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> Functional Activities, 15 mins.         | 97530    | 47-  |                                                                                                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins.     | 97032    | 24-  |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Massage, 15 mins.                                  | 97124    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Manual Therapy                                     | 97140    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Mechanical Traction                                | 97012    |      | <b>Assessment:</b><br>Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor<br><br><b>Plan:</b><br><input checked="" type="checkbox"/> Continue Plan of Care                                                                                                          |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.                   | 97112    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Gait Training, 15 mins.                            | 97116    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Self Care Training, 15 mins.                       | 97535    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> TENS Set Up                                        | 64550    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> ROM Measure & Report                               | 95851    |      |                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Other / Supplies                                   | 99070    |      |                                                                                                                                                                                                                                                                                                                                |
|                                                                             |          |      |                                                                                                                                                                                                                                                                                                                                |
|                                                                             |          |      |                                                                                                                                                                                                                                                                                                                                |
|                                                                             |          |      |                                                                                                                                                                                                                                                                                                                                |
|                                                                             |          |      | Visit Number: <u>6</u> of <u>      </u><br>Staff: <u>PTA</u><br>Therapist's Signature: <u>William E. G...</u>                                                                                                                                                                                                                  |
|                                                                             |          |      | <b>RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS</b><br>I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.<br><br>Patient or Authorized Person's Signature _____<br>Date _____ |

Time In: / Time Out:

| EXAM ROOM TIME |          |         | CHECKOUT TIME       | TICKET NO. |
|----------------|----------|---------|---------------------|------------|
| COUNT NUMBER   | DATE     | TIME    |                     |            |
| 25247          | 06/30/09 | 11:30am | PT SUMTER, 1C459421 | 1C45859    |

NAME &amp; ADDRESS TUESDAY

HAMILTON, EMMA  
2227 BOBWHITE DR

DOB: 12/04/1964 (44 years)

GENDER: F

IBG:

FCL: 6

CELL:

SUMTER, SC 29154  
803-481-9425

WRK:

INSURED: HAMILTON, EMMA

RELATION: OTHER

INS: WC/MEDRISK

REASON: FOLLOW UP RIGHT HAND / FINGERS

NICKNAME:

COPAY:

INSURANCE  
BALANCE 1,162.00ACCOUNT  
BALANCE 1,162.00CURRENT  
CHARGES 176-AMOUNT  
PAIDNEW  
BALANCE 1577-

CASH CHECK M.O. C.C.

| PROCEDURES                                                                  | CPT      | FEE  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------------------|----------|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                         | 97001    |      | Subjective: <u>3</u><br>Pain Level (0-10)<br><input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change                                                                                                                                                                                                                                                                                                                          |
| <input type="checkbox"/> OT Evaluation                                      | 97002    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Functional Capacity Evaluation                     | 97750    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Physical Performance Test                          | 97750.1  |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Work Hardening, 2 hours                            | 97545    |      | Objective:<br><input checked="" type="checkbox"/> FC <input type="checkbox"/> HI-Volt <input type="checkbox"/> Micro <input type="checkbox"/> NMES<br><input type="checkbox"/> Ultrasound 1/3 Mhz W/cm <sup>2</sup> min.<br><input type="checkbox"/> Moist Heat Pack <input type="checkbox"/> Ice Pack<br><input checked="" type="checkbox"/> Therapeutic Exercise per Flow Sheet<br><input type="checkbox"/> Manual Therapy<br><input type="checkbox"/> Functional Activities |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                       | 97546    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Acc. Sports Ach. Program                           | ASAP     |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Length                                             | STRENGTH |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> SFCP                                               | SFCP     |      | Assessment:<br>Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor<br><u>Good Progress</u><br>Plan:<br><input checked="" type="checkbox"/> Continue Plan of Care                                                                                                                                                                                                                                                    |
| <input type="checkbox"/> Paraffin Bath                                      | 97018    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Whirlpool                                          | 97022    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Ultrasound, 15 mins.                               | 97035    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Iontophoresis, 15 mins.                            | 97033    |      | Visit Number: <u>6</u> of <u>    </u><br>Staff: <u>    </u><br>Therapist's Signature: <u>William E. G...</u>                                                                                                                                                                                                                                                                                                                                                                   |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                          | 97026    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. <u>4</u> | 97110    | 152- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Functional Activities, 15 mins.                    | 97530    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins.     | 97032    | 24-  | RELEASE OF MEDICAL INFORMATION and<br>ASSIGNMENT OF BENEFITS<br>I hereby authorize the release of medical information necessary to<br>process this claim and authorize payment of medical benefits to PPT or<br>their designee for services described above.<br><br>Patient or Authorized Person's Signature<br><br>Date                                                                                                                                                       |
| <input type="checkbox"/> Massage, 15 mins.                                  | 97124    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Manual Therapy                                     | 97140    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Mechanical Traction                                | 97012    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.                   | 97112    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Gait Training, 15 mins.                            | 97116    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Self Care Training, 15 mins.                       | 97535    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> TENS Set Up                                        | 64550    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> ROM Measure & Report                               | 95851    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> Other / Supplies                                   | 99070    |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

Time In: / Time Out:

| EXAM ROOM TIME |          |         | CHECKOUT TIME | TICKET NO. |
|----------------|----------|---------|---------------|------------|
| COUNT NUMBER   | DATE     | TIME    |               |            |
| 25247          | 07/01/09 | 11:30am | PT SUMTER,    | 1C45926    |

NAME &amp; ADDRESS WEDNESDAY

HAMILTON, EMMA  
2227 BOBWHITE DRSUMTER, SC 29154  
803-481-9425

WRK:

INSURED: HAMILTON, EMMA

INS: WC/MEDRISK

REASON: FOLLOW UP RIGHT HAND / FINGERS

NICKNAME:

DOB: 12/04/1964 (44 years)

GENDER: F

IBG:

FCL: 6

CELL:

RELATION: OTHER

COPAY:

INSURANCE 1,401.00

BALANCE

ACCOUNT 1,401.00

BALANCE

CURRENT

CHARGES

192-

AMOUNT

PAID

NEW

BALANCE

1769-

CASH

CHECK

M.O.

C.C.

| PROCEDURES                                                              | CPT      | FEE  |
|-------------------------------------------------------------------------|----------|------|
| <input type="checkbox"/> Evaluation                                     | 97001    |      |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |      |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |      |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |      |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |      |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |      |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |      |
| <input type="checkbox"/> Strength                                       | STRENGTH |      |
| <input type="checkbox"/> SFCP                                           | SFCP     |      |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |      |
| <input type="checkbox"/> Whirlpool                                      | 97022    |      |
| <input checked="" type="checkbox"/> Ultrasound, 15 mins.                | 97035    | 16-  |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |      |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |      |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.      | 97110    | 152- |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |      |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24-  |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |      |
| <input type="checkbox"/> Manual Therapy                                 | 97140    |      |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |      |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |      |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |      |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |      |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |      |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |      |
| <input type="checkbox"/> Other / Supplies                               | 99070    |      |

**Subjective:**  
Pain Level (0-10) 3  
☐ Increased ☐ Decreased ☒ No Change

**Objective:**  
☒ SFC ☐ Hi-Volt ☐ Micro ☐ NMES  
☒ Ultrasound 1/3 Mhz        W/cm<sup>2</sup>        min.  
☒ Moist Heat Pack ☐ Ice Pack  
☒ Therapeutic Exercise per Flow Sheet  
☐ Manual Therapy  
☐ Functional Activities

**Assessment:**  
Tolerance ☒ Good ☐ Fair ☐ Poor  
*Steady Progress*

**Plan:**  
☒ Continue Plan of Care

Visit Number        of       

Staff:       

Therapist's Signature: William E. G...

**RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS**  
I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.

Patient or Authorized Person's Signature \_\_\_\_\_

Date \_\_\_\_\_

Time In: / Time Out

| EXAM ROOM TIME                         |          |         | CHECKOUT TIME              | TICKET NO. |
|----------------------------------------|----------|---------|----------------------------|------------|
| COUNT NUMBER                           | DATE     | TIME    |                            |            |
| 25247                                  | 07/03/09 | 11:30am | PT SUMTER,                 | 1C46050    |
| NAME & ADDRESS                         |          |         |                            |            |
| FRIDAY                                 |          |         |                            |            |
| HAMILTON, EMMA                         |          |         | DOB: 12/04/1964 (44 years) |            |
| 2227 BOBWHITE DR                       |          |         | GENDER: F                  |            |
| SUMTER, SC 29154                       |          |         | IBG:                       |            |
| 803-481-9425                           |          |         | FCL: 6                     |            |
| WRK:                                   |          |         | CELL:                      |            |
| INSURED: HAMILTON, EMMA                |          |         | RELATION: OTHER            |            |
| INS: WC/MEDRISK                        |          |         |                            |            |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |          |         |                            |            |
| NICKNAME:                              |          |         | COPAY:                     |            |
|                                        |          |         | INSURANCE BALANCE 1,769.00 |            |
|                                        |          |         | ACCOUNT BALANCE 1,769.00   |            |
|                                        |          |         | CURRENT CHARGES 227-       |            |
|                                        |          |         | AMOUNT PAID                |            |
|                                        |          |         | NEW BALANCE 1996-          |            |
|                                        |          |         | CASH                       | CHECK      |
|                                        |          |         | M.O.                       | C.C.       |

| PROCEDURES                                                              | CPT      | FEE  |  |
|-------------------------------------------------------------------------|----------|------|--|
| Evaluation                                                              | 97001    |      |  |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |      |  |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |      |  |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |      |  |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |      |  |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |      |  |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |      |  |
| <input type="checkbox"/> Length                                         | STRENGTH |      |  |
| <input type="checkbox"/> SFCP                                           | SFCP     |      |  |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |      |  |
| <input type="checkbox"/> Whirlpool                                      | 97022    |      |  |
| <input checked="" type="checkbox"/> Ultrasound, 15 mins.                | 97035    | 16-  |  |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |      |  |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |      |  |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.      | 97110    | 152- |  |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |      |  |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24-  |  |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |      |  |
| <input checked="" type="checkbox"/> Manual Therapy                      | 97140    | 36-  |  |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |      |  |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |      |  |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |      |  |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |      |  |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |      |  |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |      |  |
| <input type="checkbox"/> Other / Supplies                               | 99070    |      |  |

**Subjective:**  
Pain Level (0-10)  
☐ Increased ☒ Decreased ☐ No Change  
*It pleased to get results, + no altered back  
of back with.*

**Objective:**  
☒ IFC ☐ Hi-Volt ☐ Micro ☐ NMES  
☒ Ultrasound 10Mhz 6.5 W/cm<sup>2</sup> 5 min.  
☒ Moist Heat Pack ☐ Ice Pack  
☒ Therapeutic Exercise per Flow Sheet  
☒ Manual Therapy *Hand left side neck*  
☐ Functional Activities

**Assessment:**  
Tolerance ☒ Good ☐ Fair ☐ Poor

**Plan:**  
☒ Continue Plan of Care *Parale*

Visit Number: \_\_\_\_\_ of \_\_\_\_\_

Staff: \_\_\_\_\_

Therapist's Signature: *William E. G...*

**RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS**  
I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.

Patient or Authorized Person's Signature \_\_\_\_\_

Date \_\_\_\_\_

Time In: / Time Out:

| EXAM ROOM TIME |          |         | CHECKOUT TIME | TICKET NO. |
|----------------|----------|---------|---------------|------------|
| ACCOUNT NUMBER | DATE     | TIME    |               |            |
| 25247          | 07/07/09 | 03:00pm | PT SUMTER,    | 1C46398    |

|                                        |  |         |                            |                            |
|----------------------------------------|--|---------|----------------------------|----------------------------|
| NAME & ADDRESS                         |  | TUESDAY | DOB: 12/04/1964 (44 years) | INSURANCE BALANCE 1,996.00 |
| HAMILTON, EMMA                         |  |         | GENDER: F                  | ACCOUNT BALANCE 1,996.00   |
| 2227 BOBWHITE DR                       |  |         | IBG:                       | CURRENT CHARGES 192-       |
| SUMTER, SC 29154                       |  |         | FCL: 6                     | AMOUNT PAID                |
| 803-481-9425                           |  |         | CELL:                      | NEW BALANCE 2188-          |
| WRK:                                   |  |         | RELATION: OTHER            | CASH                       |
| INSURED: HAMILTON, EMMA                |  |         | COPAY:                     | CHECK                      |
| INS: WC/MEDRISK                        |  |         |                            | M.O.                       |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |  |         |                            | C.C.                       |
| NICKNAME:                              |  |         |                            |                            |

| PROCEDURES                                                              | CPT      | FEE  |                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------|----------|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                     | 97001    |      | <b>Subjective:</b><br>Pain Level (0-10)<br><input type="checkbox"/> Increased <input checked="" type="checkbox"/> Decreased <input type="checkbox"/> No Change<br><i>note no numbness/tingle now.</i>                                                                                                                         |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> .rength                                        | STRENGTH |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> SFCP                                           | SFCP     |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |      |                                                                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> Ultrasound, 15 mins.                | 97035    | 16-  |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |      |                                                                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.      | 97110    | 152- |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |      |                                                                                                                                                                                                                                                                                                                               |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24-  |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Manual Therapy                                 | 97140    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |      | <b>Assessment:</b><br>Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor<br><i>It notes some @ 15 fatigue &amp; 40 being at risk is good ind. with of muscle work.</i><br><b>Plan:</b><br><input checked="" type="checkbox"/> Continue Plan of Care <i>1 week</i> |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |      |                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> Other / Supplies                               | 99070    |      |                                                                                                                                                                                                                                                                                                                               |
|                                                                         |          |      |                                                                                                                                                                                                                                                                                                                               |
|                                                                         |          |      |                                                                                                                                                                                                                                                                                                                               |
|                                                                         |          |      |                                                                                                                                                                                                                                                                                                                               |

|                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Visit Number: _____ of _____                                                                                                                                                                                                                               |
| Staff: _____                                                                                                                                                                                                                                               |
| Therapist's Signature: <i>William E. G...</i>                                                                                                                                                                                                              |
| <b>RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS</b><br>I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above. |
| Patient or Authorized Person's Signature _____                                                                                                                                                                                                             |
| Date _____                                                                                                                                                                                                                                                 |

Case Manager: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Current Level: \_\_\_\_\_



Faxed

Mailed

Given to Patient

2475 Broad St  
Sumter, SC 29150  
Ph: (803) 934-8470  
Fax: (803) 934-8457

## PHYSICAL THERAPY SUMMARY - UPPER EXTREMITY

Patient: Earna Hamilton  
DX/ICD9: ② hand/wrist pain/crush  
DOB: 12/4/1964 SS#: \_\_\_\_\_

Date: 7/2/09  
Therapist: Bill Cooper PT  
Physician: Dr. Gier

## Treatment(s)/Intervention(s):

- |                                                              |                                                            |                                                                  |
|--------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Shoulder Progression                | <input type="checkbox"/> Postural Correction               | <input type="checkbox"/> Scapulothoracic Stabilization           |
| <input type="checkbox"/> Elbow Progression                   | <input checked="" type="checkbox"/> Stretching Program     | <input checked="" type="checkbox"/> Home Exercise Program        |
| <input checked="" type="checkbox"/> Wrist / Hand Progression | <input checked="" type="checkbox"/> Self-Care Training     | <input checked="" type="checkbox"/> Modalities / Physical Agents |
| <input checked="" type="checkbox"/> PROM / AROM / AROM       | <input checked="" type="checkbox"/> Open-Chain Progression | <input type="checkbox"/> Other: _____                            |

Date of initial evaluation: 6/19/09 of last Rx: 7/3/09 No. of treatments attended: 11 No. of treatments missed: 0  
Impression of patient attitude towards regaining function: Good X Fair \_\_\_\_\_ Poor \_\_\_\_\_  
Impression of patient compliance with Home Exercise Program: Good X Fair \_\_\_\_\_ Poor \_\_\_\_\_

Current Status: She is currently unable to function w/ ② hand/wrist, but is easy to fatigue + feels burning + numbness.

AROM: Wrist to all wrist + hand motions

Strength: It has 40% grip strength to move, + do individual finger/thumb work a each hand. It has

Objective Findings: It is no edema noted, there is tenderness to palpation @ AROM / ROM

Progress Toward Work Related Goals: It shows improvement in all areas, but still is weakness + imbalance / tremor.

Program being made toward all work related goals

## Established Goals Include:

- ☒ Increase functional capacity
- ☒ Education
- ☒ Decrease signs / symptoms
- ☒ Increase strength / ROM

- ☒ Increase / Decrease joint mobility
- ☐ Improve movement quality
- ☐ Independent with Clinical Ex. Prescription
- Other: \_\_\_\_\_

## Increase functional capacity in:

- ☐ Leisure Activities
- ☒ ADL's
- ☒ Work Activities
- ☐ Sport Activities

Recommendations: It needs 3-4 months of diff work handling to improve specific job tasks

## Comments: \_\_\_\_\_

\*\*\*\*Please direct physical therapist as indicated below if different from the above recommendations \*\*\*\*

I have read the above progress report and would request that:

146

\_\_\_\_\_ the patient be discharged at this time

\_\_\_\_\_ present treatment is continued for \_\_\_\_\_ times/week for \_\_\_\_\_ weeks

\_\_\_\_\_ therapist calls me concerning this patient

\*\*\*\*Please sign below and return to therapist as soon as possible \*\*\*\*

\*\*\*\*Physician/NP/PAC

Date

167

Therapist

Date

7/2/09

Time In: / Time Out:

| ACCOUNT NUMBER | DATE     | TIME    | CHECKOUT TIME       | TICKET NO. |
|----------------|----------|---------|---------------------|------------|
| 25247          | 07/08/09 | 04:03pm | PT SUMTER, 10405328 | 46481      |

**NAME & ADDRESS**  
 HAMILTON, EMMA  
 2227 BOBWHITE DR  
 SUMTER, SC 29154  
 803-481-9425  
 WRK:  
 INSURED: HAMILTON, EMMA  
 INS: WC/MEDRISK  
 REASON: \*DEMAND\*  
 NICKNAME:

**WEDNESDAY**  
 DOB: 12/04/1964 (44 years)  
 GENDER: F  
 IBG:  
 FCL: 6  
 CELL:

RELATION: OTHER  
 COPAY:

|                   |          |
|-------------------|----------|
| INSURANCE BALANCE | 1,996.00 |
| ACCOUNT BALANCE   | 1,996.00 |
| CURRENT CHARGES   | 176-     |
| AMOUNT PAID       |          |
| NEW BALANCE       | 2364-    |
| CASH              | CHECK    |
| M.O.              | C.C.     |

| PROCEDURES                                                              | CPT      | FEE  |
|-------------------------------------------------------------------------|----------|------|
| <input type="checkbox"/> Evaluation                                     | 97001    |      |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |      |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |      |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |      |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |      |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |      |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |      |
| <input type="checkbox"/> Strength                                       | STRENGTH |      |
| <input type="checkbox"/> SFCP                                           | SFCP     |      |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |      |
| <input type="checkbox"/> Whirlpool                                      | 97022    |      |
| <input type="checkbox"/> Ultrasound, 15 mins.                           | 97035    |      |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |      |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |      |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. 4    | 97110    | 152- |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |      |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 24-  |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |      |
| <input type="checkbox"/> Manual Therapy                                 | 97140    |      |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |      |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |      |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |      |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |      |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |      |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |      |
| <input type="checkbox"/> Other / Supplies                               | 99070    |      |

**Subjective:**  
 Pain Level (0-10) 0  
☐ Increased ☐ Decreased ☒ No Change  
 No pain today

**Objective:**  
☒ MFC ☐ Hi-Volt ☐ Micro ☐ NMES  
☐ Ultrasound 1/3 Mhz W/cm<sup>2</sup> min.  
☐ Moist Heat Pack ☐ Ice Pack  
☒ Therapeutic Exercise per Flow Sheet  
☐ Manual Therapy  
☐ Functional Activities

**Assessment:**  
 Tolerance ☒ Good ☐ Fair ☐ Poor

**Plan:**  
☒ Continue Plan of Care

Visit Number: 0 of PTA  
 Staff: William E. G...  
 Therapist's Signature: William E. G...

**RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS**  
 I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.

Patient or Authorized Person's Signature  
 Date

Time In: / Time Out:

| ACCOUNT NUMBER | DATE     | TIME    | CHECKOUT TIME       | TICKET NO. |
|----------------|----------|---------|---------------------|------------|
| 25247          | 07/09/09 | 02:37pm | PT SUMTER, 10466015 | 46525      |

## NAME &amp; ADDRESS

THURSDAY

HAMILTON, EMMA  
2227 BOBWHITE DRSUMTER, SC 29154  
803-481-9425

WRK:

INSURED: HAMILTON, EMMA

INS: WC/MEDRISK

REASON: \*DEMAND\*

NICKNAME:

DOB: 12/04/1964 (44 years)

GENDER: F

IBG:

FCL: 6

CELL:

RELATION: OTHER

COPAY:

INSURANCE  
BALANCE 2,188.00ACCOUNT  
BALANCE 2,188.00CURRENT  
CHARGES 176AMOUNT  
PAIDNEW  
BALANCE 2540-

CASH CHECK M.O. C.C.

| PROCEDURES                                                                  | CPT      | FEE         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------|----------|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Evaluation                                         | 97001    |             | <b>Subjective:</b><br>Pain Level (0-10) <u>1-2</u><br><input checked="" type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change<br><u>Sore from new exercise</u><br><br><b>Objective:</b><br><input checked="" type="checkbox"/> NUC <input type="checkbox"/> Hi-Volt <input type="checkbox"/> Micro <input type="checkbox"/> NMES<br><input type="checkbox"/> Ultrasound 1/3 Mhz <u>W/cm²</u> <u>min.</u><br><input checked="" type="checkbox"/> Moist Heat Pack <input type="checkbox"/> Ice Pack<br><input checked="" type="checkbox"/> Therapeutic Exercise per Flow Sheet<br><input type="checkbox"/> Manual Therapy<br><input type="checkbox"/> Functional Activities |
| <input type="checkbox"/> OT Evaluation                                      | 97002    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Functional Capacity Evaluation                     | 97750    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Physical Performance Test                          | 97750.1  |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Work Hardening, 2 hours                            | 97545    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                       | 97546    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Acc. Sports Ach. Program                           | ASAP     |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Length                                             | STRENGTH |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> SFCP                                               | SFCP     |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Paraffin Bath                                      | 97018    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Whirlpool                                          | 97022    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Ultrasound, 15 mins.                               | 97035    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Iontophoresis, 15 mins.                            | 97033    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                          | 97026    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. <u>4</u> | 97110    | <u>152-</u> | <b>Assessment:</b><br>Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor<br><br><b>Plan:</b><br><input checked="" type="checkbox"/> Continue Plan of Care<br><br>Visit Number <u>0</u> of <u>1</u><br>Staff: <u>PJA</u><br>Therapist's Signature: <u>William E. G...</u><br><br><b>RELEASE OF MEDICAL INFORMATION and<br/>ASSIGNMENT OF BENEFITS</b><br>I hereby authorize the release of medical information necessary to<br>process this claim and authorize payment of medical benefits to PPT or<br>their designee for services described above.<br><br>Patient or Authorized Person's Signature _____<br>Date _____                                  |
| <input type="checkbox"/> Functional Activities, 15 mins.                    | 97530    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins.     | 97032    | <u>24-</u>  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Massage, 15 mins.                                  | 97124    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Manual Therapy                                     | 97140    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Mechanical Traction                                | 97012    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.                   | 97112    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Gait Training, 15 mins.                            | 97116    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Self Care Training, 15 mins.                       | 97535    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> TENS Set Up                                        | 64550    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> ROM Measure & Report                               | 95851    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <input type="checkbox"/> Other / Supplies                                   | 99070    |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                             |          |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                             |          |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                             |          |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                             |          |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                             |          |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

8037745283

Industrial Medicine

Progressive Physical

08:18:59

09-03-2009

2/2

0002/0092

To M.D.:

☐ Read☐ Initialed☐ Given to Patient☐ Filed in DCCE chart

## Progressive Physical Therapy

SUMTER

2475 BROAD ST

SUMTER SC 29150

803-934-8470 ph \* 803-934-8457 fx

## PATIENT CARE DISCHARGE SUMMARY

Patient Name: EMMS HamiltonDOB: 12/04/1964Physician: Dr GeeFax # 774-5283Initial Evaluation Date: 6/19/09Treatments Attended: 13Treatments Missed: 0Treatments Cancelled: 0Last Treatment Date: 7/9/09

## It is our understanding that:

☐ Patient returned full time to position held prior to injury.☐ Patient returned full time to different position.☐ Patient is working part-time or light duty.☐ Therapy interrupted due to☒ Patient has been non-compliant with follow up visits.☐ Patient states s/he is feeling better, and wishes to continue their HEP at home.☐ Other: \_\_\_\_\_SEP 03 2009  
FAXED

## Additional Comments:

Thank you for the consult☒ We will resume this patient's Physical therapy should they call back to schedule within their authorized time period (for Tricare patients).

*Gu* We are working to provide the best service and follow up possible. If you have any questions or concerns regarding this patient, please do not hesitate to call us at 803-788-995.

Thank you for your interest and assistance.

Physician Signature: [Signature]Date: 9-3-09Therapist/Staff Signature: [Signature]Date: 9/01/09Thanks for your efforts

Time In: / Time Out:

## EXAM ROOM TIME

CHECKOUT TIME

TICKET NO.

| COUNT NUMBER   | DATE     | TIME    | PT SUMTER, | TICKET NO. |
|----------------|----------|---------|------------|------------|
| 2<br>** NEW ** | 09/22/09 | 11:00am | PT SUMTER, | 49593      |

NAME & ADDRESS  
EMMA HAMILTON

TUESDAY

DOB:  
GENDER:  
IBG:  
FCL:  
CELL:

WRK:

INSURED: EMMA HAMILTON

INS:

REASON: NEW PATIENT/EVAL

RELATION:

INSURANCE  
BALANCEACCOUNT  
BALANCECURRENT  
CHARGES

367.50

AMOUNT  
PAIDNEW  
BALANCE

367.50

CASH CHECK M.O. C.C.

| PROCEDURES                            | CPT      | FEE    |  |
|---------------------------------------|----------|--------|--|
| ✓ Evaluation                          | 97001    | 121.25 |  |
| OT Evaluation                         | 97002    |        |  |
| Functional Capacity Evaluation        | 97750    |        |  |
| Physical Performance Test             | 97750.1  |        |  |
| Work Hardening, 2 hours               | 97545    |        |  |
| Work Hardening, add'l 1 hour          | 97546    |        |  |
| Acc. Sports Ach. Program              | ASAP     |        |  |
| Length                                | STRENGTH |        |  |
| SFCP                                  | SFCP     |        |  |
| Paraffin Bath                         | 97018    |        |  |
| Whirlpool                             | 97022    |        |  |
| ✓ Ultrasound, 15 mins.                | 97035    | 20-    |  |
| Iontophoresis, 15 mins.               | 97033    |        |  |
| Infrared / LLLT, 15 mins.             | 97026    |        |  |
| Therapeutic Exercise, 15 mins.        | 97110    | 142.50 |  |
| Functional Activities, 15 mins.       | 97530    |        |  |
| ✓ Electrical Stim. (manual), 15 mins. | 97032    | 30-    |  |
| Massage, 15 mins.                     | 97124    |        |  |
| Manual Therapy                        | 97140    |        |  |
| Mechanical Traction                   | 97012    |        |  |
| Neuromuscular Re-Educ., 15 mins.      | 97112    |        |  |
| Gait Training, 15 mins.               | 97116    |        |  |
| ✓ Self Care Training, 15 mins.        | 97535    | 53.75  |  |
| TENS Set Up                           | 64550    |        |  |
| ROM Measure & Report                  | 95851    |        |  |
| Other / Supplies                      | 99070    |        |  |

S = please see and for details.

COPY:

O = HTP performed 2x10 reps to all  
ROM + amount of @ hand/wrist as in  
started.US 01.64 x 8 in 100% to @ wrist/hand.  
with TENS K5 into same.A = Self care to pain/inflammation just  
A = @ returns to pain to @ hand/wrist, but  
thickens has better function in all areas.

P = as above for the POC

Visit Number:

of

Staff:

Therapist's Signature:

RELEASE OF MEDICAL INFORMATION and  
ASSIGNMENT OF BENEFITSI hereby authorize the release of medical information necessary to  
process this claim and authorize payment of medical benefits to PPT or  
their designee for services described above.

Patient or Authorized Person's Signature

Date

150

8037745283

Industrial Medicine

11:16:57

10-07-2009

2/3

# Progressive Physical Therapy

2475 Broad Street

Sumter, SC 29166

Ph: 803-934-8470 Fax 803-934-8457

## Physical Therapy Evaluation Work Hardening Axial Skeleton

Next MD Appt. \_\_\_\_\_

Patient: Emma HamiltonSSN: 249-17-0683Date: 9-22-09

Diagnosis: \_\_\_\_\_

Physician/NP/PAC: James Gee, MDDOB: 12-4-1964 Date of Onset: \_\_\_\_\_Therapist: Bill GentrySubjective/History/Mechanism of Injury: Sp pain neck

PMH: \_\_\_\_\_

### Range of Motion

| Cervical Spine       |       |      |      | Dorsal-Lumbar Spine            |       |      |      |
|----------------------|-------|------|------|--------------------------------|-------|------|------|
|                      | Norm. | Exam | Pain |                                | Norm. | Exam | Pain |
| a. Flexion           | 60°   | 4/5  | 9/10 | a. Flexion                     | 60°   | NT   | NT   |
| b. Extension         | 75°   | ↓    | ↓    | b. Extension                   | 25°   | ↓    | ↓    |
| c. Lateral to right  | 45°   | ↓    | ↓    | c. Lateral to right            | 25°   | ↓    | ↓    |
| d. Lateral to left   | 45°   | ↓    | ↓    | d. Lateral to left             | 25°   | ↓    | ↓    |
| e. Rotation to right | 80°   | ↓    | ↓    | e. Rotation to right           | 30°   | ↓    | ↓    |
| f. Rotation to left  | 80°   | ↓    | ↓    | f. Rotation to left            | 30°   | ↓    | ↓    |
| g. Circumduction     |       |      |      | g. Difficulty Straightening Up |       |      |      |

### Vital Signs:

Blood Pressure: \_\_\_\_\_ Heart Rate: \_\_\_\_\_

in: \_\_\_\_\_ /10 @ present Pain: \_\_\_\_\_ /10 @ worst

### Special Test:

Slump: \_\_\_\_\_ SLR/Distracted: \_\_\_\_\_ Faber: \_\_\_\_\_ Hoover: \_\_\_\_\_ SI loading: \_\_\_\_\_ ; Cervical Distract: \_\_\_\_\_

Spurling's: \_\_\_\_\_ ; Waddell's Signs: 1. Tenderness: \_\_\_\_\_ 2. Simulation: \_\_\_\_\_ 3. Distraction: \_\_\_\_\_ 4. Overex: \_\_\_\_\_

5. Regional Disturbances: \_\_\_\_\_ ; Other: \_\_\_\_\_

Other ROM/ Strength Findings: \_\_\_\_\_

### Posture:

Sitting: Pelvis/LS - \_\_\_\_\_ lordosis, Scapulothoracic - \_\_\_\_\_

Cervical - Forward head \_\_\_\_\_, Standing: \_\_\_\_\_ kyphosis,

### Muscle Test

|                      | Left | Right |
|----------------------|------|-------|
| Cerv. Rot. C1        | 4/5  | 4/5   |
| Shrug C2-4           | ↓    | ↓     |
| Shld abd C5-6        | ↓    | ↓     |
| Elbow flex C5-6      | ↓    | ↓     |
| Wrist ext. C6        | ↓    | 4/5   |
| Elbow ext. C7        | ↓    | ↓     |
| Thumb ext. C7-8      | ↓    | ↓     |
| Hand intrinsic C8-T1 | ↓    | ↓     |
| Hip Flex L2-L3       |      |       |
| Knee ext. L2, L3, L4 |      |       |
| Knee flex L5, S1, S2 |      |       |
| Ankle dors. L5, S1   |      |       |
| Ankle plantar S1, S2 |      |       |

### Functional Test

| Lifting             |    |
|---------------------|----|
| Level lift          | NT |
| Floor-to-waist      | ↓  |
| Knee-to-waist       | ↓  |
| Waist-to-overhead   | ↓  |
| 100 lb weight carry | ↓  |
| Pushing             | ↓  |
| Pulling             | ↓  |
| Sustained           |    |
| Repeat Bending      | ↓  |
| Sustained overhead  | ↓  |
| Cardiovascular      |    |
| Bike                | ↓  |
| Treadmill           | ↓  |

FAX TO CASE MANAGER

1

Case Manager Name: \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_ Date Faxed: \_\_\_\_/\_\_\_\_/\_\_\_\_

8037745283

Industrial Medicine

11:17:51

10-07-2009

3/3

# Progressive Physical Therapy

2475 Broad Street

Sumner, SC 29146

Ph: 803-934-8470 Fax 803-934-8457

Patient Name Emma Hamilton

Occupation: \_\_\_\_\_

Work Status \_\_\_\_\_

Physical Demands of Job or please see attached Job Analysis: \_\_\_\_\_

Length of Time with Employer/Job \_\_\_\_\_

Meds: \_\_\_\_\_

X-ray/MRI: \_\_\_\_\_

When Worse: at useWhen Better: at rest

## Summary of Significant Findings:

- 1) Pain & tenderness locations: radial D wrist
  - a) Subjective pain rating: 9/10 currently/at rest; 6 /10 at worst.
- 2) ROM: Wrist to D wrist
- 3) Strength, Function: 1/2 by 10-15 to 20 lbs
- 4) BP/HR: AM
- 5) Lifting: 1
- 6) Sustained: 1
- 7) Cardiovascular: 1
- 8) Special Tests: Small
- 9) Other: 0

## Goals LTG ( / / ) 4-6 weeks

- 1.) Patient able to lift 30 lbs from floor to waist 2 x 5 reps.
- 2.) Patient able to push/pull \_\_\_\_\_ lbs on sled 70ft x 5 reps.

- 3.) Patient able to perform repeat bending (at waist level) continuously for 5 min.

- 4.) will control 10-20 D wrist KLF
- 5.) patient will use 1/2 and 1/2 50 M/s

- 6.) Patient to attend Back School/Neck School (mandatory).

## Recommended Plan of Care:

Work Hardening Program 3 times /week for 4 weeks (2-4 hours per session) to include progression of functional activities as pertinent to work /ADL's, lifting, pushing, pulling, sustained/repetitive activities; 20-30 minutes of general strength and conditioning, and 20-30 minutes of aerobic activities.

Rehab Potential: excellent/good/fair/guarded

\*\*\*Patient understands and is in agreement with plan of care, as well as importance of attendance YES/ NO.

\*\*\*Overall, patient's attitude appears good.

Thank you for this referral.

Please sign and return the original to the therapist as soon as possible. Thank You!

Physician/NP/PAC

Date

Therapist

Date

FAX

OCT 07 2009

FAX TO CASE MANAGER

2

Case Manager Name: \_\_\_\_\_

Fax #: ( ) -

Date Faxed: / /

Time In: / Time Out:

## EXAM ROOM TIME

## CHECKOUT TIME

## TICKET NO.

|                                                                                                                                                                                                       |                  |                 |                                                                                                              |                             |         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------|--------------------------------------------------------------------------------------------------------------|-----------------------------|---------|
| COUNT NUMBER<br>25247                                                                                                                                                                                 | DATE<br>09/25/09 | TIME<br>04:30pm | PT SUMTER,                                                                                                   | 10499110<br><del>1099</del> | 1C49764 |
| NAME & ADDRESS<br>HAMILTON, EMMA<br>2227 BOBWHITE DR<br>SUMTER, SC 29154<br>803-481-9425<br>WRK:<br>INSURED: HAMILTON, EMMA<br>INS: WC/MEDRISK<br>REASON: FOLLOW UP RIGHT HAND / FINGERS<br>NICKNAME: |                  |                 | DOB: 12/04/1964 (44 years)<br>GENDER: F<br>IBG:<br>FCL: 6<br>CELL: 803-795-8269<br>RELATION: OTHER<br>COPAY: |                             |         |
| INSURANCE BALANCE 1,138.50                                                                                                                                                                            |                  |                 | ACCOUNT BALANCE 1,138.50                                                                                     |                             |         |
| CURRENT CHARGES 172 <sup>30</sup>                                                                                                                                                                     |                  |                 | AMOUNT PAID                                                                                                  |                             |         |
| NEW BALANCE 540 <sup>-</sup>                                                                                                                                                                          |                  |                 | CASH CHECK N.O. C.C.                                                                                         |                             |         |

| PROCEDURES                                                              | CPT      | FEE               | Subjective:                                                                                                                                                                                  |
|-------------------------------------------------------------------------|----------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Evaluation                                                              | 97001    |                   | Pain Level (0-10)                                                                                                                                                                            |
| <input type="checkbox"/> OT Evaluation                                  | 97002    |                   | <input type="checkbox"/> Increased <input checked="" type="checkbox"/> Decreased <input type="checkbox"/> No Change                                                                          |
| <input type="checkbox"/> Functional Capacity Evaluation                 | 97750    |                   | <i>Some Driven</i>                                                                                                                                                                           |
| <input type="checkbox"/> Physical Performance Test                      | 97750.1  |                   | Objective:                                                                                                                                                                                   |
| <input type="checkbox"/> Work Hardening, 2 hours                        | 97545    |                   | <input checked="" type="checkbox"/> SFC <input type="checkbox"/> HI-Volt <input type="checkbox"/> Micro <input type="checkbox"/> NMES                                                        |
| <input type="checkbox"/> Work Hardening, add'l 1 hour                   | 97546    |                   | <input checked="" type="checkbox"/> Ultrasound 1/3 Mhz W/cm <sup>2</sup> min.                                                                                                                |
| <input type="checkbox"/> Acc. Sports Ach. Program                       | ASAP     |                   | <input checked="" type="checkbox"/> Moist Heat Pack <input type="checkbox"/> Ice Pack                                                                                                        |
| <input type="checkbox"/> Length                                         | STRENGTH |                   | <input checked="" type="checkbox"/> Therapeutic Exercise per Flow Sheet                                                                                                                      |
| <input type="checkbox"/> SFCP                                           | SFCP     |                   | <input type="checkbox"/> Manual Therapy                                                                                                                                                      |
| <input type="checkbox"/> Paraffin Bath                                  | 97018    |                   | <input type="checkbox"/> Functional Activities                                                                                                                                               |
| <input type="checkbox"/> Whirlpool                                      | 97022    |                   | Assessment:                                                                                                                                                                                  |
| <input type="checkbox"/> Ultrasound, 15 mins.                           | 97035    |                   | Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor                                                                               |
| <input type="checkbox"/> Iontophoresis, 15 mins.                        | 97033    |                   | <i>diff. in the ex after the 1st fatigue</i>                                                                                                                                                 |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                      | 97026    |                   | Plan:                                                                                                                                                                                        |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins. 3    | 97110    | 142 <sup>50</sup> | <input checked="" type="checkbox"/> Continue Plan of Care <i>↑ as ble.</i>                                                                                                                   |
| <input type="checkbox"/> Functional Activities, 15 mins.                | 97530    |                   | Visit Number: _____ of _____                                                                                                                                                                 |
| <input checked="" type="checkbox"/> Electrical Stim. (manual), 15 mins. | 97032    | 30 <sup>-</sup>   | Staff: _____                                                                                                                                                                                 |
| <input type="checkbox"/> Massage, 15 mins.                              | 97124    |                   | Therapist's Signature: <i>William E. G...</i>                                                                                                                                                |
| <input type="checkbox"/> Manual Therapy                                 | 97140    |                   | RELEASE OF MEDICAL INFORMATION and<br>ASSIGNMENT OF BENEFITS                                                                                                                                 |
| <input type="checkbox"/> Mechanical Traction                            | 97012    |                   | I hereby authorize the release of medical information necessary to<br>process this claim and authorize payment of medical benefits to PPT or<br>their designee for services described above. |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.               | 97112    |                   | Patient or Authorized Person's Signature _____                                                                                                                                               |
| <input type="checkbox"/> Gait Training, 15 mins.                        | 97116    |                   | Date _____                                                                                                                                                                                   |
| <input type="checkbox"/> Self Care Training, 15 mins.                   | 97535    |                   | 153                                                                                                                                                                                          |
| <input type="checkbox"/> TENS Set Up                                    | 64550    |                   |                                                                                                                                                                                              |
| <input type="checkbox"/> ROM Measure & Report                           | 95851    |                   |                                                                                                                                                                                              |
| <input type="checkbox"/> Other / Supplies                               | 99070    |                   |                                                                                                                                                                                              |

Time In: / Time Out:

## EXAM ROOM TIME

CHECKOUT TIME

TICKET NO.

