

STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM GREENWOOD COUNTY
South Carolina Workers' Compensation Commission

Appellate Panel

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NOV 26 2012

Case No. 0724852

SC Court of Appeals

John B. Leopard, ... Appellant,

v.

Greenwood County and S.C. Association of Counties, SIF, ... Respondents.

RECORD ON APPEAL - VOLUME 1

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INDEX

Volume 1

Decision and Order of the SCWCC Appellate Panel filed May 8, 2012	2
Order of Single Commissioner Avery B. Wilkerson dated October 21, 2011	13
Accord Form 4 WC-First Report of Injury or Illness dated October 31, 2007.....	30
Form 16A dated February 9, 2010.....	31
Form 19 dated February 18, 2010.....	32
Form 50 dated February 8, 2011	33
Form 51 dated February 14, 2011.....	34
Form 50 dated June 3, 2011 with attachments.....	35
Form 51 dated June 28, 2011	44
Notice of Hearing dated July 21, 2011	45
Claimant/Appellant's SCWCC Form 58 and APA Submissions dated August 9, 2011	46

Volume 2

Employer/Carrier/Respondents' SCWCC Form 58 and APA Submissions dated August 12, 2011	188
Form 30 dated November 3, 2011, consisting of 2 pages.....	495
Notice of Appeal dated June 4, 2012	497
Transcript of Full Commission Hearing dated February 22, 2012	499
Transcript of Hearing before Comm. Avery B Wilkerson dated August 24, 2011 ...	523
Dr. Shallcross' deposition, pp. 1 and 3-55 and Plaintiff's Exhibits 1a, b and c	534
Direct Examination by Ms. Meredith	535
Cross Examination by Mr. Kale.....	578
Redirect Examination by Ms. Meredith.....	584
E-mail from Billie Miller to Barbara Cheeseboro dated March 21, 2011	594
Certificate of Appellant	595

**APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 0724852**

JOHN B. LEOPARD,

CLAIMANT-APPELLANT

-VS-

GREENWOOD COUNTY AND S.C. ASSOCIATION
OF COUNTIES SIF,

DEFENDANTS-RESPONDENTS.

Appellant Panel Review held in
Columbia, South Carolina on
February 22, 2012, per notices
timely and properly served upon all
parties of interest.

Appellate Panel Decision and Order,
filed 5/8, 2012.

APPEARANCES:

Claimant-Appellant represented by
Lena Y. Meredith, Esquire of
Nicholson, Meredith and Anderson,
LLC, Greenwood, South Carolina.

Defendants-Respondents represented
by Richard B. Kale, Jr., Esquire of
Willson Jones Carter & Baxley,
P.A., Greenville, South Carolina.

STATEMENT OF THE CASE

The parties were heard by Commissioner Avery B. Wilkerson on August 24, 2011. On October 21, 2011, Commissioner Wilkerson issued the following Order:

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That all parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with Greenwood County as the Employer and South Carolina Association of Counties SIF, as Carrier.
2. That Claimant's average weekly wage pursuant to Section 42-7-65 was \$231.18, making the compensation rate of \$154.13 applicable in this case.
3. That Claimant suffered an injury to his thoracic spine on October 30, 2007, while entering an attic to fight a fire. The Claimant has had no surgery as a result of his thoracic spine injury, nor has surgery ever been recommended. He was out of work for 4 5/7 weeks from October 31, 2007 to December 2, 2007.
4. That on May 12, 2008, Dr. Phillip Hodge, neurosurgeon, completed a Form 14B indicating that the Claimant had a 3% medical impairment to the whole person as a result of his thoracic spine injury. Dr. Hodge advised that the Claimant would need future medical care consisting of intermittent anti-inflammatories and physical therapy.
5. That on February 9, 2010, the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement Compensation, under which the parties agreed that the Claimant had sustained a 40% permanent loss of use of his thoracic back and was entitled to a compensation award of \$18,495.60. The Form 16A Agreement also provided that Claimant was entitled to additional medical as shown on the attached Form 14B consisting of "intermittent anti-inflammatories and physical therapy." The Form 16A was approved by Commissioner Andrea Roche on February 10, 2010. Thereafter, Claimant signed a Form 19, Status Report and Compensation receipt on February 18, 2010, acknowledging that he received payment of the award.
6. That the last payment of compensation pursuant to an award occurred on February 18, 2010.

7. That on February 8, 2011, Claimant's attorney filed a Form 50 alleging that Claimant had suffered a change of condition for the worse under Section 42-17-90, and was entitled to additional medical treatment, to temporary total disability compensation from September 14, 2010 to present, and to compensation for total disability pursuant to Section 42-17-90. The Form 50 did not attach a medical report indicating a change in the Claimant's condition.
8. That on February 14, 2011, Defendants filed a Form 51 denying that Claimant was entitled to any additional medical care, denying that he was entitled to temporary total disability compensation, and denying that he was entitled to any further compensation for permanent disability. Defendants asserted the statute of limitations under Section 42-17-90 as an affirmative defense.
9. A hearing was scheduled before Commissioner Andrea C. Roche on April 12, 2011 in Newberry, South Carolina. Subsequently, the case was reset for hearing on April 13, 2011.
10. On March 21, 2011, Claimant's counsel advised the Hearing Commissioner that she wished to withdraw the hearing request at this time and cancel the hearing on April 13, 2011. Thereafter, the hearing was cancelled.
11. On or about June 3, 2011, Claimant's counsel filed a Form 50 requesting a hearing and again alleging that the Claimant was in need of additional medical treatment, was entitled to temporary total disability compensation from September 14, 2010 to present, and was totally disabled as a result of a change of condition under Section 42-17-90, S.C. Code Ann. (1976). The medical report of Sybil Reddick, M.D., dated March 15, 2011, was attached to the Form 50.
12. That Defendants filed a Form 51 denying that Claimant was in need of additional medical treatment, denying that he was entitled to temporary total disability compensation and denying that Claimant had suffered a change of condition for the worse. Defendants also asserted as an affirmative defense the statute of limitations under Section 42-17-90.
13. That during the course of his treatment, the Claimant had several MRI and CT scans performed of his thoracic spine. MRI scans were performed on December 19, 2007 by Greenville Radiology, March 12, 2009 by Greenville Radiology, May 7, 2010 by Physicians Health & Rehab, and August 17, 2010 by Piedmont Health Group Diagnostic & Imaging Center. CT scans were performed on December 11, 2007 by Anderson Radiology and on May 1, 2010 by Self Regional Healthcare.

14. That Claimant was treated by Dr. David L. Shallcross from June 4, 2009 to April 29, 2011. Dr. Shallcross stated in his medical reports and testified at his deposition of June 13, 2011, that it was his opinion that Claimant had not suffered a change of condition for the worse. I give great weight to the opinion of Dr. Shallcross, since he was the treating physician and saw the Claimant both before and after the date of the alleged change of condition for the worse.
15. That the Claimant was evaluated at the request of his attorney by Dr. Steven S. Poletti of Southeastern Spine Institute in Charleston, South Carolina. Dr. Poletti never treated the Claimant and never evaluated the Claimant prior to the alleged change of condition for the worse. While Dr. Poletti did review MRI and CT scans performed in 2007 and 2010, he did not review the MRI scan performed on March 12, 2009. Therefore, while Dr. Poletti might be in a position to give an opinion as to whether Claimant's fracture worsened between 2007 and 2010, he could not give a credible and reliable opinion that Claimant's fracture worsened after February 18, 2010, the date of the last payment of compensation. Because Dr. Poletti never evaluated the Claimant prior to February 18, 2010 and did not review the MRI report of March 12, 2009, I give his opinion very little weight.
16. That the Claimant was evaluated by Dr. Sybil Reddick, a physical medicine and rehabilitation specialist with Pain Management Associates. Dr. Reddick evaluated the Claimant for the first time on March 15, 2011. Because Dr. Reddick never evaluated the Claimant prior to February 18, 2011, I give her opinion very little weight.
17. That I give greater weight to the opinion of Dr. David L. Shallcross, the physician who treated the Claimant from June 4, 2009 to April 29, 2011, over the opinions of Dr. Poletti and Dr. Reddick.
18. That the Claimant has failed to prove by the greater weight of the evidence that he suffered a change of condition for the worse since the last payment of compensation on February 18, 2010.

CONCLUSIONS OF LAW

Accordingly, as provided in Section 42-17-40, S.C. Code Ann. (1976), it is the determination of this Commissioner that:

1. Under Section 42-1-130 and Section 42-7-65, S.C. Code Ann. (1976), John B. Leopard was a covered volunteer firefighter/employee at the time in question and under Section 42-1-140, S.C. Code Ann. (1976), Greenwood County was a covered employer.

2. Under Section 42-1-160, S.C. Code Ann. (1976), Claimant suffered an injury to his thoracic spine by accident arising out of and in the course of his employment with Greenwood County.
3. Under Section 42-9-30, S.C. Code Ann. (1976), and R.67-801 and 67-802, the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement Compensation on February 9, 2010, under which the Claimant was paid compensation for a 40% permanent loss of use of his thoracic spine. On February 18, 2010, the Claimant signed a Form 19, Compensation Receipt acknowledging payment of the award.
4. Under Section 42-17-90, S.C. Code Ann. (1976), Claimant has not suffered a change of condition for the worse caused by the original injury, since the last payment of compensation.

ORDER

IT IS, THEREFORE, ORDERED that the Claimant's application for a review of an award on a change of condition under Section 42-17-90, S.C. Code Ann. (1976), be, and hereby is, denied.

No hearing costs are assessed in this instance.

AND IT IS SO ORDERED.

Within the statutory period, Counsel for Claimant filed an Application for Review in the case setting forth her grounds for review, copies of which were furnished to all interested parties, prior to oral argument presented to the Appellate Panel on February 22, 2012. All proffered testimony has been taken. Such, together with all documentary evidence, has been delivered by oral argument to the individual members of the Appellate Panel and has since been under study and consideration. By appeal, Claimant submitted the following grounds for review.

1. In finding the Claimant did not prove by the greater weight of the evidence that he suffered a change of condition for the worse since the last payment of compensation on February 28, 2010, Finding of Fact 18, p. 16, Conclusion of Law 4, p. 17;
2. In finding that Dr. Poletti could not give a credible and reliable opinion that the Claimant's fracture worsened after February 18, 2010;

3. In giving little weight to the opinion of Dr. Sybil Reddick because she did not evaluate the Claimant prior to February 18, 2011.
4. In giving greater weight to the opinion of Dr. David L. Shallcross that Claimant did not suffer a change of condition for the worse when he would not review the Claimant's diagnostic films taken after February 18, 2010.
5. In finding that Claimant did not suffer a change of condition for the worse in spite of the fact that Dr. Shallcross's office notes reflect that Claimant's condition, in fact, worsened after February 18, 2010.

In an appellate review, the Appellate Panel shall, pursuant to S.C. Code Ann. Section 42-17-50 (1985), review the Award, weigh the evidence as presented at the initial hearing, and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Single Commissioner. After careful review in the instant case, the Appellate Panel, by unanimous vote, has determined that all of the Single Commissioner's Findings of Fact and Conclusions of Law are correct as stated. As such, the Appellate Panel of the South Carolina Workers' Compensation Commission, by unanimous vote, issues the following Findings of Fact and Conclusions of Law, which shall become, and hereby are, the law of the case.

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That all parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with Greenwood County as the Employer and South Carolina Association of Counties SIF, as Carrier.
2. That Claimant's average weekly wage pursuant to Section 42-7-65 was \$231.18, making the compensation rate of \$154.13 applicable in this case.

3. That Claimant suffered an injury to his thoracic spine on October 30, 2007, while entering an attic to fight a fire. The Claimant has had no surgery as a result of his thoracic spine injury, nor has surgery ever been recommended. He was out of work for 4 5/7 weeks from October 31, 2007 to December 2, 2007.

4. That on May 12, 2008, Dr. Phillip Hodge, neurosurgeon, completed a Form 14B indicating that the Claimant had a 3% medical impairment to the whole person as a result of his thoracic spine injury. Dr. Hodge advised that the Claimant would need future medical care consisting of intermittent anti-inflammatories and physical therapy.

5. That on February 9, 2010, the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement Compensation, under which the parties agreed that the Claimant had sustained a 40% permanent loss of use of his thoracic back and was entitled to a compensation award of \$18,495.60. The Form 16A Agreement also provided that Claimant was entitled to additional medical as shown on the attached Form 14B consisting of "intermittent anti-inflammatories and physical therapy." The Form 16A was approved by Commissioner Andrea Roche on February 10, 2010. Thereafter, Claimant signed a Form 19, Status Report and Compensation receipt on February 18, 2010, acknowledging that he received payment of the award.