|                                        |          |         |                      |          |         |
|----------------------------------------|----------|---------|----------------------|----------|---------|
| COUNT NUMBER                           | DATE     | TIME    | PT SUMTER,           | 1C499081 | 1C49848 |
| 25247                                  | 09/28/09 | 03:00pm |                      |          |         |
| NAME & ADDRESS                         |          |         | INSURANCE 1,138.50   |          |         |
| HAMILTON, EMMA                         |          |         | BALANCE              |          |         |
| 2227 BOBWHITE DR                       |          |         | ACCOUNT 1,138.50     |          |         |
| SUMTER, SC 29154                       |          |         | BALANCE              |          |         |
| 803-481-9425                           |          |         | CURRENT CHARGES 135- |          |         |
| WRK:                                   |          |         | AMOUNT PAID          |          |         |
| INSURED: HAMILTON, EMMA                |          |         | NEW BALANCE 675-     |          |         |
| INS: WC/MEDRISK                        |          |         | CASH                 |          |         |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |          |         | CHECK                |          |         |
| NICKNAME:                              |          |         | M.O.                 |          |         |
|                                        |          |         | C.C.                 |          |         |
|                                        |          |         |                      |          |         |

| PROCEDURES                          | CPT      | FEE  |                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------|----------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ Evaluation                        | 97001    |      | <b>Subjective:</b><br>Pain Level (0-10) _____<br><input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> No Change<br><i>Feels sore around the wrist</i>                                                                                                                            |
| OT Evaluation                       | 97002    |      |                                                                                                                                                                                                                                                                                                                            |
| Functional Capacity Evaluation      | 97750    |      |                                                                                                                                                                                                                                                                                                                            |
| Physical Performance Test           | 97750.1  |      |                                                                                                                                                                                                                                                                                                                            |
| Work Hardening, 2 hours             | 97545    | 135- |                                                                                                                                                                                                                                                                                                                            |
| Work Hardening, add'l 1 hour        | 97546    |      |                                                                                                                                                                                                                                                                                                                            |
| Acc. Sports Ach. Program            | ASAP     |      |                                                                                                                                                                                                                                                                                                                            |
| Length                              | STRENGTH |      |                                                                                                                                                                                                                                                                                                                            |
| SFCP                                | SFCP     |      |                                                                                                                                                                                                                                                                                                                            |
| Paraffin Bath                       | 97018    |      |                                                                                                                                                                                                                                                                                                                            |
| Whirlpool                           | 97022    |      |                                                                                                                                                                                                                                                                                                                            |
| Ultrasound, 15 mins.                | 97035    |      |                                                                                                                                                                                                                                                                                                                            |
| Iontophoresis, 15 mins.             | 97033    |      |                                                                                                                                                                                                                                                                                                                            |
| Infrared / LLLT, 15 mins.           | 97026    |      |                                                                                                                                                                                                                                                                                                                            |
| Therapeutic Exercise, 15 mins.      | 97110    |      |                                                                                                                                                                                                                                                                                                                            |
| Functional Activities, 15 mins.     | 97530    |      |                                                                                                                                                                                                                                                                                                                            |
| Electrical Stim. (manual), 15 mins. | 97032    |      |                                                                                                                                                                                                                                                                                                                            |
| Massage, 15 mins.                   | 97124    |      |                                                                                                                                                                                                                                                                                                                            |
| Manual Therapy                      | 97140    |      | <b>Assessment:</b><br>Tolerance <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor<br><i>No Adverse RKR to Rx</i>                                                                                                                                                                   |
| Mechanical Traction                 | 97012    |      | <b>Plan:</b><br><input checked="" type="checkbox"/> Continue Plan of Care<br><i>Cont. poc</i>                                                                                                                                                                                                                              |
| Neuromuscular Re-Educ., 15 mins.    | 97112    |      |                                                                                                                                                                                                                                                                                                                            |
| Gait Training, 15 mins.             | 97116    |      |                                                                                                                                                                                                                                                                                                                            |
| Self Care Training, 15 mins.        | 97535    |      |                                                                                                                                                                                                                                                                                                                            |
| TENS Set Up                         | 64550    |      |                                                                                                                                                                                                                                                                                                                            |
| ROM Measure & Report                | 95851    |      |                                                                                                                                                                                                                                                                                                                            |
| Other / Supplies                    | 99070    |      |                                                                                                                                                                                                                                                                                                                            |
|                                     |          |      |                                                                                                                                                                                                                                                                                                                            |
|                                     |          |      |                                                                                                                                                                                                                                                                                                                            |
|                                     |          |      |                                                                                                                                                                                                                                                                                                                            |
|                                     |          |      | Visit Number: _____ of _____<br>Staff: <i>La B...</i> PTA<br>Therapist's Signature: <i>William E. G...</i>                                                                                                                                                                                                                 |
|                                     |          |      | <b>RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS</b><br>I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above.<br>Patient or Authorized Person's Signature _____<br>Date _____ |

Time In: / Time Out:

| EXAM ROOM TIME                         |          |         | CHECKOUT TIME              | TICKET NO. |
|----------------------------------------|----------|---------|----------------------------|------------|
| ACCOUNT NUMBER                         | DATE     | TIME    |                            |            |
| 25247                                  | 10/06/09 | 04:00pm | PT SUMTER,                 | 1C50165    |
| NAME & ADDRESS                         |          |         | TUESDAY                    |            |
| HAMILTON, EMMA                         |          |         | DOB: 12/04/1964 (44 years) |            |
| 2227 BOBWHITE DR                       |          |         | GENDER: F                  |            |
| SUMTER, SC 29154                       |          |         | IBG:                       |            |
| 803-481-9425                           |          |         | FCL: 6                     |            |
| WRK:                                   |          |         | CELL: 803-795-8269         |            |
| INSURED: HAMILTON, EMMA                |          |         | RELATION: OTHER            |            |
| INS: WC/MEDRISK                        |          |         |                            |            |
| REASON: FOLLOW UP RIGHT HAND / FINGERS |          |         |                            |            |
| NICKNAME:                              |          |         | COPAY:                     |            |
|                                        |          |         | INSURANCE BALANCE 1,446.00 |            |
|                                        |          |         | ACCOUNT BALANCE 1,446.00   |            |
|                                        |          |         | CURRENT CHARGES 135-       |            |
|                                        |          |         | AMOUNT PAID                |            |
|                                        |          |         | NEW BALANCE 810-           |            |
|                                        |          |         | CASH                       | CHECK      |
|                                        |          |         | M.O.                       | C.C.       |

| PROCEDURES                                                          | CPT      | FEE  |                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------|----------|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ✓ Evaluation                                                        | 97001    |      | <b>Subjective:</b><br>Pain Level (0-10) _____<br><input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input checked="" type="checkbox"/> No Change<br><i>PT 5 new cl to the left.</i>                                                    |
| <input type="checkbox"/> OT Evaluation                              | 97002    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Functional Capacity Evaluation             | 97750    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Physical Performance Test                  | 97750.1  |      |                                                                                                                                                                                                                                                            |
| <input checked="" type="checkbox"/> Work Hardening, 2 hours         | 97545    | 135- |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Work Hardening, add'l 1 hour               | 97546    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Ass. Sports Ach. Program                   | ASAP     |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Strength                                   | STRENGTH |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> SFCP                                       | SFCP     |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Paraffin Bath                              | 97018    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Whirlpool                                  | 97022    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Ultrasound, 15 mins.                       | 97035    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Iontophoresis, 15 mins.                    | 97033    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Infrared / LLLT, 15 mins.                  | 97026    |      |                                                                                                                                                                                                                                                            |
| <input checked="" type="checkbox"/> Therapeutic Exercise, 15 mins.  | 97110    |      |                                                                                                                                                                                                                                                            |
| <input checked="" type="checkbox"/> Functional Activities, 15 mins. | 97530    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Electrical Stim. (manual), 15 mins.        | 97032    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Massage, 15 mins.                          | 97124    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Manual Therapy                             | 97140    |      | <b>Assessment:</b><br>Tolerance <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor<br><i>PT fatigued to the max. on performance, showing good work.</i>                                                  |
| <input type="checkbox"/> Mechanical Traction                        | 97012    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Neuromuscular Re-Educ., 15 mins.           | 97112    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Gait Training, 15 mins.                    | 97116    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Self Care Training, 15 mins.               | 97535    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> TENS Set Up                                | 64550    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> ROM Measure & Report                       | 95851    |      |                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Other / Supplies                           | 99070    |      |                                                                                                                                                                                                                                                            |
|                                                                     |          |      |                                                                                                                                                                                                                                                            |
|                                                                     |          |      |                                                                                                                                                                                                                                                            |
|                                                                     |          |      | <b>Plan:</b><br><input checked="" type="checkbox"/> Continue Plan of Care <i>PT stable.</i>                                                                                                                                                                |
|                                                                     |          |      | Visit Number: _____ of _____                                                                                                                                                                                                                               |
|                                                                     |          |      | Staff: _____                                                                                                                                                                                                                                               |
|                                                                     |          |      | Therapist's Signature: <i>William E. G...</i>                                                                                                                                                                                                              |
|                                                                     |          |      | <b>RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS</b><br>I hereby authorize the release of medical information necessary to process this claim and authorize payment of medical benefits to PPT or their designee for services described above. |
|                                                                     |          |      | Patient or Authorized Person's Signature _____                                                                                                                                                                                                             |
|                                                                     |          |      | Date _____                                                                                                                                                                                                                                                 |

8037745283

Industrial Medicine

10:12:02

10-28-2009

2/2

0002/0002

Progressive Physical Therapy

SUMTER

2475 BROAD ST

SUMTER SC 29150

803-934-8470 ph \* 803-934-8457 fax

To M.D.:

☐ Faxed☒ Mailed☐ Given to Patient☐ Filed in DCCS chart

43281

## PATIENT CARE DISCHARGE SUMMARY

Patient Name:

Emma Hamilton

DOB:

12/4/1964

Physician:

Dr. James Gee

Fax #

803-774-5283

Initial Evaluation Date: 9/2/09

Treatments Attended: 4

Treatments Missed: 0

Treatments Cancelled: 0

Last Treatment Date: 10/6/09

## It is our understanding that:

☐ Patient returned full time to position held prior to injury.☐ Patient returned full time to different position.☐ Patient is working part-time or light duty.☒ Therapy interrupted due to medical interest - staff + pt.☐ Patient has been non-compliant with follow up visits.☐ Patient states s/he is feeling better, and wishes to continue their HEP at home.☒ Other: He called & interest in outside work

## Additional Comments:

Called pt + left message to her to call for us (James P.D.) and call her one message to request referral to alternate service provider.☐ We will resume this patient's Physical therapy should they call back to schedule within their authorized time period (for Tricare patients).

We are working to provide the best service and follow up possible. If you have any questions or concerns regarding this patient, please do not hesitate to call us at 803-934-8470.

Thank you for your interest and assistance.

Physician Signature:

Date:

10/28/09

Therapist/Staff Signature:

Date:

10/28/09

FAXED  
OCT 28 2009

## FUNCTIONAL CAPACITY EVALUATION SUMMARY REPORT

Client: Ms. Emma R. Hamilton  
Date of service: 01/26/2010  
Diagnosis: Crush injury to right wrist; hand and lower arm caught between machine rollers.  
Job at time of injury: Color technician  
Date of injury: 07/22/2008  
Worked Since: 10/12/2001  
Work Status: No  
Position: Color Specialist  
Referred by: Dr. James Gee

### Physical Effort Findings

Overall test findings, in combination with clinical observations, suggest the presence of full physical effort on Ms. Hamilton's behalf.

### Reliability of Pain and Disability Reports Findings

Overall test findings, in combination with clinical observations, suggest client continued to display what appeared to be ~~under-reporting of her discomfort~~, similar to her pain reporting during her work hardening program. ~~Client appeared and she reported feeling motivated to return to work.~~

### Summary of Findings

Ms. Hamilton appeared to put forth a valid effort and I feel the ratings listing in this report are accurate. ~~Ms. Hamilton's overall work rated at a LIGHT strength level.~~

Ms. Hamilton demonstrated a cardiovascular ability of 4.3 METs (comparable to a LIGHT-TO-MEDIUM cardiovascular fitness level).

Ms. Hamilton's physical abilities ~~did not match the demands of the target job~~. The client did not demonstrate the ability to perform the necessary lifting, pushing, pulling, or carrying at the MEDIUM-TO-HEAVY physical demand level on the Occasional basis as required by the target job.

Preliminary results of this evaluation were reviewed with Ms. Hamilton at the conclusion of the evaluation.

Thank you for your referral of Ms. Hamilton.

Signed,

Ms. Emma Hamilton  
DOB: 12/4/1964

A handwritten signature in black ink, appearing to read "John P. Zelenka". The signature is fluid and cursive, with the first name "John" and last name "Zelenka" clearly legible.

John P. Zelenka, OTR/L  
McLeod Work Recovery Center  
Florence, SC 29501

Ms. Emma Hamilton  
DOB: 12/4/1964

### Physical Abilities and Job Match

The following table compares the client's demonstrated physical abilities to the critical physical demands of the job in question.

Ms. Hamilton's target job is Color technician. The typical work day is 720 minutes long with 60 minutes of lunch and other breaks resulting in a net time worked of 660 minutes.

The physical demands of the target job were determined by an interview with Ms. Hamilton and The Dictionary of Occupational Titles.

|                            | Job Demand                                                                      | Demonstrated Ability                                                           | Match?  |
|----------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------|
| <b>Strength</b>            |                                                                                 |                                                                                |         |
| Lifting                    | Heavy. 70 lbs. from 0 to 60 inches. Occasional (Up to 1/3 Day). Pigment.        | 10 pounds. Occasional (Up to 1/3 Day).                                         | No      |
| Carrying                   | Heavy. 70 lbs. for 10 feet. Occasional (Up to 1/3 Day). Pigment.                | 10 pounds. Occasional (Up to 1/3 Day).                                         | No      |
| *Pushing                   | Medium. 50 lbs. for 300 feet. Occasional (Up to 1/3 Day). Palet jack            | 25 pounds. Occasional (Up to 1/3 Day).                                         | No      |
| *Pulling                   | Medium. 50 lbs. for 300 feet. Occasional (Up to 1/3 Day).                       | 13 pounds. Occasional (Up to 1/3 Day).                                         | No      |
| <b>Mobility</b>            |                                                                                 |                                                                                |         |
| Sitting                    | 60 minutes longest duration, 60 minutes per shift. Occasional (Up to 1/3 Day).  | Occasional (Up to 1/3 Day).                                                    | Yes     |
| Static Standing            | Rarely.                                                                         | Occasional (Up to 1/3 Day).                                                    | Yes     |
| Dynamic Standing           | 300 minutes longest duration, 300 minutes per shift. Frequent (1/3 to 2/3 Day). | Frequent (1/3 to 2/3 Day).                                                     | Yes     |
| Walking                    | 300 minutes longest duration, 300 minutes per shift. Frequent (1/3 to 2/3 Day). | Frequent (1/3 to 2/3 Day).                                                     | Yes     |
| <b>Agility</b>             |                                                                                 |                                                                                |         |
| Stairs/Ladders             | 200 steps. Occasional (Up to 1/3 Day).                                          | Restricted. 10 steps per occasion. 10 occasions per day. Total 100 steps.      | No      |
| Balancing                  | 200 feet with narrow conditions. Occasional (Up to 1/3 Day).                    | Occasional (Up to 1/3 Day).                                                    | Yes     |
| Bending/Stooping           | Frequent (1/3 to 2/3 Day).                                                      | Occasional (Up to 1/3 Day).                                                    | No      |
| Crouching/Squatting        | Occasional (Up to 1/3 Day).                                                     | Restricted. 15 seconds per occasion. 15 occasions per day. Total: 225 seconds. | Yes     |
| Crawling                   | 3 feet. Rarely.                                                                 | Never.                                                                         | No      |
| Twisting/Spinal Rotation   | Occasional (Up to 1/3 Day).                                                     | Occasional (Up to 1/3 Day).                                                    | Yes     |
| Above-Shoulder Work        | To 72 inches. Occasional (Up to 1/3 Day).                                       | Occasional (Up to 1/3 Day) left arm only; Right arm-Never.                     | Limited |
| Low-Level Work             | Frequent (1/3 to 2/3 Day).                                                      | Occasional (Up to 1/3 Day).                                                    | No      |
| Prolonged Neck Positioning | Occasional (Up to 1/3 Day).                                                     | Occasional (Up to 1/3 Day).                                                    | Yes     |
| Impact/Jarring             | Rarely.                                                                         | Occasional (Up to 1/3 Day).                                                    | Yes     |
| <b>Dexterity</b>           |                                                                                 |                                                                                |         |
| Fine Finger                | Frequent (1/3 to 2/3 Day).                                                      | Occasional (Up to 1/3 Day)                                                     | Yes     |
| Grasping - Light           | Occasional (Up to 1/3 Day).                                                     | Occasional (Up to 1/3 Day) left arm only; Right arm-Never.                     | Limited |

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|                       |                                       |                                                                       |                    |
|-----------------------|---------------------------------------|-----------------------------------------------------------------------|--------------------|
| Grasping - Firm       | Frequent (1/3 to 2/3 Day).            | Occasional (Up to 1/3 Day) left arm only; <del>Right arm-Never.</del> | <del>No</del>      |
| Pinching              | Occasional (Up to 1/3 Day).           | Occasional (Up to 1/3 Day) left arm only; <del>Right arm-Never.</del> | <del>Limited</del> |
| Reaching Forward      | Frequent (1/3 to 2/3 Day).            | Occasional (Up to 1/3 Day) left arm only; <del>Right arm-Never.</del> | <del>No</del>      |
| Writing               | Occasional (Up to 1/3 Day).           | Occasional (Up to 1/3 Day).                                           | Limited            |
| Coordination          |                                       |                                                                       |                    |
| Eye - Hand            | Occasional (Up to 1/3 Day).           | Occasional (Up to 1/3 Day) left arm only; <del>Right arm-Never.</del> | Limited            |
| Eye - Hand - Foot     | Occasional (Up to 1/3 Day).           | Occasional (Up to 1/3 Day) left arm only; <del>Right arm-Never.</del> | Limited            |
| Driving               | Occasional (Up to 1/3 Day). Forklift. | Occasional (Up to 1/3 Day) left arm only; <del>Right arm-Never.</del> | Limited            |
| Vision/Hearing        |                                       |                                                                       |                    |
| Near Acuity (<20 in.) | Frequent (1/3 to 2/3 Day).            | Frequent (1/3 to 2/3 Day).                                            | Yes                |
| Far Acuity (>20 ft.)  | Occasional (Up to 1/3 Day).           | Frequent (1/3 to 2/3 Day).                                            | Yes                |
| Color Vision          | Occasional (Up to 1/3 Day).           | Frequent (1/3 to 2/3 Day).                                            | Yes                |
| Depth Perception      | Occasional (Up to 1/3 Day).           | Frequent (1/3 to 2/3 Day).                                            | Yes                |
| Hearing               | Occasional (Up to 1/3 Day).           | Frequent (1/3 to 2/3 Day).                                            | Yes                |

\*Pushing and pulling values are measured as pounds of force.

## CLIENT PROFILE

The following information was obtained during the interview:

|                            |                             |
|----------------------------|-----------------------------|
| Previous Problems          | MI at 37 years old. Asthma. |
| Precautions/Contradictions | Twenty pound restriction.   |
| Hand Dominance             | Right                       |
| Date of Birth              | 12/04/1964                  |
| Height                     | 63 Inches                   |
| Weight                     | 200 Pounds                  |

Additional Comments: Initial Blood Pressure: 118/80 mmHg.

Ms. Hamilton's resting heart rate was 84 beats per minute.

### Previous Treatment

Ms. Hamilton reports having attended the following treatments in an attempt to rehabilitate her condition:

| Treatment            | Results/Comments                                                     |
|----------------------|----------------------------------------------------------------------|
| Physical Therapy     | Helped.                                                              |
| Occupational Therapy | Treatment; Did not progress because of right wrist and forearm pain. |

### Medical History

Ms. Hamilton indicates the following medical history:

| Medical History Checklist           |
|-------------------------------------|
| Recent Weight Gain                  |
| Memory Loss                         |
| Numbness/Tingling                   |
| Headaches                           |
| Balance Problems                    |
| Sinus Problems                      |
| Heart Problems                      |
| Chest Pain                          |
| Rheumatic Fever                     |
| Irregular Heart Beat                |
| Ulcers                              |
| Back Injury                         |
| Joint Injury/Pain                   |
| Arthritis                           |
| Anemia                              |
| Trouble Sleeping                    |
| Stress                              |
| Depression                          |
| Shortness Of Breath                 |
| Hayfever                            |
| Asthma                              |
| Bronchitis                          |
| Pneumonia                           |
| Smoked For 10 Years                 |
| Smoke 1 Packs of Cigarettes Per Day |
| Exposed To Second-Hand Smoke        |

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Ms. Hamilton also provides the following medical history and medication information:

| Area                         | Description                                              |
|------------------------------|----------------------------------------------------------|
| Surgeries                    | Tonsilectomy - OK. Left great toe laceration sutured-OK. |
| Prescription Medications     | IBU-800mg.                                               |
| Non-Prescription Medications | Tylenol Cold and Sinus.                                  |
| Medication Allergies         | Sulfa, Prednisone.                                       |
| Medical Devices              | Right thumb spica splint                                 |
| Additional Medical History   | MI at 37 years old, Asthma.                              |

Ms. Hamilton reports the following family illnesses:

| Family Illness       |
|----------------------|
| Diabetes             |
| Stroke               |
| Seizures/Convulsions |
| Cancer               |
| Heart Disease        |
| High Blood Pressure  |

Ms. Hamilton reports the following about members of her immediate family:

| Member | Age(s) | Cause of Death<br>(If Deceased) | Other Major Health Problems | Work<br>Related |
|--------|--------|---------------------------------|-----------------------------|-----------------|
| Father | 62     | Heart embolism.                 | None.                       |                 |

Ms. Hamilton provides the following work history:

| Area              | Comments/Specifics                                                                                                                                                                                                |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Work Environment  | Fiber Mill/Foundry<br>Lifting/carrying.                                                                                                                                                                           |
| Chemical Exposure | Extreme Changes In Temperature<br>Chromates<br>Large Amounts Of Dust<br>Lead<br>Loud Noises<br>Spray Paints<br>Pesticides<br>Plastics<br>Repetitive Motion/Vibration<br>Solvents /Degreasers<br>Welding/Soldering |

Ms. Hamilton reports the following job injuries:

| Description                                       | Approx. Date | Results                     |
|---------------------------------------------------|--------------|-----------------------------|
| Back and neck injury-did not report this incident | 2/2007?      | Resolved with chiropractor. |

Ms. Hamilton also provides the following job history:

| From       | To        | Position/Job Duties | Company              |
|------------|-----------|---------------------|----------------------|
| 10/12/2001 | Present ? | Color Technician    | Color-FL, Sumter, SC |

Ms. Hamilton's home environment is as follows:

|              |                      |
|--------------|----------------------|
| Resides With | Family of 2 children |
|--------------|----------------------|

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|                       |                                     |
|-----------------------|-------------------------------------|
| <b>Vision/Hearing</b> |                                     |
| Near Acuity (<20 in.) | Slightly blurred, otherwise normal. |
| Far Acuity (>20 ft.)  | Slightly blurred, otherwise normal. |
| Color Vision          | No limitation reported.             |
| Depth Perception      | No limitation reported.             |
| Hearing               | No limitation reported.             |

### Client's Work-Related Goals

Ms. Hamilton states that her current vocational goals are: To return to work.