6. That the last payment of compensation pursuant to an award occurred on February 18, 2010.

7. That on February 8, 2011, Claimant's attorney filed a Form 50 alleging that Claimant had suffered a change of condition for the worse under Section 42-17-90, and was entitled to additional medical treatment, to temporary total disability compensation from September 14, 2010 to present, and to compensation for total disability pursuant to Section 42-

17-90. The Form 50 did not attach a medical report indicating a change in the Claimant's condition.

8. That on February 14, 2011, Defendants filed a Form 51 denying that Claimant was entitled to any additional medical care, denying that he was entitled to temporary total disability compensation, and denying that he was entitled to any further compensation for permanent disability. Defendants asserted the statute of limitations under Section 42-17-90 as an affirmative defense.

9. A hearing was scheduled before Commissioner Andrea C. Roche on April 12, 2011 in Newberry, South Carolina. Subsequently, the case was reset for hearing on April 13, 2011.

10. On March 21, 2011, Claimant's counsel advised the Hearing Commissioner that she wished to withdraw the hearing request at this time and cancel the hearing on April 13, 2011. Thereafter, the hearing was cancelled.

11. On or about June 3, 2011, Claimant's counsel filed a Form 50 requesting a hearing and again alleging that the Claimant was in need of additional medical treatment, was entitled to temporary total disability compensation from September 14, 2010 to present, and was totally disabled as a result of a change of condition under Section 42-17-90, S.C. Code Ann. (1976). The medical report of Sybil Reddick, M.D., dated March 15, 2011, was attached to the Form 50.

12. That Defendants filed a Form 51 denying that Claimant was in need of additional medical treatment, denying that he was entitled to temporary total disability compensation and denying that Claimant had suffered a change of condition for the worse. Defendants also asserted as an affirmative defense the statute of limitations under Section 42-17-90.

13. That during the course of his treatment, the Claimant had several MRI and CT scans performed of his thoracic spine. MRI scans were performed on December 19, 2007 by Greenville Radiology, March 12, 2009 by Greenville Radiology, May 7, 2010 by Physicians Health & Rehab, and August 17, 2010 by Piedmont Health Group Diagnostic & Imaging Center. CT scans were performed on December 11, 2007 by Anderson Radiology and on May 1, 2010 by Self Regional Healthcare.

14. That Claimant was treated by Dr. David L. Shallcross from June 4, 2009 to April 29, 2011. Dr. Shallcross stated in his medical reports and testified at his deposition of June 13, 2011, that it was his opinion that Claimant had not suffered a change of condition for the worse. We give great weight to the opinion of Dr. Shallcross, since he was the treating physician and saw the Claimant both before and after the date of the alleged change of condition for the worse.

15. That the Claimant was evaluated at the request of his attorney by Dr. Steven S. Poletti of Southeastern Spine Institute in Charleston, South Carolina. Dr. Poletti never treated the Claimant and never evaluated the Claimant prior to the alleged change of condition for the worse. While Dr. Poletti did review MRI and CT scans performed in 2007 and 2010, he did not review the MRI scan performed on March 12, 2009. Therefore, while Dr. Poletti might be in a position to give an opinion as to whether Claimant's fracture worsened between 2007 and 2010, he could not give a credible and reliable opinion that Claimant's fracture worsened after February 18, 2010, the date of the last payment of compensation. Because Dr. Poletti never evaluated the Claimant prior to February 18, 2010 and did not review the MRI report of March 12, 2009, we give his opinion very little weight.

16. That the Claimant was evaluated by Dr. Sybil Reddick, a physical medicine and rehabilitation specialist with Pain Management Associates. Dr. Reddick evaluated the Claimant

for the first time on March 15, 2011. Because Dr. Reddick never evaluated the Claimant prior to February 18, 2011, we give her opinion very little weight.

17. That we give greater weight to the opinion of Dr. David L. Shallcross, the physician who treated the Claimant from June 4, 2009 to April 29, 2011, over the opinions of Dr. Poletti and Dr. Reddick.

18. That the Claimant has failed to prove by the greater weight of the evidence that he suffered a change of condition for the worse since the last payment of compensation on February 18, 2010.

CONCLUSIONS OF LAW

Accordingly, as provided in Section 42-17-40, S.C. Code Ann. (1976), it is the determination of these Commissioners that:

1. Under Section 42-1-130 and Section 42-7-65, S.C. Code Ann. (1976), John B. Leopard was a covered volunteer firefighter/employee at the time in question and under Section 42-1-140, S.C. Code Ann. (1976), Greenwood County was a covered employer.

2. Under Section 42-1-160, S.C. Code Ann. (1976), Claimant suffered an injury to his thoracic spine by accident arising out of and in the course of his employment with Greenwood County.

3. Under Section 42-9-30, S.C. Code Ann. (1976), and R.67-801 and 67-802, the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement Compensation on February 9, 2010, under which the Claimant was paid compensation for a 40% permanent loss of use of his thoracic spine. On February 18, 2010, the Claimant signed a Form 19, Compensation Receipt acknowledging payment of the award.

4. Under Section 42-17-90, S.C. Code Ann. (1976), Claimant has not suffered a change of condition for the worse caused by the original injury, since the last payment of compensation.

ORDER

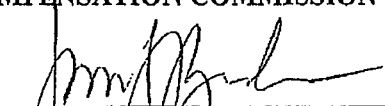
IT IS, THEREFORE, ORDERED that the Claimant's application for a review of an award on a change of condition under Section 42-17-90, S.C. Code Ann. (1976), be, and hereby is, denied.

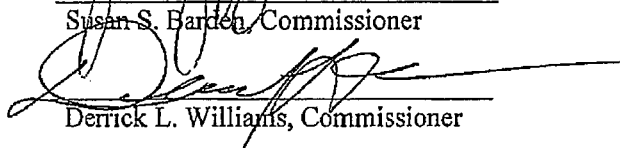
No hearing costs are assessed in this instance.

AND IT IS SO ORDERED.

**SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION**

BY:


Susan S. Barden, Commissioner


Derrick L. Williams, Commissioner


G. Bryan Lyndon, Commissioner

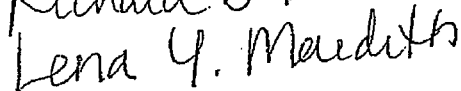
FULL AFFIRMATION

CERTIFICATE OF SERVICE

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

This 25th day of May, 2002
By Valerie D. Bates

Administrative Assistant to the Commissioner

DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 0724852

John B. Leopard, Volunteer Fireman,	)
	)
Claimant,	)
	)
-vs-	)
	)
Greenwood County, Employer, and	)
S.C. Association of Counties SIF, Carrier,	)
	)
Defendants.	)

HEARING:

Held in Clinton, South Carolina on August 24, 2011.

APPEARANCES:

Claimant represented by Lena Y. Meredith,
Esquire of Nicholson & Anderson.

Defendants represented by Richard B. Kale,
Jr., Esquire of Willson Jones Carter &
Baxley, P.A.

PURPOSE OF HEARING:

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

DECISION AND ORDER:

AVERY B. WILKERSON, JR.,
COMMISSIONER

FILED:

October 21, 2011

STIPULATIONS

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

1. That the South Carolina Workers' Compensation Commission has jurisdiction of the parties and issues involved.
2. That venue in Laurens County was agreed to by the parties.
3. That pursuant to Section 42-7-65, S.C. Code Ann. (1983), Claimant's average weekly wage as a volunteer fireman was \$231.18, making the compensation rate of \$154.13 applicable in this case.
4. That notice of the hearing was timely and properly served upon all parties of interest.

APA SUBMISSIONS

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

BY THE CLAIMANT:

APA #1 – Reports of Family Physicians of Greenwood, dated October 1, 2007 to August 13, 2010, consisting of 24 pages.

APA #2 – Reports of Self Regional Healthcare, dated October 30, 2007 to August 19, 2010, consisting of 15 pages.

APA #3 – Reports of Montgomery Center for Family Medicine, dated October 31, 2007 to December 21, 2007, consisting of 22 pages.

APA #4 – Reports of Optimum Life, dated October 7, 2007 to January 15, 2008, consisting of 8 pages.

APA #5 – Reports of Carolina Neurosurgery & Spine Center, dated November 14, 2007 to July 15, 2008, consisting of 7 pages.

APA #6 – Reports of Southeastern Neurosurgery, dated February 19, 2008 to March 23, 2009, consisting of 14 pages.

APA #7 – Reports of Upstate Medical Rehab, dated June 4, 2009 to February 2, 2011, consisting of 20 pages.

APA #8 – Reports of Piedmont Health Group – Neurology, dated August 13, 2010 to October 15, 2010, consisting of 14 pages.

APA #9 – Reports of Southeastern Spine Institute, dated November 17, 2010 to March 28, 2011, consisting of 5 pages.

APA #10 – Report of Pain Management Associates, dated March 15, 2011, consisting of 8 pages.

BY THE DEFENDANTS:

APA #1 – Reports of Dr. David L. Shallcross, dated June 4, 2009 to April 29, 2011, consisting of 20 pages.

APA #2 – Report of Select Physical Therapy FCE, dated February 13, 2011, consisting of 16 pages.

APA #3 – Report of Physicians Health & Rehab MRI, dated May 7, 2010, consisting of 1 page.

APA #4 – Reports of Select Physical Therapy, dated June 5, 2009 to January 6, 2010, consisting of 90 pages.

APA #5 – Reports of Dr. Phillip J. Hodge, dated February 19, 2008 to March 23, 2009, consisting of 16 pages.

APA #6 – Reports of Greenville Radiology, dated December 19, 2007 to March 12, 2009, consisting of 4 pages.

APA #7 – Reports of Montgomery Center for Family Medicine, dated October 31, 2007 to December 21, 2007, consisting of 18 pages.

APA #8 – Report of Anderson Radiology, dated December 11, 2007, consisting of 2 pages.

APA #9 – Reports of Optimum Life Center P.T., dated November 7, 2007 to December 3, 2007, consisting of 10 pages.

APA #10 – Reports of Self Regional Healthcare, dated October 30, 2007 to October 31, 2007, consisting of 25 pages.

**TREATMENT FOR NON-WORK
RELATED NECK INJURY**

APA #11 – Reports of Dr. Sumeer Lal, dated November 14, 2007 to July 15, 2008, consisting of 7 pages.

APA #12 – Report of Self Regional Healthcare, dated October 4, 2007, consisting of 2 pages.

**UNRELATED BILATERAL
KNEE PROBLEMS**

APA #13 – Reports of Lakelands Orthopaedic, dated April 6, 1999 to February 22, 2002, consisting of 10 pages.

APA #14 – Report of Dr. Steven T. Carawan, dated August 24, 2005 to November 16, 2005, consisting of 5 pages.

APA #15 – Report of Self Regional Healthcare, dated February 15, 2002, consisting of 2 pages.

**TREATMENT FOR UNRELATED
LOW BACK CONDITION**

APA #16 – Reports of Greenville Sports & Industrial Rehab P.T., dated September 2, 2010 to October 27, 2010, consisting of 4 pages.

APA #17 – Reports of Dr. Wayne Sida, dated August 13, 2010 to October 15, 2010, consisting of 18 pages.

APA #18 – Reports of Family Physicians of Greenwood, dated November 17, 1998 to October 21, 2010, consisting of 53 pages.

APA #19 – Report of Self Regional Healthcare, dated August 13, 2010, consisting of 2 pages.

In addition, the deposition of Dr. David L. Shallcross was submitted into evidence by the parties.

STATEMENT OF THE CASE

This hearing took place in Clinton, South Carolina on August 24, 2011. The Claimant is a volunteer firefighter for Greenwood County. On October 30, 2007, he suffered an injury to his thoracic spine when he fell while entering an attic to fight a house fire. The claim was accepted, and Defendants provided medical care for Claimant's thoracic spine. On February 9, 2010, an informal conference was held, and the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement Compensation under which the Claimant received compensation for a 40% permanent loss of use of his thoracic back. The Form 16A was approved by the Commission on February 10, 2010.