### JOB DEMANDS

The table below reflects the job demands considered in this functional capacity evaluation.

These values were determined by reference to an interview with Ms. Hamilton and The Dictionary of Occupational Titles.

Ms. Hamilton's target job is Color-Shop Helper (DOT Code 550.687-018) in the "Any" industry classification (Industry Code 1566).

The DOT describes the target job as:

Assists DYE WEIGHER (any industry) in mixing dyes and chemicals for use in dyeing textile yarns and fabrics: Opens steam valve to heat dye solution. Stirs solution with paddle to dissolve dye. Dumps contents of mixing pails into or turns valve to transfer dye solution to supply tanks in dyeing department in response to light signal or to request over speaker system. Moves barrels of dye and chemicals to dye room, using handtruck. Cleans mixing tanks and work area, using waterhose. Performs other duties as described under HELPER (any industry) Master Title.

The Industry Description is:

This designation includes occupations that are not allocated to other classifications. The principal groups of jobs included under this designation are: (1) occupations that characteristically occur in practically all industries; (2) occupations that occur in a number of industries (which number is not exactly determinable) but that do not characteristically occur in most industries; and (3) occupations that are not considered to have any particular industrial attachment. The occupations included under this designation are considered to be essentially the same wherever they occur, in that they involve the same fundamental functions, and are performed for the same general purpose wherever they exist. Familiarity with a given job in one industry, however, may not permit a worker to transfer to the same job in another industry without some training period to acquaint the worker with the processes, terminology, hazards, or other factors in the industry to which he or she is being transferred that would affect the occupation in question in that industry. Many occupations that occur in various industries, and could logically fall within this group as defined above, are allocated to such classifications as

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CLERICAL AND KINDRED OCCUPATIONS (clerical); FOUNDRY (foundry); MACHINE SHOP (machine shop); PROFESSIONAL AND KINDRED OCCUPATIONS (profess. & kin.); and WOODWORKING (woodworking); all of which embrace occupations that cut across industry lines.

The typical work day is 720 minutes long with 60 minutes of lunch and other breaks resulting in a net time worked of 660 minutes.

|                            | Job Demand                                                                      | Client Concerns                               |
|----------------------------|---------------------------------------------------------------------------------|-----------------------------------------------|
| <b>Strength</b>            |                                                                                 |                                               |
| Lifting                    | Heavy. 70 lbs. from 0 to 60 inches. Occasional (Up to 1/3 Day). Pigment.        | Unable.                                       |
| Carrying                   | Heavy. 70 lbs. for 10 feet. Occasional (Up to 1/3 Day). Pigment.                | Unable.                                       |
| *Pushing                   | Medium. 50 lbs. for 300 feet. Occasional (Up to 1/3 Day). Palet jack            | Unknown.                                      |
| *Pulling                   | Medium. 50 lbs. for 300 feet. Occasional (Up to 1/3 Day).                       | Unknown.                                      |
| <b>Mobility</b>            |                                                                                 |                                               |
| Sitting                    | 60 minutes longest duration, 60 minutes per shift. Occasional (Up to 1/3 Day).  |                                               |
| Static Standing            | Rarely.                                                                         |                                               |
| Dynamic Standing           | 300 minutes longest duration, 300 minutes per shift. Frequent (1/3 to 2/3 Day). | Able.                                         |
| Walking                    | 300 minutes longest duration, 300 minutes per shift. Frequent (1/3 to 2/3 Day). | Able.                                         |
| <b>Agility</b>             |                                                                                 |                                               |
| Stairs/Ladders             | 200 steps/feet. Occasional (Up to 1/3 Day).                                     | Steps; Unknown ability.                       |
| Balancing                  | 200 feet with narrow conditions. Occasional (Up to 1/3 Day).                    | Limited by knee pain.                         |
| Bending/Stooping           | Frequent (1/3 to 2/3 Day).                                                      | Able.                                         |
| Crouching/Squatting        | Occasional (Up to 1/3 Day).                                                     | Able.                                         |
| Crawling                   | 3 feet. Rarely.                                                                 | Able.                                         |
| Twisting/Spinal Rotation   | Occasional (Up to 1/3 Day).                                                     | Able.                                         |
| Above-Shoulder Work        | To 72 inches. Occasional (Up to 1/3 Day).                                       | Unknown.                                      |
| Low-Level Work             | Frequent (1/3 to 2/3 Day).                                                      | Able.                                         |
| Prolonged Neck Positioning | Occasional (Up to 1/3 Day).                                                     | Able.                                         |
| Impact/Jarring             | Rarely.                                                                         | Bumping by other workers who are not careful. |
| <b>Dexterity</b>           |                                                                                 |                                               |
| Fine Finger                | Frequent (1/3 to 2/3 Day).                                                      | Limited right hand.                           |
| Grasping - Light           | Occasional (Up to 1/3 Day).                                                     | Limited right hand.                           |
| Grasping - Firm            | Frequent (1/3 to 2/3 Day).                                                      | Limited right hand.                           |
| Pinching                   | Occasional (Up to 1/3 Day).                                                     | Limited right hand.                           |
| Reaching Forward           | Frequent (1/3 to 2/3 Day).                                                      | Limited right hand.                           |
| Writing                    | Occasional (Up to 1/3 Day).                                                     | Limited right hand.                           |
| <b>Coordination</b>        |                                                                                 |                                               |
| Eye - Hand                 | Occasional (Up to 1/3 Day).                                                     | Limited right hand.                           |
| Eye - Hand - Foot          | Occasional (Up to 1/3 Day).                                                     | Limited right hand.                           |

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|                       |                                              |                                                             |
|-----------------------|----------------------------------------------|-------------------------------------------------------------|
| Driving               | Occasional (Up to 1/3 Day). Fork lift truck. | Limited right hand. Felt safe in fork lift truck operation. |
| Vision/Hearing        |                                              |                                                             |
| Near Acuity (<20 in.) | Frequent (1/3 to 2/3 Day).                   | Able.                                                       |
| Far Acuity (>20 ft.)  | Occasional (Up to 1/3 Day).                  | Able.                                                       |
| Color Vision          | Occasional (Up to 1/3 Day).                  | Able.                                                       |
| Depth Perception      | Occasional (Up to 1/3 Day).                  | Able.                                                       |
| Hearing               | Occasional (Up to 1/3 Day).                  | Able.                                                       |

\*Pushing and pulling values are measured as pounds of force.

## DEXTERITY

### Purdue Pegboard Test

The Purdue Pegboard Test was used to assess Ms. Hamilton's ability to use her hands in a coordinated and efficient manner. The following results were found:

|            | Score | Percentile |
|------------|-------|------------|
| Right Hand | 14    | 3.2        |
| Left Hand  | 16    | 40         |
| Both Hands | 11    | 3.2        |
| Assembly   | 40    | 66.4       |

- The client exhibited no signs of physical discomfort during the Purdue Pegboard Test.
- Ms. Hamilton demonstrated the following signs of competitive test performance during the Purdue Pegboard Test: quick correction following error and voiced exasperation.
- The Purdue Pegboard Test was terminated as it was successfully completed.
- No pain behaviors in sitting or with right hand and forearm.

### Complete Minnesota Dexterity Test

The Complete Minnesota Dexterity Test was used to assess Ms. Hamilton's ability to use her hands in a coordinated and efficient manner and to assess medium arm and hand dexterity. The following results were found:

|                              | Score | Percentile |
|------------------------------|-------|------------|
| Placing                      | 248   | 31-40      |
| Turning                      | 207   | 15-20      |
| Displacing                   | 192   | 40-50      |
| One Hand Turning and Placing | 171   | 10-15      |

- Ms. Hamilton was noted to stoop/bend at approximately <30 - 45° (mild - moderate) during the test. She exhibited compensatory postural habits producing slowed performance at approximately the 12 minute mark.
- 2-minute interval: briefly rubbed right wrist.
- 12-minute interval: briefly rubbed right wrist after 7 trials. During 8th trial, client briefly stopped, for about 1-second, to rest her right wrist. Right wrist discomfort level 2 reported.

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- 25-minute interval. Stopped testing. Client reported right hand fatigue. She showed several, brief, 1-second, self-rest periods during last trial. She rubbed right trapezius muscle area, right lower arm and right wrist.
- The client exhibited the following signs of physical discomfort during the Complete Minnesota Dexterity Test: increased lean on table, shaking out right hand, and holding/massaging right forearm and hand.
- Ms. Hamilton demonstrated the following sign of competitive test performance during the Complete Minnesota Dexterity Test: quick correction following error.
- Standing information: No limitations noted.

### Pinch Gauge

A pinch gauge was used to screen for bilateral pinch strengths. Ms. Hamilton's performance for pinch strength (in pounds) is presented as follows:

| Pinch         |     | Mean | Norm. | Standard Deviation | Result        | Comments                                                  |
|---------------|-----|------|-------|--------------------|---------------|-----------------------------------------------------------|
| 3 Point       | Dom | 14   | 17.9  | 3                  | Below Average | Rubbed right wrist. Supported with left hand.             |
|               | Non | 18   | 17.5  | 2.8                | Average       |                                                           |
| Fingertip     | Dom | 11   | 13.2  | 3                  | Average       |                                                           |
|               | Non | 11   | 12.1  | 2.7                | Average       |                                                           |
| Lateral Pinch | Dom | 17   | 17.6  | 3.2                | Average       | Rubbed right wrist. Rubbed right forearm after this test. |
|               | Non | 14   | 16.6  | 2.9                | Average       |                                                           |

### GRIP STRENGTH

As a function of hand dynamometer testing, information about the client's grip strength was collected. Using the five scores from her strongest grip span, she compares to a normative group using a five-position grip test as:

| Dominant (Right) Hand Grip Strength |            | Non-Dominant (Left) Hand Grip Strength |            |
|-------------------------------------|------------|----------------------------------------|------------|
| Client                              | Norm Group | Client                                 | Norm Group |
| 54.67                               | 62.2       | 82                                     | 56         |

- Results are in pounds. As can be seen from this table, the client demonstrates the dominant hand as being weaker than the normative group. Her non-dominant hand demonstrates as being stronger than the normative group. Hand dynamometer serial number 006392 was used for this portion of the test.
- During the grip strength test, the client was noted to show no signs of physical discomfort.
- Ms. Hamilton was observed to demonstrate no signs of competitive test performance during grip strength testing.

### The Canadian Standardized Test of Fitness (CSTF)

#### Intake Screening

Prior to any testing being performed, the client was screened for suitability to cardiovascular testing. The PAR-Q Questionnaire was used and the results of the questionnaire were as follows:

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|                                                             | Yes | No |
|-------------------------------------------------------------|-----|----|
| History of heart problems?                                  | X   |    |
| Frequent pain in heart or chest?                            |     | X  |
| Often feel faint or have severe dizziness?                  |     | X  |
| History of high blood pressure?                             |     | X  |
| Bone or joint problems, physician advised against exercise? | X   |    |
| Any reason not to partake in exercise?                      |     | X  |
| Over age 65 and not accustomed to exercise?                 |     | X  |
| Signed consent/release form?                                |     | X  |
| Pregnant?                                                   |     | X  |
| Difficulty breathing at rest?                               | X   |    |
| Persistent cough?                                           |     | X  |
| Lower extremity swelling?                                   |     | X  |
| Currently on medication?                                    | X   |    |
| Followed preliminary instructions?                          |     | X  |

### Walking

Ms. Hamilton was observed to walk over a primarily level terrain a distance of approximately 550 feet. This activity took place over a 2 minute period. Her heart rate prior to testing was 89 beats per minute, at the end was 96 beats per minute, and the maximum was 120 beats per minute.

- Ms. Hamilton was noted to demonstrate no signs of physical discomfort.
- The client demonstrated no signs of competitive test performance during the cardiovascular tests.
- Gait information: Normal.
- Self-paced walking; brisk pace.

### Cardiovascular Testing

Ms. Hamilton was tested for cardiovascular status during the functional capacity evaluation. Prior to this testing, she was screened for suitability as follows:

|                                    | Yes | No |
|------------------------------------|-----|----|
| High blood pressure?               |     | X  |
| Client over 45 years of age?       |     | X  |
| Smoker?                            | X   |    |
| Family history of heart disease?   | X   |    |
| Resting heart rate > 100 bpm?      |     | X  |
| Client on beta-blocker medication? |     | X  |
| Insulin dependant diabetic?        |     | X  |

- The client's blood pressure prior to the test was 118/80 mm Hg and her heart rate was 89 beats per minute.
- The client demonstrated no signs of physical discomfort during the cardiovascular tests.
- The client demonstrated no signs of competitive test performance during the cardiovascular tests.
- Cardiovascular testing was terminated as it was successfully completed.

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- Treadmill walking test: attained 2.5 mph @ 4.0% grade ~ 4.3 METs (equivalent to a LIGHT-TO-MEDIUM cardiovascular fitness level). HR=122 bpm. No pain behaviors.
- Post exercise heart rate (2-minutes): 102 bpm.

## MOBILITY

### Trunk Flexibility

The National Back Fitness Test was used to evaluate Trunk Flexibility. Forward bending was completed 3 out of 3 times to 0 inches from the floor. Right side bending was completed 3 out of 3 times to 19 inches from the floor. Left side bending was completed 3 of 3 times 19 inches from the floor.

- Ms. Hamilton demonstrated no signs of physical discomfort during this test.
- She demonstrated no signs of competitive test performance.
- Excellent lumbar flexibility. HR: 105 bpm.(60% AAMHR).

### Balance

- Ms. Hamilton was observed to partake in both upper- and lower-level balance testing using a 10-foot-long, 3.5-inch-wide beam.
- The client passed the basic balance test, but failed the upper level balance test: she should therefore avoid work on slippery, wet, narrow, elevated or erratically moving surfaces.
- Ms. Hamilton demonstrated the following sign of competitive test performance: voiced frustration at poor performance.
- Needs visual component for safe balance.

### Crouching

- Ms. Hamilton was observed to assume a position of sustained crouching for 15 seconds. Repetitive crouching was completed for 5 out of five trials. Crouching was completed slowly with no support required to rise.
- She demonstrated no signs of competitive test performance.
- Showed stiffness and guarding during 3 to 5th trials. HR: 120 bpm (68% AAMHR). Increased respiratory volume and rate after testing. Restricted ability. Worked into pain barriers; reported able to safely continue to complete testing.

### Squatting

- The client was observed to squat (i.e., with a straight back) for 15 seconds in succession. Squatting was completed slowly with support required to rise.
- Ms. Hamilton demonstrated the following sign of competitive test performance: compensatory body postures.
- Squat depth: 100%; Pushed off legs to rise. HR: 115 bpm (66% AAMHR).

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|         | Handle Height<br>(Inches) | Distance<br>(Feet) | Weight<br>(Pounds) | Percentile | Rating        |
|---------|---------------------------|--------------------|--------------------|------------|---------------|
| Trial 1 | 41                        | 14                 | 10                 | <10        | Below Average |
| Trial 2 | 41                        | 14                 | 10                 | <10        | Below Average |

- The client's post-test heart rate was 96 beats per minute.
- The client's maximum heart rate was 110 beats per minute.
- The client demonstrated the following signs of physical discomfort: pausing intermittently, holding/massaging right arm and hand, and facial grimace.
- The client exhibited no signs of competitive test performance during the test.

### PUSHING

Ms. Hamilton was observed to push a sled over a level terrain. The results are presented below:

|           | Handle Height<br>(Inches) | Distance<br>(Feet) | Force<br>(Pounds) |
|-----------|---------------------------|--------------------|-------------------|
| Initial   | 41                        | 25                 | 25                |
| Sustained | 41                        | 25                 | 13                |

- The client's maximum heart rate was 104 beats per minute.
- The client was noted to show no signs of physical discomfort.
- The client exhibited no signs of competitive test performance during the test.
- The test was terminated due to limped, favored right knee. Reported fatigue..
- Sled + 60 pounds. Increased respiratory rate and volume.

### PULLING

Ms. Hamilton was observed to pull a sled over a level terrain. The results are presented below:

|           | Handle Height<br>(Inches) | Distance<br>(Feet) | Force<br>(Pounds) |
|-----------|---------------------------|--------------------|-------------------|
| Initial   | 41                        | 25                 | 13                |
| Sustained | 41                        | 25                 | 7                 |

- The client's maximum heart rate was 104 beats per minute.
- The client was noted to show no signs of physical discomfort.
- The client exhibited no signs of competitive test performance during the test.
- The test was terminated due to other.
- Sled + 10 pounds. Increased respiratory rate and volume.

### MUSCULOSKELETAL EVALUATION – UPPER EXTREMITIES

| Shoulder Movement  | Active Range |      | Muscle Power |      |
|--------------------|--------------|------|--------------|------|
|                    | Right        | Left | Right        | Left |
| Flexion            | 180°         | 180° | 5/5          | 5/5  |
| Abduction          | 180°         | 180° | 5/5          | 5/5  |
| Medial Rotation    | 80°          | 80°  | 5/5          | 5/5  |
| Lateral Rotation   | 80°          | 80°  | 5/5          | 5/5  |
| Horizontal Flexion | 45°          | 45°  |              |      |

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|                      |     |     |  |  |
|----------------------|-----|-----|--|--|
| Horizontal Extension | 90° | 90° |  |  |
|----------------------|-----|-----|--|--|

| Elbow Movement | Active Range |      | Muscle Power |      |
|----------------|--------------|------|--------------|------|
|                | Right        | Left | Right        | Left |
| Flexion        | 150°         | 150° | 5/5          | 5/5  |
| Extension      | 0°           | 0°   | 5/5          | 5/5  |
| Pronation      | 80°          | 80°  |              |      |
| Supination     | 80°          | 80°  |              |      |

| Wrist Movement   | Active Range |      |
|------------------|--------------|------|
|                  | Right        | Left |
| Flexion          | 60°          | 60°  |
| Extension        | 60°          | 60°  |
| Radial Deviation | 20°          | 20°  |
| Ulna Deviation   | 30°          | 30°  |

**Assessment**

Hand motion: Full

**MUSCULOSKELETAL EVALUATION – LOWER EXTREMITIES**

| Hip Movement     | Active Range |      |
|------------------|--------------|------|
|                  | Right        | Left |
| Flexion          | 120°         | 120° |
| Extension        | 30°          | 30°  |
| Abduction        | 45°          | 45°  |
| Adduction        | 30°          | 30°  |
| Medial Rotation  | 45°          | 45°  |
| Lateral Rotation | 45°          | 45°  |

| Knee Movement | Active Range |      | Muscle Power |      |
|---------------|--------------|------|--------------|------|
|               | Right        | Left | Right        | Left |
| Flexion       | 135°         | 135° | 5/5          | 5/5  |
| Extension     | 0°           | 0°   | 5/5          | 5/5  |

| Ankle Movement  | Active Range |      | Muscle Power |      |
|-----------------|--------------|------|--------------|------|
|                 | Right        | Left | Right        | Left |
| Dorsi-Flexion   | 20°          | 20°  | 5/5          | 5/5  |
| Plantar-Flexion | 50°          | 50°  | 5/5          | 5/5  |
| Inversion       | 35°          | 35°  |              |      |
| Eversion        | 15°          | 15°  |              |      |

**Assessment**

No observable lower extremity limitations. Fair hamstring flexibility.

**MUSCULOSKELETAL EVALUATION – CERVICAL SPINE**

| Movement | Range |
|----------|-------|
| Flexion  | 45°   |

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|                          |     |
|--------------------------|-----|
| Extension                | 45° |
| Side Flexion Right       | 30° |
| Side Flexion Left        | 30° |
| Rotation Right           | 30° |
| Rotation Left            | 30° |
| Upper Cervical Flexion   | 0°  |
| Upper Cervical Extension | 0°  |

**Assessment**

No observable cervical limitations.

**MUSCULOSKELETAL EVALUATION – LUMBAR SPINE**

| Movement           | Range |
|--------------------|-------|
| Flexion            | 80°   |
| Extension          | 25°   |
| Side Flexion Right | 25°   |
| Side Flexion Left  | 25°   |
| Rotation Right     | 45°   |
| Rotation Left      | 45°   |

**Assessment**

Excellent lumbar flexibility.

**PHYSICAL EFFORT FINDINGS**

Physical Effort testing is used to evaluate whether or not attained physical data truly represents a client's physical maximums. If a client does not partake in her testing day with full physical effort, an evaluator cannot be certain that observed performances truly represent maximal abilities.

**Maximum Voluntary Effort (MVE) Testing****Five-Position Grip**

Ms. Hamilton underwent a formal screening procedure to query maximum voluntary effort during testing. This test uses the hand dynamometer (serial number 006392) to measure isometric force generated by the hand. The hand dynamometer is used to present ten maximum gripping measurements, each repeated three times. Studies indicate that out of 10 coefficients of variation calculated, no more than two will exceed experimentally derived "cut-points" if the individual is demonstrating maximum voluntary effort.