On or about February 8, 2011, the Claimant filed a Form 50 requesting a hearing and alleging that he had suffered a change of condition under Section 42-17-90, S.C. Code Ann. (1976). On February 14, 2011, Defendants filed a Form 51 denying a change of condition for the

worse and asserting as an affirmative defense Section 42-17-90, S.C. Code Ann. (1976). The case was scheduled for hearing on April 13, 2011. Prior to the hearing, Claimant's counsel advised the Hearing Commissioner that she wished to withdraw her Form 50 and cancel the hearing. Therefore, the hearing was cancelled. On or about June 3, 2011, the Claimant filed another Form 50 requesting a hearing and again alleging a change of condition for the worse. On June 28, 2011, Defendants filed a Form 51, again denying that Claimant had suffered a change of condition for the worse and asserting the statute of limitations under Section 42-17-90.

At the hearing, Claimant's Attorney contended that Claimant had suffered a change of condition as to his back. In support of this position, Claimant's Attorney submitted reports from Dr. Steven C. Poletti and Dr. Sybil Reddick. Defendants denied that Claimant had suffered a change of condition for the worse, since the last payment of compensation on February 18, 2010. Defendants relied upon the opinion of Dr. David L. Shallcross, the treating physician, who stated in his reports and at his deposition that Claimant had not suffered a change of condition for the worse. Defendants also contended that neither Dr. Poletti or Dr. Reddick had seen the Claimant prior to the last payment of compensation on February 18, 2010, and therefore were not in as good a position as Dr. Shallcross to offer an opinion as to whether the Claimant's condition had changed for the worse. Defendants also contended that the Claimant's application for a change of condition was barred by the 12 months statute of limitations in Section 42-17-90. Defendants argued that Claimant's original Form 50, application for review on a change of condition, was withdrawn and was not refiled until on or about June 3, 2011, which was more than 12 months after the last payment of compensation. Therefore, Defendants contended that the Commission was without jurisdiction to hear the case.

After an extensive pre-hearing conference with the parties, the parties agreed to submit the issue of change of condition under Section 42-17-90, S.C. Code Ann. (1976), solely upon the

medical records submitted in the APAs and the deposition of Dr. David L. Shallcross. Therefore, no testimony was taken at the hearing. The Commission's file, except for unstipulated medical reports and self-serving declarations, was made a part of the record in this case. The decision instructions were sent to the parties by the undersigned on September 1, 2011.

EVIDENCE OF THE CASE

Numerous medical records were submitted by the parties and have been thoroughly reviewed by the undersigned. After his accident on October 30, 2007, Claimant went to the Emergency Room at Self Regional Healthcare where he was evaluated and released with prescriptions for several medications. Claimant was then seen on October 31, 2007 by Dr. Dan Divilbiss at the Montgomery Center of Family Medicine, who noted that the Claimant was complaining of pain in his mid back. Dr. Divilbiss diagnosed paraspinous back spasm and referred the Claimant for physical therapy. The Claimant had approximately 12 physical therapy sessions at Optimum Life Center. Because of continuing complaints of back pain, Dr. Divilbiss ordered a CT scan of the thoracic spine. This was performed at Anderson Radiology on December 11, 2007. It was the radiologist's impression that the Claimant had a mild flattened configuration of the central and left side of T11 vertebral body which could be the result of chronic degenerative disc disease or a subacute fracture of the T11 vertebral body. It was also noted that Claimant had moderate degenerative disc disease and posterior disc protrusion and osteophytes at T10-11 and T11-12.

Subsequently, an MRI of the thoracic spine was also performed on December 19, 2007, at Greenville Radiology. The MRI revealed multi-level Schmorl's nodes, particularly distally, and superimposed early degenerative changes at multiple levels. There was a borderline impingement at T10-11 upon the anterior aspect of the cord. At T11-12, there were asymmetric

disc bulges toward the right with borderline infringement upon the cord. At T6-7 there was a minimal disc bulge lying up against the anterior margin of the cord.

Claimant was then referred to Dr. Phillip J. Hodge, a neurosurgeon, for evaluation. Dr. Hodge reviewed the MRI and advised that it showed degenerative changes of the thoracic spine without fracture or disc herniation. It was his impression that the Claimant's injuries were muscular or ligamentous in nature and would improve with time. He recommended Naprosyn and return to work without restriction. The Claimant returned to Dr. Hodge on April 17, 2008. Dr. Hodge noted that the Claimant was doing better and that he was to return to regular duty after having worked restricted duty for 3-4 weeks. On May 12, 2008, Dr. Hodge advised that the Claimant had reached maximum medical improvement and had an impairment rating of 3% to the whole person for a thoracic back soft tissue injury. Dr. Hodge advised that the Claimant could return to work without restriction, although he might need intermittent anti-inflammatories and physical therapy to function optimally. The Claimant returned to Dr. Hodge on March 9, 2009 continuing to complain of pain. Dr. Hodge ordered another MRI. This was performed at Greenville Radiology on March 12, 2009. The MRI showed minor thoracic scoliosis, a combination of disc herniation and spondylosis producing central canal stenosis at T10-11 and similar changes, but to a lesser degree, at T11-12. The Claimant was seen in follow-up by Dr. Hodge on March 23, 2009. Dr. Hodge advised that the Claimant's thoracic spine MRI showed some stenosis in the lower thoracic region. He had mildly increased reflexes but no other symptoms of myelopathy. Dr. Hodge did not recommend surgery and advised that the rating and restrictions remained the same. He recommended referral to pain management.

The Claimant was seen by Dr. David L Shallcross, a physical medicine and rehabilitation specialist, on June 4, 2009. It was Dr. Shallcross' impression that the Claimant had a muscular thoracic sprain superimposed on thoracic herniated disc and probable mild compression fracture.

Dr. Shallcross recommended physical therapy, a TENS unit, and additional medications. Thereafter, Dr. Shallcross provided additional treatment including trigger point injections and facet injections. On October 8, 2009, Dr. Shallcross advised that the Claimant had reached maximum medical improvement. He released Claimant to continue working without restriction. Dr. Shallcross rated the Claimant as having a 25% impairment to his spine as a result of the work accident.

After the Form 16A settlement, Claimant returned to Dr. Shallcross on April 16, 2010 again complaining of mid back pain. It was Dr. Shallcross' impression that the Claimant still had mechanical back pain with no evidence of true radiculopathy or myelopathy. The Claimant had follow-up appointments with Dr. Shallcross on May 27, 2010, and July 26, 2010. On September 21, 2010, Dr. Shallcross advised in his office note:

Clinically I cannot see any true worsening in this patient's condition, but he is complaining of increase pain and I think at this point he is having an attorney help him decide on disability and out of work issues. (Defendants' APA #1, p. 12).

Thereafter, Dr. Shallcross ordered a functional capacity evaluation and saw the Claimant again on January 27, 2011. Dr. Shallcross advised that the FCE showed Claimant was capable of lifting 60 pounds from the floor to waist, 50 pounds from waist to shoulder and limited lifting from floor to shoulder of 50 pounds. He could carry 100 pounds for 25 feet. He could constantly sit and walk. He could frequently stand, stair climb, ladder climb, do desk level reaching, overhead reaching (needs to limit this with heavy weight), floor level reaching, balance, kneeling, stooping, crouching and crawling. Dr. Shallcross opined that Claimant was at maximum medical improvement with no increase in his impairment rating based upon the recent aggravation of his pain. On April 29, 2011, the Claimant was seen for a medication recheck.

On August 13, 2010, the Claimant was seen for an emergency consultation by Dr. Wayne B. Sida, a neurologist. The Claimant gave a history to Dr. Sida that he woke up that morning and developed a severe shooting pain in his back that caused him to fall to his knees. The Claimant initially had trouble urinating but had no frank incontinence. The Claimant had episodic numbness and pain into the right lower extremity. Dr. Sida indicated there was no evidence of an acute compression fracture. He noted that the Claimant complained of severe pain with a history of right lower extremity numbness and pain. Dr. Sida indicated this was “unexpected” given the location of the lower thoracic/upper lumbar spine disease. Dr. Sida ordered an MRI of the thoracic spine which was performed at Piedmont Health Group on August 17, 2010. The MRI showed multi level Schmorl’s nodes with chronic compression fractures at T10, T11 and possibly T8. The T10-11 broad base disc bulge and inplate hypertrophy contributed to moderate spinal canal stenosis at T11-12 disc bulge and inplate hypertrophy with focal herniation to the left of the midline producing anterior lateral impression upon the distal cord. An EMG/NCV study was within normal limits. The Claimant returned to Dr. Sida on August 23, 2010 noting that his pain level had diminished significantly and was near baseline. Claimant was seen again by Dr. Sida on October 15, 2010 at which time Dr. Sida offered a neurosurgical assessment but was advised by Claimant that he was not interested in that evaluation at that time.

The Claimant was sent by his attorney to Dr. Steven C. Poletti for an independent medical evaluation. The Claimant was seen by Dr. Poletti for the first time on November 17, 2010. It was Dr. Poletti’s impression that the Claimant had a thoracic (T11) fracture with multi level degenerative disc aggravated by the fall. Dr. Poletti advised that Claimant had a 15% impairment rating as a result of the fracture. Dr. Poletti did not recommend any surgery as a result of his evaluation of the Claimant on November 17, 2010. On March 16, 2011, Dr. Poletti

did an addendum to his report after reviewing scans from 2007 and 2010. It appears from Dr. Poletti's report that he reviewed both MRI scans and CT scans. The Claimant had two MRI scans in 2010, and it is not clear which 2010 MRI report that Dr. Poletti reviewed, since he did not give any dates for the scans. However, it is clear that Dr. Poletti did not review the MRI scan performed on March 12, 2009. Based on the MRIs that he reviewed, Dr. Poletti stated that the fractures at the T11 level had worsened since 2007. However, Dr. Poletti could not offer an opinion as to whether the Claimant's condition had worsened since February 18, 2010, the date of the last payment of compensation. The deposition of Dr. Poletti was not taken by Claimant's attorney.

The Claimant was also sent by his attorney to Dr. Sybil Reddick, a physical medicine and rehabilitation specialist with Pain Management Associates. Dr. Reddick saw the Claimant for the first time on March 15, 2011. Dr. Reddick noted that on August 13, 2010, the Claimant developed a severe shooting pain in his back which caused him to fall to his knees. Dr. Reddick noted that the pain was in the Claimant's low back rather than his mid-back. Dr. Reddick stated that while there was no documentation indicating any derangement in the pelvis or sacrum, it was reasonable to conclude that these changes occurred as a result of the fall that led to the thoracic compression fractures and pain. Dr. Reddick offered no opinion as to whether the Claimant had suffered a change of condition for the worse since February 18, 2010.

Claimant's attorney took the deposition of Dr. David L. Shallcross on June 13, 2011. Dr. Shallcross was questioned about the Claimant's office visit on April 16, 2010 and whether there was any change noted. Dr. Shallcross testified that he did not see any change on examination of the Claimant. As to whether the Claimant's compression fractures have progressed, Dr. Shallcross testified that while compression fractures can progress, he would not expect progression in someone whose fractures was as long ago as Claimant's. Dr. Shallcross reviewed

the radiologist's report from the MRI performed on May 27, 2010 and testified that the findings were similar to what the Claimant had previously. As to his physical examination, Dr. Shallcross testified that his findings were similar to what the Claimant had had in the past:

Q. [By Ms. Meredith] Okay. What did you find on his physical examination that day?

A. Very similar findings to what we had in the past, specifically looking at a thoracic kyphosis to be sure there wasn't any evidence of further damage to the bone. He was walking well, he had tenderness in the back. I didn't see anything really different.

Dr. Shallcross testified that his clinical evaluation of the Claimant did not show anything different. He testified that to properly compare three different MRIs (2007, 2009, and 2010), a reading radiologist or neuroimaging specialist would have to put the MRI film side by side and make the decision as to whether there had been any change.

Dr. Shallcross also saw the Claimant on December 16, 2010. Dr. Shallcross testified that Claimant's physical exam did not change, and he did not see anything different. Dr. Shallcross testified that the things that he looks for in a clinical examination to determine any change were changes in posture, changes in gait, changes in the way he presents himself, changes in his effect, changes in muscular tone, changes in spasms, changes in strength, changes in muscle bulk, and changes in reflexes or sensation. Dr. Shallcross testified that he did not detect any clinical worsening of the Claimant's condition.

A record such as was necessary for a decision was made of the proceedings in this matter, and after careful consideration and study of all the evidence, the following findings of fact are made.

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That all parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, with Greenwood County as the Employer and South Carolina Association of Counties SIF, as Carrier.

2. That Claimant's average weekly wage pursuant to Section 42-7-65 was \$231.18, making the compensation rate of \$154.13 applicable in this case.

3. That Claimant suffered an injury to his thoracic spine on October 30, 2007, while entering an attic to fight a fire. The Claimant has had no surgery as a result of his thoracic spine injury, nor has surgery ever been recommended. He was out of work for 4 5/7 weeks from October 31, 2007 to December 2, 2007.