The results (in pounds) of Ms. Hamilton's testing are presented below:

| Grip Span | Test 1 |     | Test 2 |     | Test 3 |     |
|-----------|--------|-----|--------|-----|--------|-----|
|           | Dom    | Non | Dom    | Non | Dom    | Non |
| 1 1/4"    | 24     | 77  | 22     | 73  | 40     | 77  |
| 1 3/4"    | 58     | 86  | 47     | 82  | 47     | 78  |
| 2 1/4"    | 57     | 73  | 52     | 70  | 55     | 67  |
| 2 3/4"    | 50     | 62  | 45     | 62  | 48     | 62  |
| 3 1/4"    | 45     | 61  | 39     | 61  | 42     | 60  |

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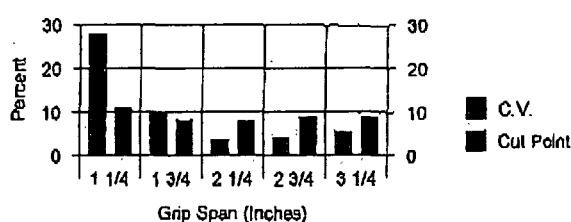
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Ms. Emma R Hamilton

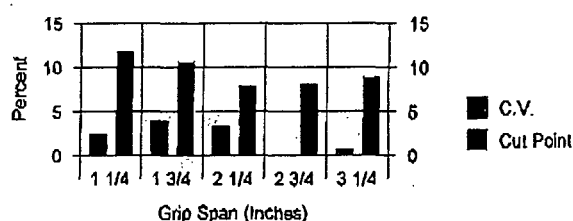
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| Grip Span | Coefficient of Variation |      | Exceed Cut Point? |     |
|-----------|--------------------------|------|-------------------|-----|
|           | Dom                      | Non  | Dom               | Non |
| 1 1/4"    | 28.1                     | 2.49 | Yes               | No  |
| 1 3/4"    | 10.23                    | 3.98 | Yes               | No  |
| 2 1/4"    | 3.76                     | 3.5  | No                | No  |
| 2 3/4"    | 4.31                     | 0    | No                | No  |
| 3 1/4"    | 5.83                     | .78  | No                | No  |

## Un-Impaired Dominant Upper Extremity



## Un-Impaired Non-Dominant Upper Extremity



Analysis of the client's scores demonstrates 2 coefficients of variation above the permissible cut-points. As a total of two scores are allowed above the cut-points, this is suggestive of maximum voluntary effort during testing.

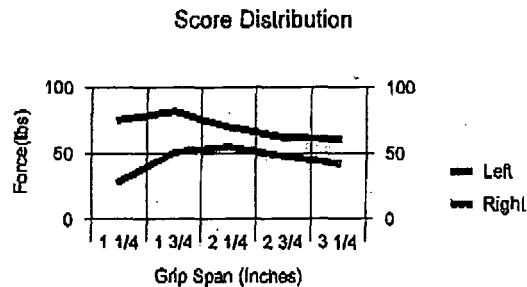
## Grip Curve Analysis

A second method of screening for the presence of maximal voluntary effort relates to the analysis of score distribution. If an evaluatee is providing maximum effort on the hand dynamometer, a bell curve pattern of score distribution is expected.

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Such a bell curve pattern was observed in Ms. Hamilton's case for her right hand and was present for her left hand, suggestive of maximum voluntary effort on the right and of maximum voluntary effort on the left. Hand dynamometer serial number 006392 was used for this portion of the test.

A second method of using bell curve analysis to gauge a client's level of physical effort relates to analysis of standard deviation. Clinical studies indicate that if a person is partaking in testing with full physical effort, a specific pattern of score distribution is expected.

**Right Upper Extremity:** Ms. Hamilton's right hand grip scores, produced a well distributed bell curve (S.D. = 9.03). Clinical studies suggest this standard deviation to be indicative of a high level of effort.

**Left Upper Extremity:** Ms. Hamilton's left hand grip scores, produced a well distributed bell curve (S.D. = 8.09). Clinical studies suggest this standard deviation to be indicative of a high level of effort.

### RELIABILITY OF PAIN AND DISABILITY REPORTS

Reliability of Pain and Disability Report testing is comprised of a battery of tests designed to better assess the dependability and accuracy of the client's subjective reports of pain and/or disability. The battery includes tests which evaluate the presence or absence of non-organic findings (findings that have more to do with illness behavior than underlying physical disease) as well as tests which compare a client's subjective reports to what she is actually capable of doing through the use of distraction based testing and observations of ability/disability.

Areas of testing, which fall under the Reliability of Pain and Disability Reports umbrella, include: symptom magnification, inappropriate illness behavior, somatic amplification, and non-organic signs.

### Pain Scales

Various pain scales were implemented with Ms. Hamilton to evaluate both the consistency and reliability of her subjective (verbal) reports. Visual Analog Pain Scale ratings correlated well with Functional Pain Scale ratings. Subjective ratings of pain

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matched well with distraction-based clinical observations. Repetitive movement reports matched well with clinical observations.

### Subjective Pain Levels

Ms. Hamilton states that she is experiencing pain in the areas indicated in the following table (these are based on the 0-10+ Functional Pain Rating Scale where 0 represents no pain and 10+ represents emergency pain warranting immediate emergency department care or hospitalization):

|             | Pre-Test Pain | Post-Test Pain |
|-------------|---------------|----------------|
| Right hand  | 1/10          | 3/10           |
| Right wrist | 1/10          | 2/10           |
| Right arm   | 3/10          | 3/10           |

Ms. Hamilton reported the following additional pain rating data:

|                                | Functional Pain Rating |
|--------------------------------|------------------------|
| Present Rating                 | 1/10                   |
| Best Rating Over Past 30 Days  | 1/10                   |
| Worst Rating Over Past 30 Days | 8/10                   |

The Visual Analog Pain Scale (Huskisson, 1974) was also used to evaluate the client's pain before and after the evaluation. The client's score at the beginning of the evaluation was 0.1 and the score at the end of the evaluation was 1.2. This indicates a difference of 1.1 points. These scores and their trend should be compared with the functional pain ratings recorded at the same time.

### Pain Assessment/Questionnaires

Ms. Hamilton completed a number of standard assessment questionnaires to assess the presence and impact of Chronic Pain Syndrome. These questionnaires have been published in peer-reviewed journals and are widely used in the industrial rehabilitation field.

| Questionnaire/Assessment                   | Score  | Interpretation                                    |
|--------------------------------------------|--------|---------------------------------------------------|
| The Visual Analog Scale (Today)            | 0.2 cm | Positive correlation with The Pain Rating Scale   |
| The Pain Rating Scale                      | 1 /10  | Positive correlation with The Visual Analog Scale |
| Oswestry Low Back Disability Questionnaire | 42 %   | Severe disability                                 |

### Comments

- During the intake interview process, the client was noted to show no signs of physical discomfort.
- Sitting behaviors: (Duration: 60 minutes). No sitting limitations but rubbed right arm during session. Client stood between events-moved because of her usual activeness.

Static testing:

|               |       |      |              |
|---------------|-------|------|--------------|
| 01/26/2010    |       |      |              |
| BTE Strength- | Right | Left | % difference |

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|                        |      |      |     |
|------------------------|------|------|-----|
| Wrist flexion (lbs.)   | 6.4  | 25.6 | 25% |
| Wrist extension (lbs.) | 2.4  | 8.2  | 29% |
| Elbow flexion (lbs.)   | 15.8 | 43.8 | 36% |
| Elbow extension (lbs.) | 22.6 | 33   | 68% |

01/26/2010

| BTE: Act.\ Date | Right | Left | Both |
|-----------------|-------|------|------|
| Bench Lift      | 29.5  | 60.2 | 50.5 |
| Cart: Push      | 21.4  | 41.7 | 40.5 |
| Cart: Pull      | 29.9  | 49.8 | 42.4 |

*End of Functional Capacity Evaluation Report for Ms. Emma R Hamilton*

Ms. Emma Hamilton

DOB: 12/4/1964

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Date/Time:** 12/1/09 8:14 am

**Start Time:** 7:45 **End Time:** 9:45  
**Session Duration:** 120

**OP OT Evaluation - Work Hardening**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning Evaluation**

**Provider #420051**

**HCIN:** 249170683

**Medical Diagnosis:** HAND/WRIST CRUSH INJURY

**Date of Injury:** 7/22/2008

**Employer:** Color Fi Inc.

**Job Title:** Color specialist

**Demographics:**

**Age:** 44

**Gender:** Female

**Primary Language:** English

**Referring Physician:** Dr. James E. Gee

**Past Medical History:** Asthma - intermittent problems. Allergic to steroids and sulfa drugs.

**Medications and Allergies:** Ibuprofen on occasion.

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No rehabilitation precautions. None.

**SUBJECTIVE**

**Premorbid Functional Level:** The patient reported the premorbid level of function was Very active.

**Patient Report:** Needs to return to work by January 14, 2010

**Patient Goals:** Patient's functional goals: To return to work at 100% as required by employer.

Client reported an active job; frequent to constant walking lifting, and carrying. She needed to carry 30 to 70 pound buckets of dye with a shoulder carry. She must also maneuver a 130-pound barrel of dye.

Additionally frequent bending, scooping, and dumping is required.

**Pain:** Patient reports pain.

**Location:** Right hand cramping feeling but no pain.

**Quality:** Cramping.

**Patient's reported level of pain** is 0 out of 10.

**Pain Interventions:** No pain intervention was facilitated because denies pain/discomfort at this time.

**Workers Comp Claim Number:** W/C 550-614499

**Case Manager:** Rasha

**Working:** Not working 1/15/2009

**Mechanism of Injury:** Hand caught in machine rollers.

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Follow-up Appt with MD:** 12/2/2009

**Pre-injury Status Job Demands:** A job description was not provided to therapist.

Dictionary of Occupational Titles Physical Demand Level: Heavy (Lift and carry up to 70 pounds)

## OBJECTIVE

**General Observation:** The patient ambulated to the clinic, was not using oxygen, and was accompanied by no one. In no apparent distress.

**Hand Dominance:** Right.

**Range of Motion:** Within Normal Limits throughout both UEs.

**Strength:**

**Sensation:** Grossly intact.

**Edema:** No edema present.

**Palpation:** No significant tenderness right hand and wrist.

**Gait:** Walking

Level of Assistance: Independent

### Pinch Summary

|        | Right | Left  |     |
|--------|-------|-------|-----|
| Palmar | 13.00 | 23    | 57% |
| Key    | 16.00 | 20.00 | 80% |
| Tip    | 11.00 | 12.00 | 92% |

### Grip

| Trial    | Right  | Left  |
|----------|--------|-------|
| 1        | 72.00  | 85.00 |
| 2        | 60.00  | 76.00 |
| 3        | 52.00  | 84.00 |
| Mean     | 61.33  | 81.67 |
| Std.Dev. | 8.22   | 4.03  |
| CV       | 13.40% | 4.93% |

| Norm-mean | Norm-SD | Patient-Mean | Patient-SD |
|-----------|---------|--------------|------------|
| 73        | 16      | 61.33        | -0.73      |
| 66        | 14      | 81.67        | 1.12       |

### BTE Static Strength Testing

| Activity            | Actual Strength | Occ. | Freq. | Const. | Rating |
|---------------------|-----------------|------|-------|--------|--------|
| Push @ cart height  | 34.5            | 17   | 9     | 3      | LIGHT  |
| Pull @ cart height  | 41.3            | 21   | 10    | 4      | LIGHT  |
| Lift @ bench height | 59              | 30   | 15    | 6      | LIGHT  |

BTE Strength-  
Wrist flexion      Right   Left  
                                 9.8   18.6   lbs.

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

|                 |      |      |       |
|-----------------|------|------|-------|
| Wrist extension | 15.8 | 54.5 | lbs.  |
| Pronation       | 47   | 72.5 | in-lb |
| Supination      | 40.3 | 53.3 | in-lb |
| Elbow flexion   | 31.6 | 32.4 | lbs.  |
| Elbow extension | 31.5 | 57.4 | lbs.  |

**Materials Handling:**

Carrying: 10 pounds-waist height carry position

Lifting: 5-pounds; 6-72 inch range-limited squatting endurance.

10-pounds; 42-72 inch range; Reported right arm fatigue; favored right arm; shook arm.

Height: 63"

Weight: 201

BP: 120/76 mmHg.

Endurance-Treadmill walk: 4.3 METs (LIGHT-TO-MEDIUM).

**Interventions:** None provided today.

**Pain Reassessment:** Patient currently has pain.

Reported pain level: Patient reports a pain level of 0 out of 10; "just fatigue".

**Education:** Education not assessed/provided this session.

**ASSESSMENT**

**Problem List:** Impaired functional mobility. Decreased strength. Limited activity tolerance.

**Equipment Needed:**

**Rehabilitation Potential:** Excellent

Motivation/Commitment to Therapy: Good.

**Support Structure:** Support structure is good. Family willing to assist patient.

**Response to Evaluation:** The session was tolerated well, as evidenced by: -

**LTG:** To return to work without restrictions (8 weeks)

**STGs:**

**1. Increase strength:**

**Carrying:**

50 pounds; 50 feet, waist height carry.

25 pounds; 50 feet. shoulder carry.

**Lift:** Floor to bench: 50 pounds; 6-48" range; power lift position with excellent body mechanics.

**Lift:** Bench to overhead; 25 pounds; 48-60" range; power lift position with excellent body mechanics.

**Leg strength:**

Crouch position: 5 reps of 15 seconds position hold.

Endurance: 6.3 METS for 5 minutes at 70% AAMHR.

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**PLAN**

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treatment Frequency, Duration, and Interventions:** Continued occupational therapy recommendations: 5 times/week x 4 weeks

Procedures: - WORK HARDENING

**Recommended Discharge Plan:**

The patient has been instructed to contact the clinic if any questions or problems should arise.

**Visit Number:** Today's visit is number 1

**Treatment Rendered:**

**Physician Certification:** This is to certify that the above named patient, who is under my care, requires skilled Occupational Therapy services as described in the above treatment plan. I further certify that the services outlined in this plan are skilled and medically necessary. I have reviewed this plan for rehabilitation services, and I recommend that these services continue from 12/1/2009 to 1/1/2010 to meet the goals stated above. **Treatment Diagnosis:** HAND/WRIST CRUSH INJURY

**Physician signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/1/09 5:00 pm

**Start Time:** 7:45 **End Time:** 9:45  
**Session Duration:** 120

**WORK RECOVERY EVALUATION - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u> | <u>Num.Performed</u> |
|-------------------------|--------------------|----------------------|
| OTWREVL                 | OTWR - EVALUATION  | 1.00                 |

**TREATMENT RENDERED:**

Work Hardening Eval: 120 minutes

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/3/09 9:16 am

**Start Time:** 10:00 **End Time:** 13:05  
**Session Duration:** 185

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

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**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 1000 hours    **Time Out:** 1305 hours

**SUBJECTIVE**

**Patient Report:** "I want to hurry up and get back to work by January 14th."  
**Pain:** Right hand  
**Pain Prior to Session:** 0/10  
**Pain After Session:** 1/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Orientation to the Work Hardening Clinic. safety and program outline.**

**Treadmill:** 2.5mph 15 minutes.

**1:1 Instruction in Back Flexibility exercises:** 3 reps each, 15 second hold.

**1:1 Instruction in Back Strengthening exercises:** 5 reps each, 2 second hold.

**UBE:** 6 minutes @ 60 rpm, 3 minutes each direction.

**Body Mechanics Education video.** 20 minutes seated.

**Body Mechanics Instruction:** She showed good carryover of knowledge gained from video.

**Lifting floor to 42" shelf:** 10 reps using good lifting techniques with 10 pounds.

**Cybex workout:** 2 sets of 10 reps completed of the following:

Arm Curls: 1 plate  
Triceps: 3 plates  
Shoulder shrugs: 3 plates  
Lats: 3 plates  
Knee extension: 3 plates  
Knee flexion: 4 plates

**Bike :** 15 minutes

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**Working overhead on 72" shelf** with a 4" step installing nuts and bolts into the Roylan Workstation, 10 minutes. She could work for approximately 2 minutes and then she would have to walk to give her UE's a

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

rest.

**ASSESSMENT**

She required cues for pacing. She wants to work full speed which is good, however due to her inactivity, she needs to gradually increase her work pace. RUE weakness demonstrated in work task requiring gripping.

**PLAN**

Increase work/exercise activity as tolerated.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 2

**Treatment Rendered:** Work Hardening I, Work Hardening II

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/3/09 9:17 am

**Start Time:** 10:00 **End Time:** 13:05  
**Session Duration:** 185

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num.Performed</u> |
|-------------------------|--------------------------------------|----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |

**TREATMENT RENDERED:**  
Work Hardening I, Work Hardening II

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/3/09 9:18 am

**Start Time:** 0:00 **End Time:** 0:00  
**Session Duration:** 0

\*\*\*This record has been deleted, please disregard\*\*\*  
**Deleted by:** NOBLES, SANDRA  
**CHARTED ON WRONG PATIENT.**

**OP OT Evaluation - Office Ergonomic**  
**Occupational Therapy**  
**Office Ergonomic Evaluation**

**Signed by:** SANDRA NOBLES - COTA/L

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Date/Time:** 12/4/09 10:03 am

**Start Time:** 8:00 **End Time:** 12:05  
**Session Duration:** 245

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0800 hours **Time Out:** 1205 hours

**SUBJECTIVE**

**Patient Report:** She reported soreness from her initial full day workout. Soreness in her UB and shoulders.  
**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 0/10; UB, Shoulders, 3/10  
**Pain After Session:** Right hand, 1/10; UB and shoulders, 1/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:  
**Hot packs to both shoulders:** For post-exercise pain.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 2.5mph 15 minutes.

**Cybox workout:** 2 sets of 10 reps completed of the following:

Arm Curls: 1 plate  
Triceps: 3 plates  
Shoulder shrugs: 3 plates  
Lats: 3 plates  
Knee extension: 3 plates  
Knee flexion: 4 plates  
Rowing: 1 plate  
Chest Fly: 1 plate

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Military Press: 1 plate

Bike : 10 minutes

Lifting floor to 42" shelf: 10 reps using good lifting techniques with 12 pounds.

Stair climber: 2 minutes.

R hand strengthening: moving 2.5 pound weights from shelf to overhead shelf, 10 reps.

Carrying 12 pound box both hands 25' from table to table. 10 reps.

Push/Pull sled: 10 reps, 30 pounds, 100'.

Right hand prehension board: 10 minutes with stretch breaks.

Right hand work at WEST using hammer and 2.5 pounds. 10 minutes from 42" to 84".

## ASSESSMENT

Hand fatigued easily during strengthening exercises. She continues to work at a fast pace.

## PLAN

Increase work/exercise activity as tolerated.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 3

**Treatment Rendered:** Work Hardening I, Work Hardening II

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/4/09 10:20 am

**Start Time:** 8:00 **End Time:** 12:05  
**Session Duration:** 245

## WORK RECOVERY PROGRESS NOTE - CHARGES ONLY

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work Hardening I, Work Hardening II

**Signed by:** SANDRA NOBLES - COTA/L

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Date/Time:** 12/7/09 1:34 pm

**Start Time:** 8:10 **End Time:** 12:20  
**Session Duration:** 250

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0810 hours **Time Out:** 1220 hours

**SUBJECTIVE**

**Patient Report:** "I have more energy today".  
**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 1/10  
**Pain After Session:** Right hand, 3/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Treadmill:** 3.0 mph 20 minutes.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Cybex workout:** 2 sets of 10 reps completed of the following:

Arm Curls: 1 plate  
Triceps: 3 plates  
Shoulder shrugs: 3 plates  
Lats: 3 plates  
Knee extension: 3 plates  
Knee flexion: 4 plates  
Rowing: 1 plate  
Chest Fly: 2 plates  
Military Press: 1 plate

187

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Bike :** 10 minutes

Break 10 minutes

**Lifting floor to 42" shelf:** 10 reps using good lifting techniques with 17 pounds.

**Lifting 42" shelf to 70" shelf:** 10 reps, 15 pounds.

**Treadmill:** 15 minutes.

**Push/Pull sled:** 10 reps, 40 pounds, 100'.

**Stair climber:** 2 minutes.

**Screw/Screwdriver board:** Kneeling/squatting, 15 minutes.

**Carrying** 15 pound box both hands 25' from table to table. 10 reps.

**10 minute break**

**Carrying bucket , right hand around clinic,** 10 reps, 10 pounds.

**BTE tool 162,** gripping, 150 seconds.

**Stair climber:** 2 minutes.

**Right hand prehension board:** 10 minutes with stretch breaks.

**Right hand work at WEST using hammer** and 2.5 pounds. 10 minutes from 42" to 84".

## **ASSESSMENT**

Increased work task today..

## **PLAN**

Increase work/exercise activity as tolerated.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 4

**Treatment Rendered:** Work Hardening I, Work Hardening II

**Signed by:** SANDRA NOBLES - COTA/L

188

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Date/Time:** 12/7/09 1:49 pm

**Start Time:** 8:10 **End Time:** 12:20  
**Session Duration:** 250

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work Hardening I, Work Hardening II

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/8/09 8:35 am

**Start Time:** 8:30 **End Time:** 12:30  
**Session Duration:** 240

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0830 hours **Time Out:** 1230 hours

**SUBJECTIVE**

**Patient Report:** "I had 1/2 of an energy dring this morning".  
**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 1/10  
**Pain After Session:** Right hand, 1/10, fatigue

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Treadmill:** 3.5 mph 30 minutes, 1.32 miles.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

189

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**BTE tool 162,** gripping, 150 seconds.