4. That on May 12, 2008, Dr. Phillip Hodge, neurosurgeon, completed a Form 14B indicating that the Claimant had a 3% medical impairment to the whole person as a result of his thoracic spine injury. Dr. Hodge advised that the Claimant would need future medical care consisting of intermittent anti-inflammatories and physical therapy.

5. That on February 9, 2010, the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement Compensation, under which the parties agreed that the Claimant had sustained a 40% permanent loss of use of his thoracic back and was entitled to a compensation award of \$18,495.60. The Form 16A Agreement also provided that Claimant was entitled to additional medical as shown on the attached Form 14B consisting of "intermittent anti-inflammatories and physical therapy." The Form 16A was approved by Commissioner Andrea Roche on February 10, 2010. Thereafter, Claimant signed a Form 19, Status Report and Compensation receipt on February 18, 2010, acknowledging that he received payment of the award.

6. That the last payment of compensation pursuant to an award occurred on February 18, 2010.

7. That on February 8, 2011, Claimant's attorney filed a Form 50 alleging that Claimant had suffered a change of condition for the worse under Section 42-17-90, and was entitled to additional medical treatment, to temporary total disability compensation from September 14, 2010 to present, and to compensation for total disability pursuant to Section 42-17-90. The Form 50 did not attach a medical report indicating a change in the Claimant's condition.

8. That on February 14, 2011, Defendants filed a Form 51 denying that Claimant was entitled to any additional medical care, denying that he was entitled to temporary total disability compensation, and denying that he was entitled to any further compensation for permanent disability. Defendants asserted the statute of limitations under Section 42-17-90 as an affirmative defense.

9. A hearing was scheduled before Commissioner Andrea C. Roche on April 12, 2011 in Newberry, South Carolina. Subsequently, the case was reset for hearing on April 13, 2011.

10. On March 21, 2011, Claimant's counsel advised the Hearing Commissioner that she wished to withdraw the hearing request at this time and cancel the hearing on April 13, 2011. Thereafter, the hearing was cancelled.

11. On or about June 3, 2011, Claimant's counsel filed a Form 50 requesting a hearing and again alleging that the Claimant was in need of additional medical treatment, was entitled to temporary total disability compensation from September 14, 2010 to present, and was totally disabled as a result of a change of condition under Section 42-17-90, S.C. Code Ann.

(1976). The medical report of Sybil Reddick, M.D., dated March 15, 2011, was attached to the Form 50.

12. That Defendants filed a Form 51 denying that Claimant was in need of additional medical treatment, denying that he was entitled to temporary total disability compensation and denying that Claimant had suffered a change of condition for the worse. Defendants also asserted as an affirmative defense the statute of limitations under Section 42-17-90.

13. That during the course of his treatment, the Claimant had several MRI and CT scans performed of his thoracic spine. MRI scans were performed on December 19, 2007 by Greenville Radiology, March 12, 2009 by Greenville Radiology, May 7, 2010 by Physicians Health & Rehab, and August 17, 2010 by Piedmont Health Group Diagnostic & Imaging Center. CT scans were performed on December 11, 2007 by Anderson Radiology and on May 1, 2010 by Self Regional Healthcare.

14. That Claimant was treated by Dr. David L. Shallcross from June 4, 2009 to April 29, 2011. Dr. Shallcross stated in his medical reports and testified at his deposition of June 13, 2011, that it was his opinion that Claimant had not suffered a change of condition for the worse. I give great weight to the opinion of Dr. Shallcross, since he was the treating physician and saw the Claimant both before and after the date of the alleged change of condition for the worse.

15. That the Claimant was evaluated at the request of his attorney by Dr. Steven S. Poletti of Southeastern Spine Institute in Charleston, South Carolina. Dr. Poletti never treated the Claimant and never evaluated the Claimant prior to the alleged change of condition for the worse. While Dr. Poletti did review MRI and CT scans performed in 2007 and 2010, he did not review the MRI scan performed on March 12, 2009. Therefore, while Dr. Poletti might be in a position to give an opinion as to whether Claimant's fracture worsened between 2007 and 2010, he could not give a credible and reliable opinion that Claimant's fracture worsened after

February 18, 2010, the date of the last payment of compensation. Because Dr. Poletti never evaluated the Claimant prior to February 18, 2010 and did not review the MRI report of March 12, 2009, I give his opinion very little weight.

16. That the Claimant was evaluated by Dr. Sybil Reddick, a physical medicine and rehabilitation specialist with Pain Management Associates. Dr. Reddick evaluated the Claimant for the first time on March 15, 2011. Because Dr. Reddick never evaluated the Claimant prior to February 18, 2011, I give her opinion very little weight.

17. That I give greater weight to the opinion of Dr. David L. Shallcross, the physician who treated the Claimant from June 4, 2009 to April 29, 2011, over the opinions of Dr. Poletti and Dr. Reddick.

18. That the Claimant has failed to prove by the greater weight of the evidence that he suffered a change of condition for the worse since the last payment of compensation on February 18, 2010.

CONCLUSIONS OF LAW

Accordingly, as provided in Section 42-17-40, S.C. Code Ann. (1976), it is the determination of this Commissioner that:

1. Under Section 42-1-130 and Section 42-7-65, S.C. Code Ann. (1976), John B. Leopard was a covered volunteer firefighter/employee at the time in question and under Section 42-1-140, S.C. Code Ann. (1976), Greenwood County was a covered employer.

2. Under Section 42-1-160, S.C. Code Ann. (1976), Claimant suffered an injury to his thoracic spine by accident arising out of and in the course of his employment with Greenwood County.

3. Under Section 42-9-30, S.C. Code Ann. (1976), and R.67-801 and 67-802, the parties entered into a Form 16A, Agreement for Permanent Disability/Disfigurement

Compensation on February 9, 2010, under which the Claimant was paid compensation for a 40% permanent loss of use of his thoracic spine. On February 18, 2010, the Claimant signed a Form 19, Compensation Receipt acknowledging payment of the award.

4. Under Section 42-17-90, S.C. Code Ann. (1976), Claimant has not suffered a change of condition for the worse caused by the original injury, since the last payment of compensation.

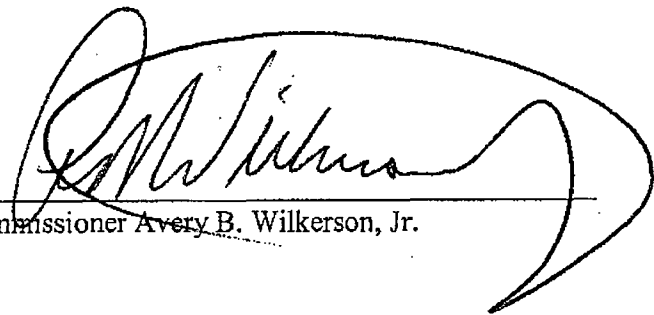
ORDER

IT IS, THEREFORE, ORDERED that the Claimant's application for a review of an award on a change of condition under Section 42-17-90, S.C. Code Ann. (1976), be, and hereby is, denied.

No hearing costs are assessed in this instance.

AND IT IS SO ORDERED.

**SOUTH CAROLINA WORKERS
COMPENSATION COMMISSION**



Commissioner Avery B. Wilkerson, Jr.

CERTIFICATE OF SERVICE

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

October 21, 2011

By: Elaine Boyd, Administrative Assistant to Commissioner Wilkerson.

ACORD™ WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS							
EMPLOYER (NAME & ADDRESS INCL. ZIP) Greenwood County 600 Monument Street, Box P-103 Greenwood, SC 29646 DEPARTMENT # (SEE BACK) SIC CODE EMPLOYER FEIN 57-6000358				CARRIER CLAIM NUMBER		REPORT PURPOSE/CODE	
				JURISDICTION		JURISDICTION CLAIM NUMBER	
				LOCATION CODE			
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		PHONE # (864) 942-8644					
CARRIER/CLAIMS ADMINISTRATOR							
CARRIER (NAME, ADDRESS & PHONE NO) Association of Counties P.O. Box 8207 Columbia, SC 29202			POLICY PERIOD TO CHECK IF APPLICABLE ☐ SELF INSURANCE		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) Companion Property & Casualty Insurance Company P.O. Box 100159 Columbia, SC 29202 (800) 922-1282 FAX: 1-800-290-1858		
CARRIER FEIN		POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN		
AGENT NAME & CODE NUMBER							
EMPLOYEE/WAGE							
NAME (LAST, FIRST, MIDDLE) Leopard, John Benjamin		DATE OF BIRTH 9/17/1970		SOCIAL SECURITY NUMBER 247-63-1193		DATE OF HIRE STATE OF HIRE SC	
ADDRESS (INCL ZIP) 712 Stillwell Road Greenwood, SC 29646		SEX ☒ MALE ☐ FEMALE ☐ UNKNOWN		MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☒ MARRIED ☐ SEPARATED ☐ UNKNOWN		OCCUPATION/JOB TITLE Volunteer Fireman	
						VOLUNTEER ☒ Yes ☐ No	
PHONE # 864-8763		# OF DEPENDENTS		EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME		INMATE/PRISONER ☐ Yes ☐ No	
				NCCI CLASS CODE			
RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO		DID SALARY CONTINUE? ☐ YES ☐ NO	
OCCURRENCE/TREATMENT							
TIME EMPLOYEE ☐ AM ☐ PM BEGAN WORK		DATE OF INJURY/ILLNESS 10/30/07		TIME OF OCCURRENCE ☐ AM ☒ PM 8:00		LAST WORK DATE n/a	
DATE EMPLOYER NOTIFIED 10/31/07		DATE DISABILITY BEGAN n/a					
CONTACT NAME/SUPERVISOR/PHONE NUMBER Tony Gambrell 223-0923			TYPE INJURY/ILLNESS Back Pain/Strain		PART OF BODY AFFECTED Back		
DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☒ NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED Back		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED 1215 Ninety Six Hwy, Greenwood SC 29646				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED Entering Attic from outside of house while fighting a fire				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED Fire Fighting			
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OF SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL While fighting a house fire, he fell and injured his back							CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK n/a		IF FATAL, GIVE DATE OF DEATH n/a		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?		☒ YES ☐ NO ☒ YES ☐ NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS) Self Regional Health Care 1325 Spring Street Greenwood, SC 29646			INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR CLINIC HOSP ☒ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED	
WITNESSES (NAME & PHONE #) Tony Gambrell 864-223-0923							
DATE ADMINISTRATOR NOTIFIED 10/31/07		DATE PREPARED 10/31/07		PREPARER'S NAME & TITLE Elease W. Robinson, Workers Comp Administrator		PHONE NUMBER (864) 942 - 8644	

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



State
WCC File #: 0724852
Carrier File #: 580000223652
Carrier Code #: SF930
Employer FEIN #: 576000358

Claimant's Name: John Leopard
Address: 712 Stillwell Road
City: Greenwood State: SC Zip: 29646
Home Phone: 803 238 8163 Work Phone: 803 942 6599
Preparer's Name: Elvia Swainson
Employer's Name: Greenwood County Fire
Address: 600 Monument St. Box P-103
City: Greenwood State: SC Zip: 29646
Carrier: SC Counties Trust Association
Preparer's Phone #: 803 234 5332

This form is only applicable to injuries by accident occurring on or after July 1, 2007 pursuant to Title 42-15-60 (A) as amended. The execution of this document is an agreement between the parties relating to a Workers' Compensation claim under §§42-1-160, 42-1-172 or 42-11-10.

Date of Injury or Illness 10/30/2007

The above parties agree to pay and accept compensation based on the following facts:
A compensable ☒ Injury ☐ Illness ☐ Repetitive Trauma occurred on: 10/30/2007 (month/day/year).

The injury was to thoracic spine body part(s) injured and also the injury affected other body part(s).

The authorized treating physician has released the Claimant from his or her care and has found maximum medical improvement on 5/12/2008 (month/day/year).
with an impairment rating of 30%

Average weekly wage 231.18 Compensation rate 154.13

By agreement of the parties, the following award has been referred to the Commission for approval:

40% Percentage loss of use to: thoracic back (body part(s) injured). 120 weeks
Percentage loss of use to: (body part(s) affected). weeks
Percentage loss of use to: whole person weeks
Disfigurement to: weeks
Wage Loss: \$ amount weeks
Total and Permanent Disability: weeks
Other: weeks

RECEIVED

Estimated award (number of weeks times compensation rate) \$ 18,495.60 FEB 25 2010
The estimated award is subject to verification by the Commission

Additionally, the Employer's Representative agrees to pay and the Claimant accepts the following medical care and treatment as recommended by the authorized treating physician pursuant to the attached physician's statement, Form 14B

Additional medical ordered: X Yes No
See attached 14B physician's statement dated: 5/12/2008

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition must be filed no later than one (1) year from the date of the last payment of compensation. Only medical care specifically detailed herein will be paid under this agreement. If a dispute arises with regard to continued medical treatment, either party may request a hearing before the Commission pursuant to 42-15-60(B) 3 and (C).

Claimant's Signature
Employer's Representative
Deputy Commissioner

Date Agreement Signed 2.9.10
Attorney for Carrier
Date agreement approved February 9 2010

Attorney/Witness/Translator
Email
FEB 10 2010
Jurisdictional Commissioner

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

Received
Companion P&C Claims
02/22/10
WCC File #
Carrier File #
Carrier Code #
Employer FEIN

0724852
580000223852
SF930
576000358

STATE
Form

Claimant's Name: JOHN LEOPARD
SSN 247-63-1183

Employer's Name GREENWOOD COUNTY FIREMAN

Address: 712 STILLWELL RD

Address: 600 MONUMENT ST, BOX P-103

City: GREENWOOD State: SC Zip: 29646

City / State: GREENWOOD, SC Zip: 29646

Home Phone: # 864-227-8763

Insurance Carrier: SC COUNTIES TRUST ASSOCIATION

Work Phone: # 864-223-8763

Preparer's Name: Elvia Swanson

Phone # 1-800-845-2724

Compensation Paid:	Number of Weeks	From	To	Amount
1 Number of weeks T.T.	4 5/7	10/31/2007	12/02/2007	\$ 726.61
2 Number of Weeks T.P.				\$
3 Number of Weeks P.P.	120			\$ 18495.60
4 Disfigurement				\$
5 Agreement and Final Release				\$
Total Compensation Paid.....				\$ 19222.21
6 Total Medical Benefits Paid.....				\$ 11822.70
7 Funeral Benefits...				\$

☐ Case Denied

Date of Injury: 10/30/2007

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: [Signature]
Claimant 2-46-8

By: [Signature]
Employer's Representative

Date: 2/10/2010

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of additional Fees and Re-

A. Carrier Reimbursement by Third Party

B. Attorney's Fee Paid by Employer

C. Attorney's Fee Paid by Claimant

(Non contingent fees, only)

RECEIVED
MAR 2 5 2010
COMPANION P&C GROUP
CLAIMS DEPT.

\$ _____
\$ _____
\$ _____

File this form with the claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, cost of autopsy, birth certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied.

WCC FORM # 19 REV. DATE 3/98

19

STATUS REPORT AND COMPENSATION RECEIPT

RECEIVED
MAR 2 4 2010
FRONT DESK

South Carolina Workers' Compensation Commission

1612 Marion Street • Post Office Box 1715

Columbia, South Carolina 29202-1715

(803) 737-5723

www.wcc.sc.gov

WCC File #: 0724852Carrier File #: 58-223652Carrier Code #: SF930Employer FEIN # 576000358Claimant's Name: John B. Leopard SSN: 247-63-1193Employer's Name: Greenwood County (Fireman)Address: 712 Stillwell RoadAddress: 600 Monument Street, P-103City: Greenwood State: SC Zip: 29646City: Greenwood State: SC Zip: 29646Home Phone: (864) 227-8763 Work Phone: () -Insurance Carrier: SC Assoc of Counties SIF
Companion TPAPreparer's Name: Lena Y. MeredithLaw Firm: Nicholson & AndersonPreparer's Phone #: (864) 229-7241**Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.****A claim for workers' compensation benefits is made based on the following grounds:****Date of Injury or Illness: 10/30/2007**☒ Injury ☐ Illness ☐ Repetitive Trauma1a. The claimant sustained an injury to back (Part(s) of Body Injured) on 10/30/07 (Month/Day/Year) in Greenwood county, state of SC.1b. Body part(s) affected are: backBriefly describe how the accident occurred. Fell through second story of burning house

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

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

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

5. Notice of the accidental injury was given to the Employer on 10/30/07 (Month/Day/Year) in the following manner:Verbally to Tony Gambrell☒ 6. Due to injury, the claimant is in need of (check one):☐ (a) medical examination and treatment for: _____☒ (b) additional medical examination and treatment for: Change of condition under 42-17-90☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:TTD from 9/14/10 to present☒ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one): 42-17-90☒ (1) General Disability:☒ Total☐ (2) Specific Disability:☐ Total☐ (3) Wage Loss☐ Partial☐ Partial☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

10a. At the time of the injury, the Claimant was paid weekly wages of \$_____, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

Advanced Technology Services, Inc.

11a. Further grounds or unusual aspects of claim:

Section 42-17-90

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:

Optimum Life, 115 Academy Ave, Greenwood, SC 29646; Montgomery Center, 155 Academy Ave, Greenwood, SC 29646; Upstate Medical Rehab, 111 Doctors Dr, Greenville, SC 29605; Dr. Sida, 105 Vinecrest Ct, #1000, Greenwood, SC 29646; Dr. Bartz, 1506 Spring St, Greenwood, SC 29646; Self Regional Healthcare, 1325 Spring St, Greenwood, SC 29646; Greenwood Sports Rehab, 105 Vinecrest Ct, #400, Greenwood, SC 29646; Southeastern Neurosurgical, 111 Doctors Dr, Greenville, SC 2960511c. To the best of your knowledge, did you have any prior permanent disability? YesIf yes, describe: 40% to the back

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

☐ 13a. I am filing a claim. I am not requesting a hearing at this time.☒ 13b. I am requesting a hearing. A \$25 fee is required.14. Estimated time needed for hearing: 30 minutes**I verify the contents of this form are accurate and true to the best of my knowledge.**Lena Y. Meredith Attorneylena@nicholsonanderson.com Email2/8/11 Date

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

South Carolina Workers' Compensation Commission

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

WCC File # 0724852
Carrier File # 58-223652
Carrier Code # SF930
Employer FEIN 576000358

John B. Leopard 247-63-1193
Claimant's Name SSN
712 Stillwell Road, Greenwood, SC 29646
Address City State Zip

Home Phone

Work Phone

Richard B. Kale, Jr.

Preparer's Name

Greenwood County

Employer's Name

600 Monument St., Box P-103, Greenwood, SC 29646

Address City State Zip

S.C. Association of Counties SIF

Insurance Carrier

(864) 527-3272

Phone #

**Complete each information blank. Specify clearly when contentions are admitted in part and denied in part.
The employer-insurance carrier in answer to the claim, respectfully shows:**

1. It is (admitted) that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: _____
2. It is (admitted) that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: _____
3. It is (admitted) that the relationship of employer and employee existed at the time in question. The reasons for denial are: _____
4. It is (admitted) that at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: _____
5. It is (admitted) that notice of injury was given the employer. The reasons for denial are: _____
6. It is (denied) that the employee needs or is entitled to additional medical care as a result of injury. The reasons for denial are: Claimant has reached maximum medical improvement.
7. It is (denied) that the employee is entitled to temporary total disability for the period(s) of: _____
8. It is (denied) that the employee is permanently disabled. The reasons for denial are: No medical evidence.
9. It is (denied) that the employee has a serious disfigurement.
10. It is contended that an average weekly wage of \$ 231.18 applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: Section 42-17-90; Defendants reserve the right to amend.

I certify that I have served this document pursuant to R.67-212 by delivering a copy to Lena Y. Meredith, Esquire,
Name

P.O. Box 457, Greenwood, SC 29648 and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202
Address

on the 14th day of February, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

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

Richard B. Kale, Jr.
Preparer's Signature, Attorney for Defendants
Richard B. Kale, Jr.
Willson Jones Carter & Baxley, P.A.
872 S. Pleasantburg Drive
Greenville, SC 29607

Jane C. Watkins
Jane C. Watkins, Certifier

February 14, 2011
Date

Refer to R.67-205 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.



Claimant's Name: John B. Leopard SSN: 247-63-1193 Employer's Name: Greenwood County (Fireman)
Address: 712 Stillwell Road Address: 600 Monument Street, P-103
City: Greenwood State: SC Zip: 29646 City: Greenwood State: SC Zip: 29646
Home Phone: (864) 227-8763 Work Phone: () - Insurance Carrier: SC Assoc of Counties SIF
Companion TPA
Preparer's Name: Lena Y. Meredith Law Firm: Nicholson & Anderson Preparer's Phone #: (864) 229-7241

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

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

Date of Injury or Illness: 10/30/2007

☒ Injury ☐ Illness ☐ Repetitive Trauma

- 1a. The claimant sustained an injury to back (Part(s) of Body Injured) on 10/30/07 (Month/Day/Year) in Greenwood county, state of SC.
1b. Body part(s) affected are: back

Briefly describe how the accident occurred. Fell through second story of burning house

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the Employer on 10/30/07 (Month/Day/Year) in the following manner:
Verbally to Tony Gambrell

☒ 6. Due to injury, the claimant is in need of (check one):

☐ (a) medical examination and treatment for: _____

☒ (b) additional medical examination and treatment for: Change of condition under 42-17-90

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
TTD from 9/14/10 to present

☒ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one): 42-17-90

☒ (1) General Disability:

☒ Total

☐ (2) Specific Disability:

☐ Total

☐ (3) Wage Loss

☐ Partial

☐ Partial

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

10a. At the time of the injury, the Claimant was paid weekly wages of \$_____, and demands accounting of days worked and wages earned as provided by law.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
Advanced Technology Services, Inc.

11a. Further grounds or unusual aspects of claim:
Section 42-17-90

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
Optimum Life, 115 Academy Ave, Greenwood, SC 29646; Montgomery Center, 155 Academy Ave, Greenwood, SC 29646; Upstate Medical Rehab, 111 Doctors Dr, Greenville, SC 29605; Dr. Sida, 105 Vinecrest Ct, #1000, Greenwood, SC 29646; Dr. Bartz, 1506 Spring St, Greenwood, SC 29646; Self Regional Healthcare, 1325 Spring St, Greenwood, SC 29646; Greenwood Sports Rehab, 105 Vinecrest Ct, #400, Greenwood, SC 29646; Southeastern Neurosurgical, 111 Doctors Dr, Greenville, SC 29605; Southeastern Spine Institute, 1106 Chuck Dawley Blvd, Ste 200, Mt Pleasant, SC 29646; Matrix/VBS Physical Therapy, 712 North A St, Easley, SC 29640; Select Physical Therapy, 110 ByPass 225, Greenwood, SC 29646

11c. To the best of your knowledge, did you have any prior permanent disability? Yes
If yes, describe: 40% to the back

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

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

☒ 13b. I am requesting a hearing. A \$25 fee is required.

14. Estimated time needed for hearing: 30 minutes

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

Preparer's Signature

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

WCC Form # 50

Revised 9/07

AMENDED

50

Lena Y. Meredith Attorney
Title
Email lena@nicholsonanderson.com

Date

6.3.11

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

Pain Management Associates

PatientID: 88551JL
Patient Name: JOHN B LEOPARD
Date of Birth: 09/17/1970
Physician Requesting Consult:
Date of Service: March 15, 2011

PHYSICIAN REQUESTING CONSULT: Dr. Lena Meradith
CHIEF COMPLAINT: The patient presents with lumbar pain.

INFO/RECORDS REVIEWED & SCANNED INTO CHART:

CURRENT ALLERGY LIST:
NEOSPORIN

CURRENT MEDICATION LIST:
TRAMADOL 50 MG, 4-5 times a day
ZANAFLEX ORAL TABLET 4 MG, 3-4 times a day
LORTAB 10/500 MG, 1-2 times a day
RELAFEN ORAL TABLET 750 MG, 1-2 times a day
LEXAPRO ORAL TABLET 20 MG, 1 time a day

PAST MEDICAL HISTORY:
MEDICAL: No history of significant medical diseases.
SURGICAL: Right knee arthroscopy, hernia, c6-c7 fusion

FAMILY HISTORY:

SOCIAL HISTORY:
MARITAL STATUS: Patient is married.
ALCOHOL: Does not give any significant history of alcohol usage.
TOBACCO USE: Currently smokes 1 PPD, has smoked for 20 to 25 years.
ILLCIT DRUG USE: No history of illicit drug use or prescription misuse.