**Carrying bucket , right hand around clinic,** 10 reps, 15 pounds.

**Cybex workout:** 3 sets of 10 reps completed of the following:

Arm Curls: 3 plates  
Triceps: 3 plates  
Shoulder shrugs: 3 plates  
Lats: 3 plates  
Knee extension: 3 plates  
Knee flexion: 4 plates  
Rowing: 3 plates  
Chest Fly: 2 plates  
Military Press: 1 plate

Break 10 minutes

**Bike :** 10 minutes

**Lifting floor to 42" shelf:** 10 reps using good lifting techniques with 20 pounds.

**Lifting 42" shelf to 70" shelf:** 10 reps, 15 pounds.

**Valpar work bench:** 1 hour. She reported hand fatigue.

**Push/Pull sled:** 10 reps, 60 pounds, 100'.

**Roylan box** 15 minutes from the floor.

**Treadmill:** 15 minutes.

## **ASSESSMENT**

Increased lifting weight today. She shows motivation and determination during treatments.

## **PLAN**

Increase work/exercise activity as tolerated.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 5

190

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/8/09 1:19 pm

**Start Time:** 8:30 **End Time:** 12:30  
**Session Duration:** 240

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num.Performed</u> |
|-------------------------|--------------------------------------|----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |

**TREATMENT RENDERED:**  
Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/9/09 8:37 am

**Start Time:** 8:25 **End Time:** 11:30  
**Session Duration:** 185

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1130 hours

**SUBJECTIVE**

**Patient Report:** "I can tell that I can get in and out of the car better now".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 1/10

**Pain After Session:** Right hand, 1/10, fatigue

**OBJECTIVE**

Ms. Hamilton completed/received the following:

191

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 3.8 mph 30 minutes, 1.35 miles.

**BTE tool 162,** gripping, 150 seconds.

**Lifting 42" shelf to 70" shelf:** 10 reps, 15 pounds.

**Carrying 20 pound** box around clinic 10 reps.

**10 minute break**

**Bike 10 minutes**

**Carrying bucket up and down stairs,** 5 reps, 10 pounds.

**Push/pull sled:** 60 pounds 100 feet, 10 reps.

**Screwing screws** into wood board, 10 minutes.

**Lifting floor to 42" shelf:** 3 reps using good lifting techniques with 25 pounds.

**Cybex workout:** 3 sets of 10 reps completed of the following:

Arm Curls: 3 plates  
Triceps: 3 plates  
Shoulder shrugs: 3 plates  
Lats: 3 plates  
Knee extension: 3 plates  
Knee flexion: 4 plates  
Rowing: 3 plates  
Chest Fly: 2 plates  
Military Press: 1 plate

Carrying a bucket 1/3 filled with water 20 feet and raising to 36" sink to pour out, 3 reps.

**ASSESSMENT**

Improvement noted in carrying and lifting and using right hand for tools.

**PLAN**

Increase work/exercise activity as tolerated.

192

The patient has been instructed to contact our clinic if any questions or problems should arise.

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Visit Number:** 6

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/9/09 8:40 am

**Start Time:** 8:25 **End Time:** 11:30  
**Session Duration:** 185

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num.Performed</u> |
|-------------------------|--------------------------------------|----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |

**TREATMENT RENDERED:**  
Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/11/09 8:25 am

**Start Time:** 8:30 **End Time:** 12:10  
**Session Duration:** 220

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0830 hours **Time Out:** 1210 hours

**SUBJECTIVE**

**Patient Report:** None

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 1/10

**Pain After Session:** Right hand, 1/10

**OBJECTIVE**

193

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Ms. Hamilton completed/received the following:

**Treadmill:** 3.8 mph 30 minutes, 1.35 miles.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**BTE tool 162:** gripping, 150 seconds.

**Lifting 42" shelf to 70" shelf:** 10 reps, 15 pounds.

**Carrying 20 pound** box around clinic 10 reps.

**10 minute break**

**Push/pull sled:** 60 pounds 100 feet, 10 reps.

**Lifting floor to 42" shelf:** 10 reps, 25 pounds.

**Cybox workout:** 3 sets of 10 reps completed of the following:

Arm Curls: 3 plates

Triceps: 3 plates

Shoulder shrugs: 3 plates

Lats: 3 plates

Rowing: 3 plates

Chest Fly: 2 plates

Military Press: 1 plate

Paper cutting between activities.

**Stair climber** 2 minutes

**Treadmill** 15 minutes

**Flexibility exercises**

**Bike** 5 minutes.

## **ASSESSMENT**

She continues to do well.

## **PLAN**

Increase work/exercise activity as tolerated.

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 7

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/11/09 8:50 am

**Start Time:** 8:30 **End Time:** 12:10  
**Session Duration:** 220

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num.Performed</u> |
|-------------------------|--------------------------------------|----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |

**TREATMENT RENDERED:**  
Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/14/09 8:36 am

**Start Time:** 8:30 **End Time:** 9:30  
**Session Duration:** 60

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0830 hours **Time Out:** 0930 hours

**SUBJECTIVE**

**Patient Report:** "My hand has really been hurting right here since yesterday". See below,

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 5/10

195

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Pain After Session:** Right hand, 5/10

**OBJECTIVE**

I observed Ms. Hamilton shaking her right hand and rubbing the ulnar side of her hand. She stated that she had not injured her hand over the weekend nor could she pin point any activity that could have caused the increased discomfort. I asked the OTR to assess her hand and advise tx. The OTR advised that we not have her participate in activity today other than her treadmill and stretches due to the hand pain and lack of use observed by therapist. The OTR placed a call to the physician, however he was not in the office today. The Dr. will return our call on Tuesday.

Ms. Hamilton completed/received the following:

**Hot pack to right hand:** 20 minutes.

**Treadmill:** 3.8 mph 30 minutes, 1.35 miles.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**ASSESSMENT**

Increased hand pain today. Decreased use of right hand noted.

**PLAN**

Hold resistive activities today per OTR and have hand reassessed tomorrow.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 8

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/14/09 8:45 am

**Start Time:** 8:30 **End Time:** 9:30  
**Session Duration:** 60

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work Hardening

196

**Signed by:** SANDRA NOBLES - COTA/L

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Date/Time:** 12/15/09 8:30 am

**Start Time:** 8:25 **End Time:** 12:15  
**Session Duration:** 230

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1215 hours

**SUBJECTIVE**

**Patient Report:** "I took 1/2 of an Ibuprofen last night and I think that helped". She reported that her whole hand had been numb during the night.

**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 1/10  
**Pain After Session:** Right hand, 3/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Treadmill:** 3.8 mph 30 minutes, 1.53 miles.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

BTE tool 162 and 151.

Lifting shelf to overhead 15 lb. 10 reps.

Carrying 20 lb. 10 reps.

10 minute break.

197

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Push/Pull sled 60 lb. 10 reps. She was observed shaking her hand and rubbing her hand between reps.

Lifting floor to shelf, 20 lb, 10 reps. She was unable to complete the goal of 25 lbs. today. She reported that it caused the ulnar side of her hand to hurt.

Arm curls, 3 plates, 3X10.  
Triceps, 4 plates, 3X10.  
Rowing, 3 plates, 3X10.  
Shoulder shrugs, 2 plates, 3X10  
Chest fly, 2 plates, 3X10  
Lats, 3 plates, 3X10  
Military press, 1 plate 3X10

Stair stepper, 2 minutes

10 minute break

Paper cutting, 5 minutes

Carry bucket around clinic 10 reps, 15lbs.

Treadmill 30 minutes.

### **ASSESSMENT**

Pain behaviors were displayed today however she only reported minimal increase in her hand pain. I feel that she may be under reporting her hand pain due to the deadline she has for returning to work.

### **PLAN**

Continue to await call from MD.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 9

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/15/09 8:45 am

**Start Time:** 8:25 **End Time:** 12:15  
**Session Duration:** 230

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

| <u>Completed Orders</u>                      | <u>Description</u>                   | <u>Num.Performed</u> |
|----------------------------------------------|--------------------------------------|----------------------|
| OTWRWKADD                                    | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKADD                                    | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKINT2                                   | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |
| <b>TREATMENT RENDERED:</b><br>Work Hardening |                                      |                      |

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/16/09 9:25 pm

**Start Time:** 8:25 **End Time:** 11:10  
**Session Duration:** 165

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u>                                   | <u>Description</u>                   | <u>Num.Performed</u> |
|-----------------------------------------------------------|--------------------------------------|----------------------|
| OTWRWKADD                                                 | OTWR - WORK HARDENING EA. ADD        | 1.00                 |
| OTWRWKINT2                                                | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |
| <b>TREATMENT RENDERED:</b><br>Work hardening: 165 minutes |                                      |                      |

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/16/09 10:12 pm

**Start Time:** 8:25 **End Time:** 11:10  
**Session Duration:** 165

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1110 hours

**SUBJECTIVE**

**Patient Report:** Client reported that her right hand feels all right (level 0). Client reported discomfort in her hand "but the rest of my body hurt."

I spoke with Dr. Gee's nurse, and later to Dr. Gee. Both instructed me to continue with therapy and help client work through her discomfort. He reported that an MRI was performed which did not indicate a navicular fracture. Dr. Gee said he would recheck the MRI report and would advise me. (Received fax of MRI report - no fracture mentioned.)

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

During her therapy session, client reported information about a previous right wrist evaluation from a second opinion physician. She said that she possessed a report that used the words: avascular necrosis and snuff box.

**Pain:** Patient currently without complaints of pain.

**Pain Prior to Session:** The patient reported the following with regard to pain this date: Location and Level: No discomfort during beginning of therapy but feels intermittent pain with moderate hand use.

**Pain After Session:** The patient reported the following with regard to pain this date: Location and Level: No discomfort.

**OBJECTIVE**

**General Observation:** In no apparent distress.

**Treadmill:** Client completed exercise on the treadmill for 30 minutes, 2.5-2.7 mph, 4.0% grade. Her heart rate measured varied between 120 and 130 bpm. She reported ankle discomfort during her walk.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**BTE tool 162 and 151.** Client completed her program of right hand grip and pinch exercises. She reported an increase of her right hand and wrist discomfort.

**Lifting:** 15-pounds. Shelf to overhead. completed 10 repetitions.

**Carrying:** 20 pounds. Bilateral, 30 feet, 10 repetitions.

**Break:** 15 minutes

**Push/Pull sled:** 30 feet, 3 repetitions.

Client reported increased right wrist discomfort and she began to withdraw during my check of her wrist. She reported increased tenderness in her snuff box with moderate pressure and withdrew her hand.

Client reported increased right wrist discomfort to a significant level. This decreased to no discomfort after 15 to 20 minutes of rest. During this time client reported of her e-mailed report from Dr. Moore, a general surgeon from Columbia, a second opinion physician. Client thought that Dr. Moore's report was sent to Dr. Gee, but was not certain of this delivery.

Client said that she would e-mail this report to me.

200

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Time:** Decreased  
**Performance:** Decreased.

**Material Handling**

**Current Demonstrated Physical Demand Level:** LIGHT  
**Performance:** Decreased.  
**Static Postures:** No change.

**Job Simulation**

**Current Demonstrated Physical Demand Level:** Light  
**Performance:** Decreased.  
**Static Postures:** No change

Client completed job simulated tasks of: Lifting, carrying, pushing and pulling.

**Pain Reassessment:**

Response to Pain Intervention: Pain reduced to level 0 with rest.  
Post Intervention Pain Quality: Throbbing.  
Patient Reports Post Intervention Pain Level of: 0 out of 10  
Pain Acceptable: Yes

**Education:**

The patient's preferred learning method is: Doing.  
Barriers to Learning: No barriers.  
Education Needs: Instructed, practiced, and given home exercise program. Precautions.

Education Provided: Precautions.

Audience: Patient.

Mode: Explanation.

Response: Applied knowledge.

**ASSESSMENT**

**Therapy Diagnosis:** Right hand crush injury

**Response to Visit:** Appears to understand information presented. Tolerated session without difficulty.

**Clinical Status Changes:** Patient has experienced significant, unusual or unexpected change in clinical status since their last visit. Patient does not require a re-evaluation. Physician instructed to continue with right wrist exercise.

**Progress Toward Goals:** See Progress Summary.

**PLAN**

**Treatment Frequency, Duration, and Interventions:** Occupational Therapy is recommended for 5 days per week for 4 hours. Occupational Therapy treatment is to include: Work Hardening.

**Equipment Provided:** None issued this visit.

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**Development of Plan of Care:** There was no change to plan of care today.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Visit Number:** Today's visit is number 10

**Treatment Rendered:**

Work Hardening - Initial 2 hours minutes.  
Work Hardening - Each Additional minutes.

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/17/09 10:23 am

**Start Time:** 8:15 **End Time:** 12:15  
**Session Duration:** 240

OP OT Note - Work Hardening Daily Progress  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0815 hours **Time Out:** 1215 hours

**SUBJECTIVE**

**Patient Report:** She reported no hand pain today.

**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 0/10  
**Pain After Session:** Right hand, 0/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Treadmill:** 30 minutes

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

202

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**BTE tool 162**

**BTE tool 151**

**BTE tool 504**

**BTE tool 302**

**Carrying 25 lb.** 10 reps.

**Push/Pull sled** 70 lb. 10 reps.

**Lifting floor to shelf**, 25 lb, 10 reps. She was observed grasping different areas of the box for hand comfort.

**Stair stepper**, 2 minutes

10 minute break

**Treadmill** 15 minutes.

**Carry bucket around clinic** 10 reps, 15lbs.

**Lifting floor to shelf**, 25 lb, 10 reps.

**Filling bucket 1/3 full with water** and carrying 20 feet to empty in sink. 5 reps.

**Cybex Program:**

Arm curls, 3 plates, 3X10.

Triceps, 4 plates, 3X10.

Rowing, 3 plates, 3X10.

Shoulder shrugs, 2 plates, 3X10

Chest fly, 2 plates, 3X10

Lats, 3 plates, 3X10

Military press, 1 plate 3X10

**Paper cutting**, 5 minutes

10 minute break

**Filling bucket 1/3 full with water** and carrying 20 feet to empty in sink. 5 reps.

**ASSESSMENT**

Less pain behaviors displayed today during job simulation activities.

203

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**PLAN**

Progress in activity as tolerated.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 11

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/17/09 1:18 pm

**Start Time:** 8:15 **End Time:** 12:15  
**Session Duration:** 240

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening: 240 minutes

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/18/09 12:50 pm

**Start Time:** 8:25 **End Time:** 12:15  
**Session Duration:** 230

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1215 hours

204

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**SUBJECTIVE**

**Patient Report:** "I have more of a tired feeling in my hand than pain".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

**Pain After Session:** Right hand, 1/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Treadmill:** 30 minutes

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Cybex Program:**

Arm curls, 3 plates, 3X10.

Triceps, 4 plates, 3X10.

Rowing, 3 plates, 3X10.

Shoulder shrugs, 2 plates, 3X10

Chest fly, 2 plates, 3X10

Lats, 3 plates, 3X10

Military press, 1 plate 3X10

**10 minute break**

**Carrying 25 lb.** 10 reps.

**Push/Pull sled** 70 lb. 10 reps.

**Stair stepper,** 2 minutes

**Lifting floor to shelf,** 25 lb, 10 reps. She was observed grasping different areas of the box for hand comfort.

**Carry bucket around clinic** 10 reps, 25lbs.

**Lifting floor to shelf,** 25 lb, 10 reps.

**10 minute break**

**Positional tolerance:** Working overhead, forward reach and squatting at the WEST bars, placing nuts and bolts in holes from 72" to 12".

205

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Paper cutting**, 5 minutes

**Lifting shelf to overhead:** 10 reps, 15 pounds.

**Treadmill** 20 minutes.

**WORK CIRCUIT:**

Carry box around clinic 5 reps, 25 pounds.  
Paper cutting 3 minutes  
Stair climbing 1 minute  
Carry bucket around clinic 3 reps  
Push pull sled 3 reps  
She completed this circuit for 1 hour.

She was observed grimacing during activities. She was also observed shaking her hand and rubbing her hand and wrist. She never reported an increase in her hand pain despite her pain behaviors. I feel that she may be under reporting her pain so that she can return to work by the January 14th deadline.

**ASSESSMENT**

I feel that she may be under reporting her pain so that she can return to work by the January 14th deadline.

**PLAN**

Progress in activity as tolerated. Continue to monitor her pain behaviors and pain reports.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 12

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/18/09 1:31 pm

**Start Time:** 8:25 **End Time:** 12:15  
**Session Duration:** 230

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**

Work hardening:

206

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/21/09 1:34 pm

**Start Time:** 8:25 **End Time:** 9:45  
**Session Duration:** 80

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 0945 hours

**SUBJECTIVE**

**Patient Report:** "I don't have any pain, it just feels heavy and tired".

**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 0/10  
**Pain After Session:** Right hand, 1/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:  
spontaneous

**Treadmill:** 15 minutes

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Carrying 30 lb.** 5 reps. around clinic 75 feet. She carried the box with both hands for 1 lap and then transferred the weight to carry on her right shoulder. She stated, "This is how we carry weight at work when we get too tired".

**Push/Pull sled** 70 lb. 5 reps. She was observed with facial grimacing, shaking her right hand and rubbing/grasping her wrist. She stated, "It's just tired".

207

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Stair stepper, 2 minutes

Lifting shelf to overhead, 20 lb, 5 reps. I observed her using her arm for support on the right side rather than her hand.

Carry bucket up 2 steps and around clinic 75': Bucket weighted with 22 pounds water. She carried this for 1 round and she was observed with increased facial grimacing, making blowing sounds with her mouth and rubbing her wrist, shaking her RUE and stating, "Man", in an exaggerated fashion. She stated her hand felt tired and heavy. Again, she did not report an increase in pain when asked her to report her discomfort on the 10 point pain scale.

Refer to OTR's note dated today's date for details on action taken today.

**ASSESSMENT**

I feel that she may be under reporting her pain so that she can return to work by the January 14th deadline.

**PLAN**

See OTR's note dated today's date for plan.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 13

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/21/09 1:59 pm

**Start Time:** 8:25 **End Time:** 9:45  
**Session Duration:** 80

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num.Performed</u> |
|-------------------------|--------------------------------------|----------------------|
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/21/09 2:15 pm

**Start Time:** 17:00 **End Time:** 17:10  
**Session Duration:** 10

**OP OT WR Note - Contact Note**

MFR  
12/21/2008

208

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Ms. Emma Hamilton continued to show signs of right hand and arm discomfort. She persisted to show intermittent right hand and forearm rubbing, grimacing and protection signs of her right upper extremity.

Ms. Hamilton seemed to be underestimating her discomfort by limiting her pain-level reports along with the discussion of her pain characteristics. She continually focused on her return to work next month.

Last week, I received a faxed copy of client's MRI report, from Dr. Gee, that did not identify significant wrist pathology. He sent this to me because of my report to Dr. Gee of signs of possible wrist pathology. In response, Dr. Gee directed me to continue with work hardening to help client work into her pain barriers to attain her job requirements.

Additionally last week, client provided a copy of an email from a second-opinion physician, which identified wrist problems. Client did not know whether or not Dr. Gee received a copy of this report; however, she felt that he should have received this note.

Today, I asked client to take a copy of the email from her second-opinion physician to Dr. Gee, to discuss this issue with him as necessary and return with a note (to hold therapy until a possible evaluation or continue with therapy). Client said that she would follow my directive.

Next step: Client will return to the WRC after a review of above email with Dr. Gee.

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/28/09 12:47 pm

**Start Time:** 8:40 **End Time:** 12:10  
**Session Duration:** 210

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0840 hours **Time Out:** 1210 hours

209

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

## **SUBJECTIVE**

**Patient Report:** She reported that she went to the doctor and she gave the following report:

1. She presented an order from the physician to continue work hardening.
2. She stated, "Dr. Gee said he knew all about my hand and that I needed to stop complaining and keep working my hand. He also said that I could go and see that other doctor if I wanted to have surgery and go on disability".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

**Pain After Session:** Right hand, 5/10

## **OBJECTIVE**

Ms. Hamilton completed/received the following:

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 30 minutes

**Carrying 30 lb.** 5 reps. around clinic 75 feet. She was observed grimacing on the 3rd rep of this exercise. She stated, "My hand is just tired".

**Push/Pull sled** 70 lb. 5 reps. She was observed with facial grimacing, shaking her right hand and rubbing her wrist. She stated, "Pushing is much harder than pulling". She was also observed not fully grasping the handle of the sled with her right hand.

**Lifting floor to shelf:** 28 lbs. She was again observed grimacing and favoring the right hand with these lifts. She never reported an increase in pain only fatigue.

**Stair stepper,** 2 minutes

**Lifting shelf to overhead,** 20 lb, 5 reps. She hesitated between reps of this exercise.

**Carry bucket up 2 steps and around clinic 75':** Bucket weighted with 22 pounds water. She carried 5 rounds and she was observed with increased facial grimacing. She reported, "My hand is just tired and it feels heavy".

I cautioned her about her increasing pain levels and her increased pain with activity. She again stated that she was only having a feeling of heaviness and fatigue.

**Screw 1 screw** into the screwboard with right hand.

210

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Treadmill 15 minutes

**Carrying 30 lb.** 5 reps. around clinic 75 feet.

**Push/Pull sled** 70 lb. 5 reps. She was observed with facial grimacing, shaking her right hand and rubbing her wrist.

**Lifting floor to shelf:** She was unable to do the 28# and I reduced this to 25#. She stated this was better, however, she was still observed grimacing.

**Carrying 30 lb.** 5 reps. around clinic 75 feet. She was observed grimacing on the 3rd rep of this exercise. She stated, "My hand is just tired".

**Push/Pull sled** 70 lb. 5 reps. She was observed with facial grimacing, shaking her right hand and rubbing her wrist.

**Lifting floor to shelf:** She was unable to do the 28# and I reduced this to 25#. She stated this was better, however, she was still observed grimacing.

**Screw 1 screw** into the screwboard with right hand.

**ASSESSMENT**

She continues with pain behaviors when using her right hand. I feel that she is still under reporting her hand pain.

**PLAN**

Continue to monitor pain behaviors.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 14

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/28/09 1:06 pm

**Start Time:** 8:40 **End Time:** 12:10  
**Session Duration:** 210

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/28/09 2:35 pm

**Start Time:**13:00 **End Time:**13:30  
**Session Duration:** 30

**OP OT WR Note - Contact Note**  
**12/28/2009**  
**Additional Testing:**

Today, Ms. Hamilton brought a new prescription for the continuation of her work hardening program. She saw Dr. Gee last week. She will follow-up with Dr. Gee after her program.

I completed additional testing of functional performance because of client's current pain behaviors and report of "moderate discomfort". Results follow:

**GRIP:**

**Jamar Dynamometer Grip Test, Position 2**

| Trial           | Right | Left  |
|-----------------|-------|-------|
| 1               | 55.00 | 88.00 |
| 2               | 70.00 | 80.00 |
| 3               | 62.00 | 78.00 |
| <b>Mean</b>     | 62.33 | 82.00 |
| <b>Std.Dev.</b> | 6.13  | 4.32  |
| <b>CV</b>       | 9.83% | 5.27% |

|              | Norm-mean | Norm-SD | Patient-Mean | Patient-SD |
|--------------|-----------|---------|--------------|------------|
| <b>RIGHT</b> | 73        | 17      | 62.33        | -0.63      |
| <b>LEFT</b>  | 66        | 17      | 82.00        | 0.94       |

**%R/L= 76**

**Grip strength:**

On 12/1/2009, client's right hand grip strength measured 61.3 pounds.

On 12/1/2009, client's left hand grip strength measured 81.7 pounds.

**PINCH-Tip:**

| Tip          | Norm-mean | Norm-SD | Patient-Mean | Patient-SD |
|--------------|-----------|---------|--------------|------------|
| <b>RIGHT</b> | 18.7      | 4.9     | 10.00        | -1.78      |
| <b>LEFT</b>  | 17.6      | 4.1     | 14.00        | -0.88      |

**%R/L= 71**

212

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Tip strength,**

On 12/1/2009, client's right pinch -tip strength measured 11.0 pounds.  
On 12/1/2009, client's left pinch-tip strength measured 12.0 pounds.

**PINCH-Palmar:**

|              | Palmar | Norm-mean | Norm-SD | Patient-Mean | Patient-SD |
|--------------|--------|-----------|---------|--------------|------------|
| <b>RIGHT</b> | 17.9   | 3         | 16.00   | -0.63        |            |
| <b>LEFT</b>  | 17.5   | 2.8       | 17.00   | -0.18        |            |

**%R/L= 94**

**Palmar strength,**

On 12/1/2009, client's right pinch -palmar strength measured 13.0 pounds.  
On 12/1/2009, client's left pinch-palmar strength measured 23.0 pounds.

**PINCH-Lateral:**

|              | Lateral | Norm-mean | Norm-SD | Patient-Mean | Patient-SD |
|--------------|---------|-----------|---------|--------------|------------|
| <b>RIGHT</b> | 25.8    | 3.9       | 15.00   | -2.77        |            |
| <b>LEFT</b>  | 24.8    | 4.4       | 15.00   | -2.23        |            |

**%R/L= 100**

**Lateral strength,**

On 12/1/2009, client's right pinch -lateral strength measured 16.0 pounds.  
On 12/1/2009, client's left pinch-palmar strength measured 20.0 pounds.

**ASSESSMENT:**

GRIP: NO SIGNIFICANT CHANGE FROM INITIAL EVALUATION  
PINCH:TIP: NO SIGNIFICANT CHANGE FROM INITIAL EVALUATION  
PINCH:PALMAR: IMPROVEMENT FROM INITIAL EVALUATION  
PINCH:LATERAL: NO SIGNIFICANT CHANGE FROM INITIAL EVALUATION

**PLAN:** Continue with present treatment plan. To re-evaluate next week.

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/29/09 9:57 am

**Start Time:** 8:15 **End Time:** 12:10  
**Session Duration:** 235

**OP OT Note - Work Hardening Daily Progress**

213

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0815 hours    **Time Out:** 1210 hours

**SUBJECTIVE**

**Patient Report:** She reported that she had minimal hand pain today. "I just feel like it wants to lock up after it gets tired".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 1/10

**Pain After Session:** Right hand, 1/10, fatigue

**OBJECTIVE**

Ms. Hamilton completed/received the following:

I modified her program today with lighter weights and resistance due to the increase in pain behaviors displayed in the clinic during her last 2 treatments.

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 30 minutes

**BTE Program:** She completed the 4 exercises. Her resistance was reduced on these exercises. She was observed rubbing her hand after the exercise on tool 302, turning jar lid.

**Carrying 25 lb.** 5 reps. around clinic 75 feet. She used a crate to carry today for the handles. She reported a burning sensation in her wrist on the last rep.

**Arm curls:** 3 X 10 2 plates.

**Push/Pull sled** 60 lb. 10 reps. She showed facial expressions of grimacing with pushing.

214

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Triceps:** 3 X 10 3 plates.

**Lifting floor to table:** 28 lbs. 5 reps. Grimacing noted and she reported, "I think it's the gripping that bothers me".

**Stair stepper,** 3 minutes

**Rowing:** 3 plates, 3 X 10.

**Lifting shelf to overhead,** 20 lb, 5 reps. She was observed favoring the right hand and primarily using her left hand for this activity.

**Shoulder shrugs:** 2 plates, 3 X 10.

**Minnesota Board:** Using only her right hand, 2:07.

**Chest fly:** 2 plates, 3 X 10.

**Treadmill 15 minutes.**

**Lats:** 3 X 10, 3 plates.

**Carry 10 lb. bucket up and down 2 steps:** 10 reps. She again reported the "gripping" of the handle caused her hand to feel as if it was locking up".

**Military press:** 1 plate, 3 X 10.

**Lifting floor to shelf 1.25lb. weights 10 reps.**

**Minnesota Board:** Using only her right hand, 1:39.

**Lifting floor to table:** 20 lbs. 5 reps.

## **ASSESSMENT**

Pain behaviors continue even though her weights and resistance reduced.

## **PLAN**

Break up activities tomorrow to decrease repetitive lifting and monitor pain behaviors.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 15

215

**Treatment Rendered:** Work Hardening

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/29/09 10:26 am

**Start Time:** 8:15 **End Time:** 12:10  
**Session Duration:** 235

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/30/09 8:01 am

**Start Time:** 8:15 **End Time:** 12:20  
**Session Duration:** 245

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0815 hours **Time Out:** 1220 hours

**SUBJECTIVE**

**Patient Report:** Minimal pain reported today. No increase in pain or symptoms reported from yesterday's treatment.

After therapy, she reported, "Today wasn't as bad with the things broke up". She was referring to the break up of her work activities.

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 1/10

**Pain After Session:** Right hand, 1/10

216

**NAME:** HAMILTON, EMMA  
**ROOM:** WR:  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

## OBJECTIVE

Ms. Hamilton completed/received the following:

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 20 minutes

**BTE Program:** She completed the 4 exercises. I did not increase her resistance today. She reported less fatigue after these.

## **Work Circuit:**

**Carrying 25 lb.** around clinic 75 feet. She carried the weight low with her arms fully extended. She stated that she had a hard time bringing the weight up to her waist height.

**Arm curls:** 1 X 10 2 plates.

**Push/Pull sled** 60 lb.

**Triceps:** 1 X 10 3 plates.

**Lifting floor to table:** 20 lbs. She was unable to complete the goal weight today of 28 lbs.

**Stair stepper,** 1 minute

**Rowing:** 3 plates, 1 X 10.

**Lifting shelf to overhead,** 20 lb

**Shoulder shrugs:** 2 plates, 1 X 10.

**Minnesota Board:** Using only her right hand, 1:30, 1:36, 1:40.

**Chest fly:** 2 plates, 1 X 10.

**Treadmill 15 minutes.**

**Lats:** 1 X 10, 3 plates.

**Carry 10 lb. bucket up and down 2 steps:** 3 reps.

**Military press:** 1 plate, 1 X 10.

**Lifting floor to shelf 1.25lb. weights 10 reps.**

***She repeated the above work circuit 1 rep each unless otherwise noted. She completed this circuit 4 times.***

## ASSESSMENT

She showed decreased pain behaviors today with the change in her work circuit.

## PLAN

Continue to monitor pain behaviors and increase work task slowly.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 16

217

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 12/30/09 8:27 am

**Start Time:** 8:15 **End Time:** 12:20  
**Session Duration:** 245

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/5/10 12:31 pm

**Start Time:** 8:25 **End Time:** 12:20  
**Session Duration:** 235

\*\*\*This record has been deleted, please disregard \*\*\*

Deleted by: NOBLES, SANDRA  
DUPLICATE CHARTING

OP OT Note - Work Hardening Daily Progress

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi. Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1220 hours

**SUBJECTIVE**

**Patient Report:** "The driver did not pick me up yesterday"

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Pain After Session:** Right hand, 3/10

## OBJECTIVE

Ms. Hamilton completed/received the following:

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 20 minutes

**BTE Program:** She completed the 4 exercises. I did not increase her resistance today. She reported less fatigue after these.

## Work Circuit:

**Carrying 25 lb.** around clinic 75 feet. She carried the weight low with her arms fully extended. She stated that she had a hard time bringing the weight up to her waist height.

**Arm curls:** 1 X 10 2 plates.

**Push/Pull sled** 60 lb.

**Triceps:** 1 X 10 3 plates.

**Lifting floor to table:** 20 lbs. She was unable to complete the goal weight today of 28 lbs. She was observed rubbing her hand after this.

**Stair stepper:** 1 minute

**Rowing:** 3 plates, 1 X 10

**Lifting shelf to overhead:** 20 lb

**Shoulder shrugs:** 2 plates, 1 X 10.

**Minnesota Board:** Using only her right hand, 1:30, 1:36, 1:40.

**Chest fly:** 2 plates, 1 X 10.

**Treadmill 15 minutes.**

**Lats:** 1 X 10, 3 plates.

**Carry 10 lb. bucket up and down 2 steps:** 3 reps.

**Military press:** 1 plate, 1 X 10. She hesitated between each rep. She showed facial grimacing.

**Lifting floor to shelf 1.25lb. weights 10 reps.**

*She repeated the above work circuit 1 rep each unless otherwise noted. She completed this circuit 5 times.*

## ASSESSMENT

She reported her hand pain increased today with today's workout. No increased weights added today compared to last workout.

## PLAN

Continue to monitor pain behaviors and increase work task slowly.

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The patient has been instructed to contact our clinic if any questions or problems should arise.

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Visit Number:** 17

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/5/10 12:46 pm

**Start Time:** 8:25 **End Time:** 12:20  
**Session Duration:** 235

\*\*\*This record has been deleted, please disregard\*\*\*

**Deleted by:** NOBLES, SANDRA  
**DUPLICATE CHARTING**

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

**TREATMENT RENDERED:**

Work hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/15/10 4:54 pm

**Start Time:** 0:00 **End Time:** 0:00  
**Session Duration:** 0

**OP OT Note - Work Hardening Discharge Summary**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Discharge Summary**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

Patient has been seen for skilled occupational therapy services through the McLeod Work Recovery/Work Hardening Program since 12/1/2009. Patient participated in work hardening treatment sessions

**Progress Toward Goals:**

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Ms. Emma Hamilton completed 23 work hardening visits from 12/01/2009 to 01/13/2010.

Ms. Hamilton showed minimal improvement in therapy as related to her right hand and wrist. Her limiting factor involved her right wrist and forearm pain. She showed consistent and objective pain behaviors of right

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

wrist pain. These behaviors included but not limited to right wrist rubbing, right forearm protective posturing, right hand shaking, and right hand favoring. She showed these behaviors during mild and moderate level activities. Client received constant cueing to self-limit her right wrist pain during therapy (and at home) to protect her wrist joint and to minimize the development of overuse syndromes. Client showed increased work ability in cardiovascular and some bilateral arm activities.

Ms. Hamilton consistently showed high levels of motivation and she focused on returning to work by mid-January 2010. She constantly remarked of a desire to return to work. Client typically reported minimal right wrist discomfort, with a range from NO discomfort to moderate levels of discomfort. At times, it appeared that Ms. Hamilton possibly felt more discomfort than she reported, as shown by her pain behaviors. Often, she was stopped during her clinic work to assure and at times to demand rest to her arm to allow for recovery and pacing. Client's right wrist pain seemed focused in her right anatomical snuff box. I called Dr. Gee about this finding. He reported obtaining the MRI report of Ms. Hamilton's wrist. I received a copy of this report which did not identify significant pathology but mild degenerative changes. Dr. Gee advised me to continue to work with Ms. Hamilton to see if we could improve her work abilities.

Shortly afterwards, during the course of Ms. Hamilton's therapy, she mentioned to me that she obtained a second opinion from a Columbia SC physician who associated her with wrist pathology. He suggested an abutment syndrome and avascular necrosis as possibilities of Ms. Hamilton's condition. I advised Ms. Hamilton to notify Dr. Gee, and give him a copy of this e-mail report, because client did not know if Dr. Gee ever obtained this information. Client said there was another report but she could not find it. In turn, Ms. Hamilton presented a copy of this report to Dr. Gee for his review. On 12/28/2009, Ms. Hamilton returned with a prescription to continue with therapy.

Based upon client's right wrist continued discomfort, objective and consistent pain behaviors, the possibility of underestimating pain with possibly working into high pain levels, and minimal increases of her right hand function, I stopped therapy.

At the end of therapy, client showed the following work abilities:

Lift: Occasional, 20 pounds from floor to bench height  
Lift: Occasional, 10 pounds from bench to eye level  
Carry: Occasional, bilateral carry, 20 pounds for 15 feet, 10 occasions per day.  
Carry: Occasional, right hand: 10 pounds for 15 feet, 10 occasions per day.  
Push: Occasional, 15 pounds, 25 feet.  
Pull: Occasional, 15 pounds, 25 feet.  
Sit: Unrestricted.  
Stand: Unrestricted.  
Walk: Unrestricted.  
Reach:

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Left hand-all positions: Unrestricted.

Forward and/or bended reach, right hand: Impaired- 5 minutes per occasion; four occasions per day.

Total 20 minutes.

Overhead reach, right hand: Impaired- 2 minutes per occasion; five occasions per day; Total 10 minutes.

Lower level work: Unrestricted.

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/01/2009  
**CHART:** WR 11825

**Account ID:** 000116529934  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Grasping/fingering-Light: Left hand: Unrestricted.  
Grasping/fingering-Heavy: Left hand: Unrestricted.  
Grasping/fingering-Light: Right hand: Impaired- 5 minutes per occasion; four occasions per day. Total 20 minutes.  
Grasping/fingering-Heavy: Right hand: Never.

| Right UE              | 12/01/2009 | 01/07/2010 | % change |
|-----------------------|------------|------------|----------|
| Elbow flexion (lbs)   | 31.6       | 25.1       | 79%      |
| Elbow extension (lbs) | 31.56      | 28.7       | 91%      |
| Wrist flexion (lbs)   | 15.8       | 15.7       | 99%      |
| Wrist extension (lbs) | 9.8        | 10.9       | 111%     |
| Pronation (lbs)       | 47         | 42.8       | 91%      |
| Supination            | 40.3       | 43         | 107%     |

| Act.\ Date | 12/01/2009 | 12/31/2009 | % change |
|------------|------------|------------|----------|
| Grip-R     | 61         | 64         | 105%     |
| Lift       | 59         | 20         | 34%      |
| Carry      | 10         | 20         | 200%     |
| Push       | 35         | 59         | 169%     |
| Pull       | 41         | 63         | 154%     |
| METs       | 4.3        | 5          | 116%     |

Patient has been discharged from therapy and a report has been sent to the physician.

**Treatment Rendered:** None.

**Signed by:** JOHN ZELENKA - OTR/L

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Date/Time:** 12/31/09 8:06 am

**Start Time:** 9:00 **End Time:** 11:00  
**Session Duration:** 120

**WORK RECOVERY REEVALUATION - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>   | <u>Num. Performed</u> |
|-------------------------|----------------------|-----------------------|
| OTWRREVL                | OTWR - RE-EVALUATION | 1.00                  |

**TREATMENT RENDERED:**  
Work Hardening re-evaluation: 120 minutes

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 12/31/09 8:08 pm

**Start Time:** 9:00 **End Time:** 11:00  
**Session Duration:** 120

**OP OT Reassessment - Work Hardening**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning Re-Evaluation**  
**Document Type:** Re-evaluation

**Provider #**420051  
**HCIN:** 249170683  
**Medical Diagnosis:** HAND/WRIST CRUSH INJURY  
**Date of Injury:** 7/22/2008  
**Employer:** Color Fi Inc.  
**Job Title:** Color specialist  
**Demographics:**  
    **Age:** 44  
    **Gender:** Female  
**Primary Language:** English  
**Referring Physician:** Dr. James E. Gee  
**Past Medical History:** Asthma - intermittent problems. Allergic to steroids and sulfa drugs.  
**Medications and Allergies:** Ibuprofen on occasion.  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No rehabilitation precautions. None.

**SUBJECTIVE**

**Premorbid Functional Level:** The patient reported the premorbid level of function was independent ADLs and competitive work ability.  
**Current Functional Limitations:** The patient/caregiver reports the following functional limitations: Reduced right arm and hand strength.  
**Patient Report:** Reduced right hand strength and dexterity because of wight forearm and wrist pain.  
**Patient Goals:** Patient's functional goals: To return to work without restrictions.  
**Pain:** Patient currently has pain.  
**Location:** Right wrist  
**Type:** Chronic

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Quality: Aching.

Patient reports a current pain level of 1 out of 10.

Patient's reported highest level of pain 8 out of 10.

Patient's reported at rest pain 1 out of 10.

Patient's reported lowest level of pain 0 out of 10.

Pain is alleviated by: Rest to right hand and wrist.,

Pain is exacerbated by: Prolonged use of right hand.

**Pain Interventions:** No pain intervention was facilitated because denies pain/discomfort at this time.

**Self-reported Quality of Life:** At present time, patient reports having a fair quality of life/health status.

## **OBJECTIVE**

### **Strength**

**Lifting:** Job demand: 70 pounds, floor to shoulder height Reported ability: 20 pounds, floor to shoulder  
Demonstrated: 20-pounds from floor to shoulder height; limited by right wrist strength in both pronation and  
supination in this bilateral lift. Left hand lift, floor to waist: 70 pounds. Right hand lift, floor to waist: 30  
pounds.

**Carrying:** Job demand: 70 pounds, 100 feet Reported ability: 28 pounds, 100 feet Demonstrated: 20  
pounds bilateral.

**Pushing:** Job demand: 200-300 pound pallet and box Reported ability: 30 pounds, 60 feet Demonstrated:  
30 pounds

**Pulling:** Job demand: 200-300 pound pallet and box Reported ability: 30 pounds, 60 feet. Demonstrated: 32  
pounds

### **BTE strength testing:**

Push: Right: 42.5 pounds; Left: 55.7 pounds; Both: 59.3 pounds

Pull: Right: 40.0 pounds; Left: 68.4 pounds; Both: 63.9 pounds

### **Mobility**

**Sitting:** Job demand: 60 minutes, intermittent sitting Reported ability: Client reported able to meet job  
demands. Demonstrated: No limitations noted.

**Static Standing:** Job demand: NA Reported ability: Client reported able to meet job demands.  
Demonstrated: No limitations noted.

**Dynamic Standing:** Job demand: 11 hours Reported ability: Client reported able to meet job demands.  
Demonstrated: No limitations noted.

**Walking:** Job demand: 11 hours Reported ability: Client reported able to meet job demands. Demonstrated:  
Client completed treadmill walk - 3.0 mph @ 4.0% grade with HR at 123 bpm (70% AAMHR); 5.0 METs  
(light-to-medium CV level)

### **Agility**

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Stairs/Ladders: Job demand: Ladders only: 30 reps of 2 floors Reported ability: Client reported able to meet job demands. Demonstrated: No limitations noted.

Balancing: Job demand: Ladders Reported ability: Client reported able to meet job demands. Demonstrated: No limitations noted.

Bending/Stooping: Job demand: 1-2 hours Reported ability: Client reported able to meet job demands. Demonstrated: No limitations noted.