REVIEW OF SYSTEMS:
GI: Has frequent heartburn.
MUSCULOSKELETAL: Has joint pain, muscular pain.
NEUROLOGICAL: Has generalized muscle weakness, loss of sensation.
PSYCHIATRIC: Has sleep disturbances, depressive symptoms.
ENDOCRINE: Has a decreased libido.

PHYSICAL EXAM:
CONSTITUTIONAL:
GENERAL APPEARANCE: White male, well nourished body habitus, appears stated age, appropriately groomed. In no acute distress.
GENERAL EXAM:
ORIENTATION/MOOD/AFFECT: Oriented to person, place, time and general circumstances. Mood and affect appropriate.

Ryan A. Wetzel, MD LIC# 2033017 DEA FW1996593

105 Vinecrest Court*Greenwood, SC 29646*Phone:(864)953-9885*Fax: (864)953-9883
1005 Grove Rd*Greenville, SC 29605*Phone:(864) 242-6447*Fax: (864)242-6517

Pain Management Associates

PatientID: 88551JL

Patient Name: JOHN B LEOPARD

Date of Birth: 09/17/1970

Physician Requesting Consult:

Date of Service: March 15, 2011

SKIN: Warm, dry.

HEAD/FACE: The head is normocephalic. There are no maxillofacial abnormalities. Normal facial appearance.

EYES: Lids are normal without ptosis, edema. Conjunctivae are normal and without inflammation, injection, hemorrhages or exudates. Pupils are equal, round. EOMs full and conjugate.

EARS/NOSE/THROAT: Teeth are in good repair, gums are normal. Oral mucosa is pink.

PAIN BEHAVIORS: Behaviors are within expected context of disease. Facial appearance is relaxed. Normal verbalization. Mobility and range of motion are generally reduced. Appropriate social interaction.

MUSCULOSKELETAL EXAM:

HEAD/NECK (POSTERIOR), SHOULDER GIRDLE: There are well healed scars consistent with previous surgeries listed in HPI/PMH. Generalized mild tenderness over the neck and shoulder girdle. Head and neck in neutral position. Actively touches chin to chest, extension mildly restricted. Normal stability. Normal strength and tone.

SPINE, RIBS, PELVIS: Mild edema in the right thoracic/rib area. Moderate tenderness in the right paraspinal area. No kyphosis, lordosis, or scoliosis. Thoracic rotation mildly restricted bilaterally. Normal stability. Normal strength and tone.

LEFT UPPER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No muscle or joint tenderness to palpation. No crepitation.

MUSCLE STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone of the major groups is normal. Normal muscle bulk (no atrophy). No fasciculations.

RIGHT UPPER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No muscle or joint tenderness to palpation. No crepitation.

MUSCLE STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone of the major groups is normal. Normal muscle bulk (no atrophy). No fasciculations.

LEFT LOWER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No tenderness. No crepitation.

JOINT STABILITY: No instability of the hip. No evidence of medial instability of the knee. No ankle instability.

STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone is normal. Normal muscle bulk (no atrophy). No fasciculations.

RIGHT LOWER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No tenderness. No crepitation.

JOINT STABILITY: No instability of the hip. No evidence of medial instability of the knee. No ankle instability.

STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone is

Ryan A. Wetzel, MD LIC# 2033017 DEA FW1996593

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1005 Grove Rd*Greenville, SC 29605*Phone:(864) 242-6447*Fax: (864)242-6517

Pain Management Associates

PatientID: 88551JL

Patient Name: JOHN B LEOPARD

Date of Birth: 09/17/1970

Physician Requesting Consult:

Date of Service: March 15, 2011

normal. Normal muscle bulk (no atrophy). No fasciculations.

MUSCLE SPASMS: Right middle paraspinal muscle tenderness. No CVA tenderness. Negative straight leg raising.

SENSATION:

NERVE ROOTS: Sensation to touch and pressure intact. Sensation to pinprick (sharp/dull) intact.

RANGE OF MOTION: Normal in the major joints. The neck is restricted in flexion and extension.

POSTURE: Altered due to dorsal spine position.

GAIT/STATION: Gait intact. Does not use mobility aids.

IMAGING STUDIES:

PLAN: SEE DICTATION..PER DR. REDDICK. KD

Electronically Signed by: Sybil Reddick, M.D. on Monday, May 16, 2011

Ryan A. Wetzel, MD LIC# 2033017 DEA FW1996593

105 Vinecrest Court*Greenwood, SC 29646*Phone:(864)953-9885*Fax: (864)953-9883

1005 Grove Rd*Greenville, SC 29605*Phone:(864) 242-6447*Fax: (864)242-6517

PAIN MANAGEMENT ASSOCIATES

115 Academy Avenue
Greenwood, SC 29646

Phone: 864-855-1633

Fax: 864-855-1323

PATIENT'S NAME: John B. Leopard
DATE OF BIRTH: 09/17/1970
MRN: S8551JL
DATE OF EVALUATION: 03/15/2011

INDEPENDENT MEDICAL EVALUATION

HISTORY OF PRESENT ILLNESS:

This patient is seen and evaluated today, secondary to ongoing disability and pain as it relates to his thoracic compression fracture and back pain. This examinee was seen and evaluated on today's date, March 15, 2011, at the above address. The examinee's evaluation started at approximately 10:30 a.m. and ended at 11:30 a.m. The examinee came to the office unaccompanied. This is an Independent Medical Evaluation. I introduced myself to this patient. I advised the patient that I was seeing him for an Independent Medical Evaluation and that all information gained would be used in the assessment and would be presented in my report. The examinee was told that I would not be a treating physician and a doctor/patient relationship would not be established. The examination process was explained and the patient understood.

Prior to this evaluation, multiple medical records were available for review. The records evaluated included:

- Two reports from Self Regional Healthcare Emergency Department (10/30/2007, 08/09/2010).
- MRI of the lumbar spine (05/01/2010) and CT of the thoracic spine (05/01/2010).
- Progress notes from Dr. Daniel Divilbliss at Montgomery Center for Family Medicine (10/31/2007-12/21/2007).
- CT of the thoracic spine (12/11/2007) and MRI of the thoracic spine (12/19/2007).
- Physical therapy progress notes from Optimum Life Center of Self Regional Healthcare (11/07/2007-01/15/2008).
- Multiple reports from Dr. Philip Hodge at Southeastern Neurosurgery and Spine Institute (02/19/2008-02/23/2009).
- Progress notes from Dr. David Shallcross at Upstate Medical Rehabilitation (06/04/2009-02/02/2011).
- Physical therapy notes from Select Physical Therapy (06/12/2009-11/18/2009, 01/13/2011).
- Progress notes from Dr. Mark Bartz (08/13/2010).
- Multiple reports from Dr. Wayne Sida at Piedmont Neurology Associates (08/13/2010-10/15/2010).
- A functional capacity evaluation Matrix ZBS (could not verify) Physical Therapy (01/14/2011).

Continued . . .

John B. Leopard

03/15/2011

PAGE 2

The patient indicates he was injured October 30, 2007, when he fell through the second story of a burning house. He was working as a volunteer fireman at the time of injury. He was evaluated at the Self Regional Healthcare Emergency Department. X-ray of the spine demonstrated mild osteoarthritis affecting the lower cervical and lower thoracic levels with no acute skeletal abnormality noted. He was seen by Dr. Divilbliss the following day on October 31, 2007. He was treated for contusion and paraspinous spasm of the back. He underwent therapy and was progressing with improvement in all areas, except in mid back pain. He was returned to work light duty and CT of the thoracic spine was done December 11, 2007. The study did not demonstrate the occult fracture, but there was noted possibility of disc protrusion at multiple levels of the thoracic spine (T10-T11, T11-T12). MRI of the thoracic spine was ordered and completed December 19, 2007. The study showed impingement on the anterior aspect of the cord at multiple levels. The patient was referred for neurosurgical evaluation by Dr. Sunber Lal.

The patient was discharged from Self Regional Physical Therapy on January 15, 2008. His therapy was placed on hold because of continued pain and limitation of therapy secondary to pain. The patient was seen by Dr. Hodge who noted mildly increased reflexes, but no other symptoms of myelopathy. He did not feel surgery was warranted. He recommended pain management. He was evaluated by Dr. Hodge May 12, 2008, and he stated that he felt the injury was likely a soft tissue injury. The patient had reached MMI and was able to return to work without restriction.

On August 13, 2010, he reports he developed a severe, shooting pain in his back, causing him to fall to his knees. He states he stood up to get ready for work and felt the typical pain that he experiences in his mid back. He turned to the right to take a step with sudden onset of severe pain in the low back. He states he had previously had pain from the mid back radiating to the lateral aspect of his right leg. He has had some pain into the left lower extremity, but not as much as the right. He states that in addition to the mid back, he felt pain in the low back, which has persisted. He was evaluated that same day by Dr. Sida at Piedmont Health Group - Neurology, after referral from Dr. Bartz. Dr. Sida began a Decadron taper and prescribed Avenza and Valium.

MRI on August 17, 2010, demonstrated broad-based disc bulge at T10-T11 with ventral impression on the distal cord. Posterior element hypertrophy contributes to reduced moderate spinal canal stenosis. At T11-T12, broad-based disc bulge with focal herniation to the left of midline producing anterolateral impression upon the distal cord without cord signal change. Previous anterior cervical discectomy and fusion at C6-C7. Also noted, a small T4-T5 central disc protrusion with ventral impression on the thecal sac and cord. SSEP studies were stable with no evidence of cord conduction delay. _____ (unclear - possibly "SCVEMP" - please confirm) studies were within normal limits. There was no surgical intervention recommended.

The patient continued care at Upstate Medical Rehabilitation with Dr. David Shallcross. The patient was released and returned to work with restrictions after completing a functional capacity evaluation. Presently, the patient complains of mid back pain that radiates down the right side to the lower back and then into the right leg. He describes it as an aching, sharp, shooting pain that is typically 7/10 with use of medications. He states too much bending, sitting, standing, or twisting exacerbates his pain. Medication helps alleviate his pain. He reports no relief with physical therapy, exercise, or injections. He reports moderate relief of symptoms with massage, TENS unit, and

Continued . . .

John B. Leopard;

03/15/2011

PAGE 3

medication. The patient is not currently working. The patient's complete history and physical, as well as medication survey has been reviewed by me and included in the chart.

ALLERGIES:

NEOSPORIN.

CURRENT MEDICATIONS:

Zanax 4 mg 3-4 times a day, tramadol 50 mg 4-5 times a day, Lortab 10/500 taken 1-2 times per day, Relafen 750 mg 1-2 times per day, Lexapro 20 mg once a day.

PAST SURGICAL HISTORY:

C6-C7 fusion, right knee surgery, hernia repair.

FAMILY HISTORY:

Noncontributory. Chronic health problems, GERD.

SOCIAL HISTORY:

The patient smokes 1 pack of cigarettes per day and denies use of alcohol.

REVIEW OF SYSTEMS BY HISTORY:

General:	Denies fever, chills, weight loss/gain, fatigue, weakness.
Skin:	Denies rash, pruritus, lesions, bruising.
Head/EENT:	The patient denies abnormal discharge from the eyes, ears, nose.
Cardiovascular:	Denies palpitations, chest pain, syncope, dyspnea on exertion, orthopnea, peripheral edema, PND.
Respiratory:	Denies shortness of breath, dyspnea, cough, hemoptysis, wheezing, sputum.
Gastrointestinal:	Positive for heartburn. Denies constipation, diarrhea, change in bowel habits, nausea, vomiting, abdominal pain, dysphagia.
Neuropsychiatric:	Positive for problems with sleeping, depression. Denies syncope, seizures, weakness, memory/mood problems, drug/alcohol-related problems.
Neuromuscular:	As noted in HPI.
Endocrine/Hematologic:	Positive for decreased sex drive. The patient denies temperature intolerance, changes in hair/skin texture, bleeding tendency, easy bruising, lymph node enlargement, increase thirst, hunger, or weight gain/loss.

PHYSICAL EXAMINATION:

Ht: 5'10" Wt: 220 lbs. BP: 154/78 Pulse: 70 Temp: Afebrile.

Continued ...

John B. Leopard!

03/15/2011

PAGE 4

General:

The patient is a white male, well nourished body habitus, appears stated age, appropriate groomed, in no acute distress. The patient is oriented to person, place, time, and general circumstances. Mood and affect appear appropriate. The patient answers questions appropriate. It is felt the history is reliable.

HEENT:

The patient is normocephalic with normal hair distribution. His face is symmetrical with no maxillofacial abnormalities noted. Eyes are clear. The lids are normal without ptosis or edema. Extraocular muscles are intact. Ear, nose, and throat are intact.