Crouching/Squatting: Job demand: 30 to 60 minutes Reported ability: Client reported able to meet job demands. Demonstrated: No limitations noted.

Crawling: Job demand: Never

Twisting/Spinal Rotation: Job demand: 60 minutes Reported ability: Client reported able to meet job demands. Limited endurance possible. Demonstrated: No limitations noted.

Above-Shoulder Work: Job demand: 60 minutes Reported ability: Client reported able to meet job demands. Demonstrated: 30 minutes

Prolonged Neck Positioning: Job demand: Never

Impact/Jarring: Job demand: Never.

Dexterity: Reported limited use of right hand.

Fine Finger: Job demand: 11 hours. Reported ability: Limitations with right hand. Demonstrated: Right hand: 4 hours; Left hand-unrestricted.

Purdue: No limitations observed. All movements smooth and fluid.

R: 15

L: 14

Both-bilateral: 11

Both -assembly: 36

Minnesota: Placing test.

Right: 70 / 70 / 64 (rubbed right wrist, reported "burning")

Left: 61 / 57 / 59

Grasping (Light) : Demonstrated: Right hand: 4 hours; Left hand-unrestricted.

Jamar Dynamometer Grip Test, Position 2

Trial Right Left

1 70.00 86.00

2 64.00 84.00

3 58.00 87.00

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Mean 64.00 85.67  
Std.Dev. 4.90 1.25  
CV 7.65% 1.46%

**Right**

Norm mean: 73  
Norm SD: 17  
Patient mean: 64  
Patient SD: -0.53

**Left**

Norm mean: 66  
Norm SD: 17  
Patient mean: 85.7  
Patient SD: 1.2

Pinching: Demonstrated: Right hand: 1-hour; Left hand-unrestricted.

**Pinch Summary**

Right Left  
Palmar 16 20  
Key 17 15  
Tip 10 12

Reaching Forward: Job demand: 11 hours. Reported ability: Limited right hand usage. Demonstrated: Right hand: 5 hours; Left hand-unrestricted.

BTE- Right forward reach: 241 seconds

BTE- Right overhead reach: 115 seconds-did not complete 120 second scree test.

**Right Left comparison (today):**

12/31/2009

| BTE Strength-          | Right | Left | % change |
|------------------------|-------|------|----------|
| Wrist flexion (lbs.)   | 9.8   | 18.6 | 53%      |
| Wrist extension (lbs.) | 15.8  | 54.5 | 29%      |
| Pronation (in-lb)      | 47    | 72.5 | 65%      |
| Supination (in-lb)     | 40.3  | 53.3 | 76%      |
| Elbow flexion (lbs.)   | 31.6  | 32.4 | 98%      |
| Elbow extension (lbs.) | 31.5  | 57.4 | 55%      |

Right hand showing continued weakness.

| Act.\ Date | 12/01/2009 | 12/31/2009 | % change |
|------------|------------|------------|----------|
| Grip-R     | 61         | 64         | 5%       |
| Lift       | 30         | 20         | -30%     |

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

|       |     |    |      |
|-------|-----|----|------|
| Carry | 10  | 20 | 100% |
| Push  | 35  | 59 | 69%  |
| Pull  | 41  | 63 | 54%  |
| METs  | 4.3 | 5  | 16%  |

Client significantly limited in right hand activities.

-Showed no significant change in right grip strength.

-Showed decreased lifting ability (Used two different tests, static rating (50% of max) and dynamic testing. Static testing may rate higher than dynamic testing.

-Showed increased ability in bilateral strength in carry, push and pull.

-Showed increased cardiovascular ability.

Writing: Client reported able to meet job demands. Demonstrated: No limitations noted.

Coordination: No limitations noted.

Vision/Hearing: No limitations noted.

**Interventions:** None provided today.

**Pain Reassessment:**

Response to Pain Intervention:

Post Intervention Pain Quality: None.

Patient Reports Post Intervention Pain Level of: 1 out of 10

Pain Acceptable: Yes

**Education:**

The patient's preferred learning method is: Doing.

Barriers to Learning: Desire and motivation limiting progress by under-rating pain and over exercise.

Education Needs: Plan of care. Safety. Precautions.

Education Provided: No education provided this session.

## ASSESSMENT

**Problem List:** Right wrist pain.

**Strengths:** Activity tolerance. Motivated to improve function.

**Equipment Needed:** None.

**Other Rehabilitation Considerations:** Patient's progress may be impaired by the following potential barriers: Medical condition.

**Rehabilitation Potential:** Fair- Physician reported need to continue therapy based upon no significant findings on MRI. Guarded based upon limited progress with respect of continued wrist pain during therapy. Will continue to monitor.

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

Motivation/Commitment to Therapy: Excellent.

**Support Structure:** Support structure is good. Family willing to assist patient.

**Initial Evaluation Date:** 12/1/2009

**Reporting Period:** 12/31/2009 to 1/31/2010

**Response to Visit:** Fair

**Goal Review:**

**LONG TERM GOAL REVIEW:**

Time frame to achieve long term goal(s): 4 weeks

**Progress Summary:** Client making minimal progress due to right wrist discomfort.

#### **PLAN**

**Treatment Frequency, Duration, and Interventions:** Occupational Therapy is recommended for As ordered: 5 days per week for 4 weeks. Occupational Therapy treatment is to include: Work Hardening.

#### **Recommended Consults:**

**Development of Plan of Care:** Patient participated in plan of care development today. The patient has been instructed to contact our clinic if any questions or problems should arise.

LTG: To return to the job of Color Technician without restrictions.

STGs: In 30 days, client will attain the following goals:

1. Lifting:
  - a. 40-pounds bilaterally floor to shoulder
  - b. 30-pounds right hand, floor to waist
2. Carrying: 40 pounds bilateral. 100 feet.
3. Pushing: 40 pounds, 50 feet
4. Pulling: 45 pounds, 50 feet.
5. Walking: 6.3 METs (medium CV level)
6. Stairs: 30 steps.
7. Bending/Stooping/Crouching/Squatting: 30 minutes continuously.
8. Above-Shoulder Work:
  - a. Bilateral: 30 minutes
  - b. Right upper extremity: 10 minutes
9. Reaching Forward:
  - a. Bilateral: 60 minutes
  - b. Right upper extremity: 10 minutes
10. Grasping (Light) : Demonstrated: Right hand: 75 pounds
11. Pinching:
  - a. Palmar: 20 pounds
  - b. Key: 19 pounds
  - c. Tip: 15 pounds

**Visit Number:** Today's visit is number 1

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treatment Rendered:** None this date.

**Physician Re-Certification:** This is to certify that the above named patient, who is under my care, requires skilled Occupational Therapy services as described in the above treatment plan. I further certify that the services outlined in this plan are skilled and medically necessary. I have reviewed this plan for rehabilitation services, and I recommend that these services continue from 12/31/2009 to 1/31/2010 to meet the goals stated above. **Treatment Diagnosis:** Hand pain

**Physician signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Signed by:** JOHN ZELENKA - OTR/L

**Date/Time:** 1/5/10 9:31 am

**Start Time:** 8:25 **End Time:** 12:20  
**Session Duration:** 235

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1220 hours

**SUBJECTIVE**

**Patient Report:** "The driver did not pick me up yesterday".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

**Pain After Session:** Right hand, 3/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

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**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 20 minutes

**BTE Program:** She completed the 4 exercises. I did not increase her resistance today. She reported less fatigue after these.

**Work Circuit:**

**Carrying 25 lb.** around clinic 75 feet. She carried the weight low with her arms fully extended. She stated that she had a hard time bringing the weight up to her waist height.

**Arm curls:** 1 X 10 2 plates.

**Push/Pull sled** 60 lb.

**Triceps:** 1 X 10 3 plates.

**Lifting floor to table:** 20 lbs. She was unable to complete the goal weight today of 28 lbs. *She was observed rubbing her hand after this.*

**Stair stepper,** 1 minute

**Rowing:** 3 plates, 1 X 10.

**Lifting shelf to overhead,** 20 lb

**Shoulder shrugs:** 2 plates, 1 X 10.

**Minnesota Board:** Using only her right hand, 1:30, 1:36, 1:40.

**Chest fly:** 2 plates, 1 X 10.

**Treadmill 15 minutes.**

**Lats:** 1 X 10, 3 plates.

**Carry 10 lb. bucket up and down 2 steps:** 3 reps.

**Military press:** 1 plate, 1 X 10. *She hesitated between each rep. She showed facial grimacing.*

**Lifting floor to shelf 1.25lb. weights 10 reps.**

***She repeated the above work circuit 1 rep each unless otherwise noted. She completed this circuit 5 times.***

**ASSESSMENT**

She reported her hand pain increased today with today's workout. No increased weights added today compared to last workout.

**PLAN**

Continue to monitor pain behaviors and increase work task slowly.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 17

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**Treatment Rendered:** Work Hardening

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/5/10 9:35 am

**Start Time:** 8:25 **End Time:** 12:20  
**Session Duration:** 235

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/7/10 11:14 am

**Start Time:** 8:20 **End Time:** 12:20  
**Session Duration:** 240

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0820 hours **Time Out:** 1220 hours

**SUBJECTIVE**

**Patient Report:** "My hand does not hurt at all today".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

**Pain After Session:** Right hand, 3/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

231

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 20 minutes

**BTE Program:** She completed the 6 exercises. Increase in resistance by 1 pound today.

**Work Circuit:**

**Assembling** 20 nuts and bolts.

**Overhead work.** Weaving a rope through a wire shelf, 10 minutes. She reported shoulder fatigue after this. She took her arms down on 2 occasions due to fatigue.

**Hammering nails** into a board. She was unable to complete this due to the impact causing increased hand pain. She was observed grimacing and rubbing her hand after hammering 1 nail. Her goal today was 10 nails. I stopped this activity due to the increased pain behaviors.

**Carrying 10 pound bucket** from 22" shelf 15 feet and placing it on a 36" shelf, 3 reps.

**Low level working: kneeling**, moving 8, 2.5 pound weights from floor to 24" shelf. She showed pain behaviors of rubbing her hand and dropping the weights on 2 occasions.

**Climbing ladder** while carrying 10 pound bucket up and down, 3 reps. She reported that her knees were beginning to ache after this activity.

**Bike 10 minutes.**

**Right hand use.** Placing nuts onto bolts using an adjustable wrench.

**Working floor level:** She assembled pieces of PVC pipe and joints. She was observed changing her position of kneeling and crawling to stooping due to reported increased knee pain.

**Right hand strength:** Using a sponge, she squeezed water from 1 pan to another, 5 minutes.

**ASSESSMENT**

Increased pain behaviors today. She was unable to complete the low level work goals due to reported knee discomfort. She appeared to be quiet today during her activities.

**PLAN**

Continue to monitor pain behaviors and increase work task slowly.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 18

**Treatment Rendered:** Work Hardening

232

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/7/10 11:29 am

**Start Time:** 8:20 **End Time:** 12:20  
**Session Duration:** 240

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/8/10 11:30 am

**Start Time:** 8:25 **End Time:** 11:00  
**Session Duration:** 155

**OP OT Note - Work Hardening Daily Progress**  
**Occupational Therapy**  
**Outpatient Work Hardening/Work Conditioning**  
**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury  
**Date of Injury:** 07/22/08  
**Employer:** Color Fi Inc.  
**Job Title:** Color Specialist  
**Medications:** None Today  
**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0825 hours **Time Out:** 1100 hours

**SUBJECTIVE**

**Patient Report:** "My hand started aching on the way home yesterday after squeezing on the sponge".  
"I would like to keep on exercising. I've got to keep going that's how I do at work. If I am hurting, you just have to keep going".  
"I was trying to fix the dogs fence yesterday and the screws were real sharp and they just sliced my finger".

**Pain:** Right hand  
**Pain Prior to Session:** Right hand, 0/10  
**Pain After Session:** Right hand, 4/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

**Treadmill:** 20 minutes

233

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Work Circuit:**

**Push/Pull sled,** 60 lb. 2 reps. Facial grimacing noted with the pushing aspect of this task.

**Overhead work,** Weaving a rope through a wire slots on a 70" shelf and removing it. She had to take breaks during this activity due to arm/shoulder fatigue.

**Ladder climbing while carrying** 1.25 pound weights from floor to overhead shelf, 8 reps. I observed her stopping half way up the ladder on 3 occasions resting, "My knees are wanting to ache again". She was encouraged to take a break and pace herself with this activity.

**Hand strengthening/use:** completing 2 knobs on the prehension board. She was observed grimacing, rubbing her right and left hand. She would stand in a forward bent posture rubbing her hands together as if she were in pain.

**Carrying 10 pound bucket** from 36" shelf 15 feet and placing it on a 68" shelf, 3 reps. She verbalized, "Man that's hard" while lifting the bucket to the shelf. When bring the weight down she would grimace and frown.

**Bike 10 minutes.** No resistance. She was observed pedaling and leaning over onto the bike while exercising. I asked her why she was leaning over and she replied "My legs are tired and achey". I asked her to sit in an upright position for posture while exercising. Although her legs were tired and achey, she then added resistance to the bike and began to show increased grimacing and pain behaviors.

**Assembling** 20 nuts and bolts.

**Lifting 25 pounds from 42" shelf to floor.** She was unable to complete this goal today of 4 reps. She was observed not being able to control the weight after she picked the weight up from the shelf to go down to the floor. She reported that she could not handle the weight with her right hand.

I stopped her treatment today due to the increased pain in her hand and her onset of reported left hand pain. She showed increased pain behaviors as her work activities continued up to this point. She became tearful today when I stopped her, however I explained to her that having her to work through pain at this point could possibly be causing further injury.

**Hot packs to both hands:** 20 minutes. For decreasing pain.

**ASSESSMENT**

Her pain behaviors are increasing. She is not making the progress that she should be making at this point due to the increased pain.

**PLAN**

Continue to monitor pain behaviors and increase work task slowly.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 18

234

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/8/10 12:00 pm

**Start Time:** 8:25 **End Time:** 11:00  
**Session Duration:** 155

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/11/10 9:25 am

**Start Time:** 8:30 **End Time:** 11:45  
**Session Duration:** 195

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0830 hours **Time Out:** 1145 hours

**SUBJECTIVE**

**Patient Report:** "I hurt my knees a long time ago. I was in a motorcycle wreck and they said I would never walk again but I did". "My knees have always given me pain".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

**Pain After Session:** Right hand, 5/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

235

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treadmill:** 20 minutes

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Work Circuit:**

**Carry 8# water jugs:** 15 feet, using right hand to move jug from 24" shelf to 36" shelf to 48" shelf to 60" shelf and back down in this fashion and back to the shelf. After the second carry, she was observed rubbing her wrist and shaking her arm. She continued to complete the 5 reps.

**Push/Pull sled,** 60 lb. 3 reps. Facial grimacing noted with the pushing aspect of this task.

**Positional tolerance,** and right UE exercise: Stooping to the floor and picking up pool balls and placing into and overhead box. She completed 16 balls in 1 minute. She was observed not being able to grasp hold to the balls after she reached overhead to place them into the bin.

**Right UE use: BTE tool 122,** She demonstrated fatigue after 1 minute. She required constant breaks.

**Stair climbing:** She climbed 1 flight of stairs 11 steps, up and down while carrying a 20 pound bucket.

**Simulation of pulling material from barrel.** She pulled tied sheets from box using both hands. She was observed using her left hand to do a majority of the work.

**Writing:** She wrote for 15 minutes. I asked her to write her job duties from the time she clocked in throughout her day.

**Stair climbing:** She climbed 1 flight of stairs 11 steps, up and down without carrying a bucket.

**Lifting floor to 42" shelf,** 20 pounds 5 reps. She was unable to do this using the handles on the crate. She preferred to grab the box side to side.

**Valpar board 5 minutes,** using tools. She was observed being unable to grasp the tools fully. She attempted to use her left hand, as well as shaking her hand and rubbing her wrist.

She reported her hand pain had increased to 3/10. She was showing a constant facial expression of pain as well as pain behaviors of shaking her right arm and leaning over onto the table during a break to take the pressure off of her knees per her report.

**ASSESSMENT**

I do not see the worker making progress at this point. She appears to be regressing as evidenced by the decreased weights and resistance in the last 2 weeks and the increase in pain behaviors as noted. She appears to be having more knee discomfort as well as indicated from her pain behaviors.

**PLAN**

I have asked the OTR to place a call into the physician for guidance in this situation. The patient reports that the doctor wants her to complete the entire Work Hardening program.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 19

**Treatment Rendered:** Work Hardening

236

**McLeod Health**  
**Charting Report**

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/11/10 10:24 am

**Start Time:** 8:30 **End Time:** 11:45  
**Session Duration:** 195

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKADD               | OTWR - WORK HARDENING EA. ADD        | 1.00                  |
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**

Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/12/10 9:59 am

**Start Time:** 8:30 **End Time:** 10:50  
**Session Duration:** 140

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

**Time In:** 0830 hours **Time Out:** 1050 hours

**SUBJECTIVE**

**Patient Report:** "I have a hard time cutting a cabbage at home. I have to get my son to do it".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 0/10

**Pain After Session:** Right hand, 2/10

**OBJECTIVE**

Ms. Hamilton completed/received the following:

237

**Treadmill:** 20 minutes, Facial grimacing noted during this exercise. "I'm just tired". She reports the grimacing is due to being "tired", however she appears to be having knee pain.

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**ASSESSMENT**

Her treatment stopped today due to safety issues with the patient and the validity of her pain reports v/s pain behaviors.

**PLAN**

I have asked the OTR to place a call into the physician for guidance in this situation. The patient reports that the doctor wants her to complete the entire Work Hardening program.

The patient has been instructed to contact our clinic if any questions or problems should arise.

**Visit Number:** 20

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/12/10 11:46 am

**Start Time:** 8:30 **End Time:** 10:50  
**Session Duration:** 140

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num.Performed</u> |
|-------------------------|--------------------------------------|----------------------|
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                 |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/13/10 12:49 pm

**Start Time:** 8:25 **End Time:** 10:50  
**Session Duration:** 145

**OP OT Note - Work Hardening Daily Progress**

**Occupational Therapy**

**Outpatient Work Hardening/Work Conditioning**

**Daily Progress Note**

**Medical Diagnosis:** Right hand crush injury

**Date of Injury:** 07/22/08

**Employer:** Color Fi Inc.

**Job Title:** Color Specialist

**Medications:** None Today

**Rehabilitation Precautions/Restrictions/Barriers to Treatment:** No restrictions.

239

**Time In:** 0825 hours **Time Out:** 1050 hours

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

## SUBJECTIVE

**Patient Report:** "I can't cut things at home. I can't carry my glass baking dishes either".

**Pain:** Right hand

**Pain Prior to Session:** Right hand, 1/10

**Pain After Session:** Right hand, 6/10

## OBJECTIVE

Ms. Hamilton completed/received the following:

**Back Flexibility exercises:** 3 reps each, 15 second hold.

**Back Strengthening exercises:** 5 reps each, 2 second hold.

**Treadmill:** 45 minutes, She reported increased leg fatigue after this. Average speed 2.7 MPH.

### **Work Circuit:**

**Overhead work:** Weaving rope through grid. 13 minutes. She was observed shrugging her shoulders and shaking her right arm. She required 3 rest breaks during this work period.

**Push/Pull:** sled weighted 70 pounds, 2 reps. I observed the sled moving to the right during the push. This was due to her lack of pushing. She reported that she did not push with the right hand due to pain in the wrist and hand when pressure was applied to the hand.

**Low level work tolerance:** She was able to work at floor level for 8 minutes, 35 seconds. She showed frequent positional changes; bilateral kneeling, single kneeling, extending the left leg out to the side and leaning on the box for support.

**Work simulation:** Carrying crates (5) weighted, 0-15 pounds. One at a time she carried the crates using both hands, 20 feet to place onto 36" table. She performed this task for 20 minutes. She showed increased fatigue during and after this exercise.

**Forward reach tolerance:** She was able to work for 4 minutes and 55 seconds placing large pegs into a pegboard. She was observed having a hard time in placing the pegs into the holes. She stated that this was due to lack of control of her hand.

She was observed not being able to fully grasp the pegs and overshooting her aim for the peg holes. She stated at the end of this activity, "My hand is about a 6/10 now".

## ASSESSMENT

She reported a 6/10 hand pain today. I feel that this could have been an accurate report.

## PLAN

The OTR stated to discontinue treatment with this pt. Please see notes.

The patient has been instructed to contact our clinic if any questions or problems should arise.

240

**Visit Number:** 21

**NAME:** HAMILTON, EMMA  
**ROOM:** WR  
**ADMIT DATE:** 12/31/2009  
**CHART:** WR

**Account ID:** 000116693656  
**Date of Birth:** 12/04/1964  
**Med. Record # :** 01202405

**Treatment Rendered:** Work Hardening

**Signed by:** SANDRA NOBLES - COTA/L

**Date/Time:** 1/13/10 1:14 pm

**Start Time:** 8:25 **End Time:** 10:50  
**Session Duration:** 145

**WORK RECOVERY PROGRESS NOTE - CHARGES ONLY**

| <u>Completed Orders</u> | <u>Description</u>                   | <u>Num. Performed</u> |
|-------------------------|--------------------------------------|-----------------------|
| OTWRWKINT2              | OTWR - WORK HARDENING INITIAL 2 HRS. | 1.00                  |

**TREATMENT RENDERED:**  
Work hardening:

**Signed by:** SANDRA NOBLES - COTA/L