Neck:

Supple. There are no carotid bruits. There are well-healed scars consistent with previous surgery, as listed in HPI and Past Medical History. There is generalized mild tenderness to palpation of the neck and shoulder girdle. The head and neck are in neutral position. He is able to actively touch his chin to his chest. Extension is mildly restricted. There is normal stability noted. There is normal strength and tone noted in the posterior and anterior musculature.

Chest:

Clear inspiratory and expiratory excursion is intact.

Cardiac:

Heart rate and rhythm are regular.

Abdomen:

Soft, nondistended. Bowel sounds are present.

Spine:

There was mild edema noted in the right thoracic rib area. There is elevation of the right hemipelvis with some obliquity of the right hemipelvis noted. Moderate tenderness in the right paraspinal area at the T10-T11 level. There is no kyphosis, lordosis, or scoliosis. Thoracic rotation is restricted bilaterally with rotation to the right 20 degrees and to the left 30 degrees. Lumbar range is mildly reduced in flexion plane. There is tenderness to palpation of the right SI joint.

Extremities:

There was no edema, erythema, or ecchymosis noted in the upper or lower extremities. There is no muscle or joint tenderness to palpation. There is no evidence of atrophy or muscle fasciculation in the upper or lower extremities. He has 4/5 muscle strength noted in the right hip, abductors, extensors, and right flexors. The remainder of the muscle testing of the upper and lower extremities is 5/5. Gait intact. The patient does not use mobility or assistive devices.

ASSESSMENT/PLAN:

1. Thoracic compression fractures at T10-T11, L1 (chronic).
2. Thoracic pain.
3. Right SI joint dysfunction.
4. Lumbosacral radicular pain.

It is my opinion to a reasonable degree of medical certainty that the additional symptoms described are related to the original injury. I noted on my exam evidence of

Continued . . .

John B. Leopard:

03/15/2011

PAGE 5

SI joint dysfunction on the right. There was previous documentation of a leg length discrepancy with the right longer, associated with anterior rotation of the ileum. Given the description of the onset of pain, I think these findings are most likely the source of increased pain, August 13, 2010. The question is how does the thoracic injury relate to these findings. There was no documentation noted indicating any derangement in the pelvis or sacrum, but I think it is reasonable to conclude that these changes occurred as a results of the fall that lead to the thoracic compression fractures and pain. Current treatment regimen is appropriate, but I would add treatment for the SI joint, pelvic tilt, and resultant functional leg length discrepancy. This should include strengthening, spinal stabilization exercises, lower extremity and spinal stretches, and soft tissue mobilization. It is also my opinion, based on my examination and review of the most recent functional capacity evaluation of January 14, 2011, that this patient is unable to perform the duties of maintenance and/or volunteer firefighter jobs.

This Independent Medical Evaluation includes both objective and subjective findings. I follow the applicable professional and ethical guidelines. These opinions are based on the facts as related to both the medical records and to the examination and to the historical examination of the examinee. I declare under penalties of perjury that the information contained within this document was prepared and is the work product of this undersigned physiatrist. It is true to the best of my knowledge and information.

Sybil Reddick, MD
Physical Medicine and Rehabilitation

SR:ats46
Voice file: 0330-335

Transcription dictated but not read in order to expedite records.

South Carolina Workers' Compensation Commission

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

WCC File # 0724852

Carrier File # 58-223652

Carrier Code # SF930

Employer FEIN 576000358

John B. Leopard 247-63-1193
Claimant's Name SSN
712 Stillwell Road, Greenwood, SC 29646
Address City State Zip

Home Phone

Work Phone

Richard B. Kale, Jr.

Preparer's Name

Greenwood County

Employer's Name

600 Monument St., Box P-103, Greenwood, SC 29646

Address City State Zip

S.C. Association Of Counties SIF

Insurance Carrier

(864) 527-3272

Phone #

**Complete each information blank. Specify clearly when contentions are admitted in part and denied in part.
The employer-insurance carrier in answer to the claim, respectfully shows:**

1. It is (admitted) that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: _____
2. It is (admitted) that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: _____
3. It is (admitted) that the relationship of employer and employee existed at the time in question. The reasons for denial are: _____
4. It is (admitted) that at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: _____
5. It is (admitted) that notice of injury was given the employer. The reasons for denial are: _____
6. It is (denied) that the employee needs or is entitled to additional medical care as a result of injury. The reasons for denial are: Claimant has reached maximum medical improvement; No medical evidence.
7. It is (denied) that the employee is entitled to temporary total disability for the period(s) of: _____
8. It is (denied) that the employee is permanently disabled. The reasons for denial are: Deny that claimant has had a change of condition for the worse; No medical evidence.
9. It is (denied) that the employee has a serious disfigurement.
10. It is contended that an average weekly wage of \$ 231.18 applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: Section 42-17-90 (statute of limitations); Defendants reserve the right to amend.

I certify that I have served this document pursuant to R.67-212 by delivering a copy to Lena Y. Meredith, Esquire,
Name

P.O. Box 457, Greenwood, SC 29648 and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202
Address

on the 28th day of June, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

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

Richard B. Kale, Jr.
Preparer's Signature, Attorney for Defendants
Richard B. Kale, Jr.

Willson Jones Carter & Baxley, P.A.
872 S. Pleasantburg Drive
Greenville, SC 29607

Jane C. Watkins
Jane C. Watkins, Certifier

June 28, 2011
Date

Refer to R.67-205 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723



WCC File #: 0724852
Carrier File #: 580000223652
July 21, 2011

NOTICE OF HEARING

JOHN B LEOPARD v. GREENWOOD COUNTY FIREMAN

Subject: To determine issues as set forth on Forms 50 and 51.
Date: August 24, 2011 at 02:15 PM
Location: City Hall-Public Safety, 404 North Broad St., City Council Chambers
Clinton, SC 29325

South Carolina Regulations 67-601 through 67-615 govern hearings before the South Carolina Workers' Compensation Commission. The claimant must attend when not represented by an attorney or when disfigurement is involved. Corporations must be represented by an attorney, and uninsured employers must attend.

Attorneys must file a Form 58 with proof of service pursuant to Regulation 67-611. Postponements are only granted pursuant to Regulation 67-613. Please visit www.wcc.sc.gov/Commissioners to view Commissioners' Preferences. If you have questions regarding this matter, please contact the office of the undersigned Jurisdictional Commissioner.

Commissioner Avery B. Wilkerson Jr.
803-737-5697, eboyd@wcc.sc.gov

CERTIFICATE OF SERVICE – This is to certify the undersigned has served this notice in the above entitled action upon all parties to this cause by sending a copy hereof by electronic mail or United States mail.

By: Elaine Boyd, SC Workers' Compensation, July 21, 2011

Party

Employee: JOHN B LEOPARD

Employer: GREENWOOD COUNTY FIREMAN
Carrier: SC Association of Counties SIF

Attorney

Lena Y Meredith
lana@nicholsonanderson.com
864-229-7241

Richard B. Kale, Jr
rbkale@wjlaw.net
864-527-3272

South Carolina Workers' Compensation Commission

1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739
www.wcc.sc.gov



PRE-HEARING BRIEF
WCC File No: 0724852

Claimant's Name: <u>John B. Leopard</u>	Employer's Name: <u>Greenwood County (Volunteer Fireman)</u>
Address: <u>712 Stillwell Rd</u>	Address: <u>600 Monument St., P-103</u>
City: <u>Greenwood</u> State: <u>SC</u> Zip: <u>29646</u>	City: <u>Greenwood</u> State: <u>SC</u> Zip: <u>29646</u>
Home Phone: <u>864-227-8763</u> Work Phone: _____	Carrier: <u>SC Assoc of Counties SIF Companion TPA</u>
Preparer's Name: <u>Lena Y. Meredith, Attorney for Claimant</u>	Preparer's Phone #: <u>864-229-7241</u>

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$ 154.13 2. AWW: \$ Date of Injury: 10/30/2007
3. Type of injury and body part(s): Back -- thoracic compression fractures.
4. Facts in controversy: Claimant would show that his degree of permanent impairment to the back has increased since previous award of 40% February 2010.
5. Legal issues involved: Change of condition under §42-17-90, PPD §42-9-30 vs. TPD 42-9-10(b). Claimant argues that Brown v. Bilo and §42-15-95 operate to exclude Dr. Shallcross's opinion that he has not suffered a change of condition, as it was obtained via ex parte submission of work performance related information transmitted by nurse case manager representing employer/carrier.
6. Unusual aspects: Claimant requests a continuance or that the record be left open for records of Dr. Sida, Piedmont Neurology.
7. Witnesses (designate if expert):* Claimant; wife; Dr. Shallcross (by deposition).
8. Exhibits: Deposition of Dr. Shallcross.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): See APA
10. Name, address, and specialty, if any, of the treating physician: Pain Management Assoc, 105 Vinecrest Ct, Greenwood, SC 29646;
Optimum Life, 115 Academy Ave, Greenwood, SC 29646; Montgomery Center, 155 Academy Ave, Greenwood, SC 29646; Upstate Medical Rehab, 111 Doctors Dr, Greenville, SC 29605; Dr. Sida, 105 Vinecrest Ct, #1000, Greenwood, SC 29646; Dr. Bartz, 1506 Spring St, Greenwood, SC 29646; Self Regional Healthcare, 1325 Spring St, Greenwood, SC 29646; Greenwood Sports Rehab, 105 Vinecrest Ct, #400, Greenwood, SC 29646; Southeastern Neurosurgical, 111 Doctors Dr, Greenville, SC 29605; Southeastern Spine Institute, 1106 Chuck Dawley Blvd, Ste 200, Mt Pleasant, SC 29464; Matrix/VBS Physical Therapy, 712 North A St, Easley, SC 29640; Select Physical Therapy, 110 ByPass 225, Greenwood, SC 29646
11. Impairment rating(s); body part(s); physician and date of opinion: Additional 15% spine/whole person; Steven C. Poletti, Southeastern Spine Institute, 116 Chuck Dawley Blvd, Ste 200, Mt Pleasant, SC 29464
12. I am amending my Form 50/51 in the following manner: Claimant, in the alternative, requests an aware of increased PPD.

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

Signature: _____

Lena Y. Meredith, Nicholson & Anderson

Email: lena@nicholsonanderson.com

Date of hearing: August 24, 2011

Time needed for hearing: 1/2 hour

On behalf of ☒ Claimant ☐ Employer

I certify that I have served this document pursuant to R.67-212 by delivering a copy to

Richard B. Kale, Jr., Willson, Jones,
Name

Carter & Baxley, P.A., 872 S Pleasantburg Dr, Greenville, SC 29607

Address

on the 9th day of August, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

Lena Y. Meredith, Certifier

Date

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.

58

PRE-HEARING BRIEF

STATE OF SOUTH CAROLINA)
COUNTY OF GREENWOOD)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION
COMMISSION

John B. Leopard,)
Employee/Claimant,)
vs.)
Greenwood County,)
Employer/Defendant.)
and)
Association of Counties,)
Carrier/Defendant.)

APA SUBMISSION
WCC NO: 0724852

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND
RICHARD B. KALE, JR., ESQUIRE

YOU ARE HEREBY NOTIFIED that the Claimant, pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-12-330 (1976, as amended) herewith submits the following reports/physicians or other evidence on behalf of the Claimant, to wit:

<u>Name of Physician/Other</u>	<u>Date</u>	<u>No. Of Pages</u>
1. Family Physicians of Greenwood	10-1-07 to 8-13/10	1-24
2. Self Regional Healthcare	10-30-07 to 8-19-10	25-39
3. Montgomery Center for Family Medicine	10-31-07 to 12-21-07	40-61
4. Optimum Life	11-07-07 to 1-15-08	62-69
5. Carolina Neurosurgery and Spine Center	11-14-07 to 7-15-08	70-76
6. Southeastern Neurosurgery	2-19-08 to 3-23-09	77-90

7. Upstate Medical Rehab	6-4-09 to 2-2-11	91-110
8. Piedmont Health Group – Neurology	8-13-10 to 10-15-10	111-124
9. Southeastern Spine Institute	11-17-10 to 3-28-11	125-129
10. Pain Management Associates	3-15-11	130-137

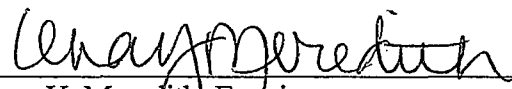
** In addition to those listed about, Claimant will rely on submissions of Employer/Carrier, in order not to duplicate submissions.

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 deposition(s) of any of the physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER HEREBY NOTIFIED that the originals of the documents referred to herein, or photocopies received from said physicians/others, will be presented before 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 Claimant at the hearing regarding this claim.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called: Claimant, wife, as well as any witnesses listed by the Employer/Carrier.

RESPECTFULLY SUBMITTED,


 Lena Y. Meredith, Esquire
 NICHOLSON & ANDERSON
 109 W. Court Avenue
 P.O. Box 457
 Greenwood, SC 29648

August 9, 2011.

Date: 05/04/10
Time: 1034

SELF REGIONAL HEALTHCARE
Abstract Summary Form

Page : 1
Report: EPABFA

Patient: LEOPARD, JOHN B Address: 712 STILLWELL RD
DOB: 09/17/70 Fin Class: WORKER'S COMPENS GREENWOOD
Sex: MALE Ins. Plan: WORKER'S COMPENSATION SC, 29646
Guarantor: SELF Phone #: (864) 227-8763

Adm Date: 05/01/10 Adm Source: EMERGENCY ROOM Acct. #: 1012100998
Adm Time: 20:01 Adm Type: EMERGENCY Unit. #: 000157622
Dis Date: 05/01/10 Trans From: Pt. Type: EMERGENCY
Dis Time: 23:45 Service: EMERGENCY SERVICES Trans To:
LOS: 1 Dis Status: HOME OP Coder: BP

Admitting DR: LOGAN, JOSEPH W Referring DR: MISCELLANEOUS, MIS
Attending DR: LOGAN, JOSEPH W Discharge DR: LOGAN, JOSEPH W
ER Physician: LOGAN, JOSEPH W Primary DR: HILL, JOSEPH B

DRG: 552 MEDICAL BACK PROBLEMS W/O MCC

Admit Diagnosis: 724.5 BACKACHE NOS

Principal Diagnosis: 724.2 LUMBAGO

Secondary Diagnoses/POA:

530.81 ESOPHAGEAL REFLUX/

POA:

305.1 TOBACCO USE DISORDER/

Reason for Visit:

Principal Procedure:

Date:

Primary Surgeon:

Secondary Procedures:

HCPCS:

Modifiers:

Date:

Surgeon:

Pre APC:

Consultants:

Date:

Specialty:

End of Report

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05-1-10 2025 32-2
DATE: TIME: ☐ on arrival ROOM: EMS Arrival

HISTORIAN: patient spouse paramedics
HX / EXAM LIMITED BY:

HPI

chief complaint: injury / pain to back neck

hx of chronic: neck / back pain

onset / duration: min / hrs / days ago continues in ED

intermittent my 2007 better
↑ pain today gone now
worse

recent injury? no yes possibly

context: lifting turning / bending fall / near fall trauma

fx of back in 2007 comp
↑ but dx - in 1st time

Where? home work school

Other injuries? neck head back other

severity of pain: mild moderate severe (1/10)

quality:

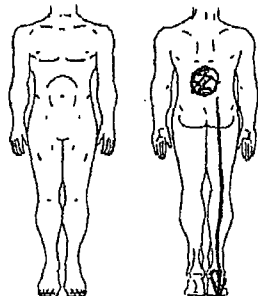
burning

sharp

dull

similar to
prior back
pain(s)

location of pain:



radiation show radiation → R

associated symptoms:

fever / chills

sweating

constipation / incontinence

nausea / vomiting

problems urinating

difficulty walking

light-headedness

dizziness

numbness / weakness

worsened by: nothing

supine upright position

movement to right / to left / flexion

cough / deep breaths

relieved by: nothing

supine upright position

remaining still

no help TENS unit

Similar symptoms previously

Recently seen / treated by doctor / hospitalized Shellcross
has pt 11 June 10

Addressograph

John Leopard



1012100998 000157622
LEOPARD, JOHN B
Rm: - 09/17/70 - M

© 1996 - 2008 T-System, Inc.
Circle or check affirmatives, backlash (V) negatives
EMERGENCY PHYSICIAN RECORD
Emergency Care Center
SELF REGIONAL
HEALTHCARE

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08 Low Back Pain / Injury

ROS

CONST

recent illness

CVS / RESP

chest pain

shortness of breath

GI / GU

abdominal pain

black stools

EYES / ENT

problem with vision

sore throat

LNMP N/A preg post-menop

MS / SKIN / LYMPH

calf / leg pain

leg / ankle swelling

rash

swollen glands

NEURO / PSYCH

headache

anxiety / depression

All systems neg except as marked

* CONST / GI / GU / NEURO / MS components also addressed in HPI

PAST HX

arthritis

back injury

back pain

episode(s) chronic

compression fracture(s)

gall stones

sciatica

Interv. disc disease

kidney stones

pancreatitis

GERD

old records ordered / summary:

aortic aneurysm

cancer chemo / rad tx

cardiac disease

CAD arrhythmias angina CHF

CVA / TIA deficit

diabetes Type 1 Type 2

diet / oral / insulin

hepatitis / HIV

hypertension

peptic ulcer disease

prostatitis

cholesterol

Surgeries / Procedures none

back surgery

CT / MRI

neck surgery - Jan 08

appendectomy

cholecystectomy

hysterectomy / BTL / C-section

Tetanus immun. UTD / given in ED

Medications none see nurses note

aspirin coumadin clopidogrel NSAID

narcotic

Allergies NKDA

see nurses note

heosprin

Dental

SOCIAL HX smoker

alcohol (recent / heavy / occasional)

drugs IVDA

occupation

FAMILY HX

aortic disease

BM, CAD, cancer



1ECTS600

09 - 08 / t-sheet / Page 1 of 2

☒ Nursing Assessment Reviewed ☐ Vitals Reviewed

PHYSICAL EXAM

General Appearance

☒ no acute distress
☒ alert

EENT

☒ normal eye exam
☒ normal ENT inspection
☒ pharynx nml

NECK

☒ nml inspection
☒ non-tender
☒ painless ROM

RESP / CVS

☒ chest non-tender
☒ breath sounds nml
☒ heart sounds nml

ABDOMEN

☒ non-tender
☒ no organomegaly
☒ no pulsatile mass

BACK

☒ non-tender
☒ nml inspection
☒ painless ROM

RECTAL / GENITAL

☒ nml rectal exam
☒ heme neg. stool
☒ nml ext inspection

c-collar / backboard (PTA / in ED)

mild / moderate / severe distress

anxious / lethargic

scleral icterus / pale conjunctivae

pharyngeal erythema

lymphadenopathy

limited ROM

tenderness / swelling / ecchymosis

crepitus / subcutaneous emphysema

decreased breath sounds

wheezes / rales / rhonchi

tachycardia / bradycardia

see diagram

hepatomegaly / splenomegaly

mass / prominent aortic pulsation

abdominal bruit

see diagram

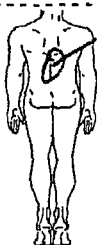
decreased ROM

muscle spasm

vertebral point / CVA tenderness

decreased rectal tone

discharge / lesions



T=Tenderness
P/T=Point
T=Tenderness
S=Swelling
E=Ecchymosis
L=Laceration
A=Abrasion
B=Burn
(Ø=without m=mild
mod=moderate
sev=severe)

STRAIGHT RIGHT- negative pain at degrees

LEG RAISING LEFT- negative pain at degrees

NEURO / PSYCH

☒ oriented x3
☒ motor nml
☒ sensation nml
☒ dorsiflexion of great
toes normal bilaterally
☒ reflexes nml
☒ mood / affect nml

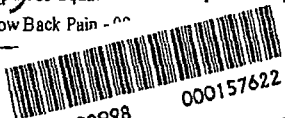
SKIN

☒ color nml, no rash
☒ warm, dry

EXTREMITIES

☒ non-tender, full ROM
☒ no pedal edema
☒ pulses equal

Low Back Pain -



1012100998

LEOPARD, JOHN B

Rm: -

000157622

09/17/70 - M



LABS & XRAYs

CBC

normal except

WBC

Hgb

Hct

Platelets

Chemistries

normal except

Gluc

BUN

Creat

Na

K

Anion Gap

Osmolality

UA

normal except

HCG

serum / urine

POS NEG

ETOH

TOX

XRAYs

Interp. by me

Reviewed by me

Discd w/ radiologist

T-spine LS-spine

nml / NAD

no fracture

nml alignment

soft tissues nml

CT Scan / MRI

nml / NAD

Discd w/ radiologist

Other

Still same pain

unchanged

improved

re-examined

Time 2325

Discd w/ radiologist

Additional history from:

family caretaker paramedics

Rx given

CRIT CARE TIME (excluding separately billable procedures)

min

CLINICAL IMPRESSION

Low Back Pain - acute

Strain / Sprain - acute

thoracic lumbosacral

Aortic Aneurysm

ruptured enlarging

Cancer - metastatic

Cauda Equina Syndrome

Cholecystitis / Biliary Colic

Compression Fracture at

Contusion - lumbar thoracic

Degenerative Disc Dz

Epidural Abscess / Mass

Herniated Disc - acute at

Sciatica - acute R / L

Spinal Hematoma

Ureterolithiasis / Renal Colic

UTI / Pyelonephritis

Discharge Instructions

Rest to back

Rest

Follow up with Dr. Puro

Rx given: Lorazepam #30 / Ativan #12

Return to work/school

Return to ECC

DISPOSITION

Time 2340

CONDITION

Care transferred to Dr.

Time:

x NP / PA x MD

x Resident

x PSD

Attending

Template Complete

See Addendum (Dictated / Template #)

09 - 08 / t-sheet / Page 2 of 2

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3

51

Date: <u>5-1-10</u>	Additional Orders	Physician Orders	Staff Initials/Time
2100	Dilaudid 2mg/m - Port	☐ Old Records	
		☐ FSBS	
		☐ CBC ☐ Hemogram	
		☐ Basic Metabolic Profile	
		☐ Comp Metabolic Profile	
		☐ Liver Profile	
		☐ Amylase ☐ Lipase	
		☐ PT ☐ PTT	
		☐ BNP ☐ D-dimer	
		☐ CKI ☐ w/Troponin	
		☐ Cardiac Labs	
		☐ Trauma Labs	
		☐ Blood Culture x	
		☐ Rapid Strep	
		☐ Drug Levels	
		☐ Psych Panel	
		☐ U/A void/cath	
		☐ Urine Culture	
		☐ UCG ☐ hCG	
		☐ Quantitative HCG	
		☐ Urine Drug Screen	
		☐ GC/Chlamydia	
		☐ Wet Prep	
		☐ CXR ☐ Port	
		☐ C-Spine ☐ Port	
		☐ Pelvis ☐ Port	
		☐ Abd Series	
		☐ IVP	
		☐ CT	
		☐ U/S	
		☐ Xrays:	
		☐ ECG	
		☐ ABG	
		☐ Monitor ☐ Pulse Ox	
		☐ IV	
		☐ O2 at Lpm via	
		☐ Trauma Alert called at	
		☐	
		☐	

CT of Thoracic spine
 Hx of old comp fx - T-10-11
 (+L)
 major fx on Today.

Percent 5/325 TTH
 Port

ECC MD/Mid Level reviewed patient supplied medication list.
 Signature [Signature]
 Signature [Signature]
 Addressograph



1012100998 000157622
 LEOPARD, JOHN B
 Rm: - 09/17/70 - M

Emergency Physician Orders
 Self Regional Healthcare



1EPO708

Form # N-859/ 1-09/Single/Page 1 of 1

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SELF REGIONAL HEALTHCARE
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: LEOPARD, JOHN B

Check-in Date: 05/01/10 2200

Unit Number: A000157622

Location: DIS - ED

Account # 1012100998

BD: 09/17/70 Age: 39Y

Sex: M

Ordering Physician LOGAN, JOSEPH W

Admit Phys: LOGAN, JOSEPH W

LOGAN, JOSEPH W
1325 SPRING STLOGAN, JOSEPH W
1325 SPRING ST

GREENWOOD SC

29649

GREENWOOD

SC 29649

Chk-in #	Order	Exam
1223538	0001	70238 CT SPINE THORACIC WO CONTRAST Ord Diag: BACK PAIN
1223539	0002	70320 CT 3D WITHOUT W/S Ord Diag: BACK PAIN

CT THORACIC SPINE with RECONSTRUCTIONS: 1 May 2010

TECHNIQUE: Helical imaging of the thoracic was performed and sagittal and coronal reconstructed images were obtained at the CT scanner console.

ESTIMATED DOSE: 37 mSv

FINDINGS: A mild sigmoid thoracic scoliosis is noted dextroconvex at T5-6 and levoconvex at T12-L1. Small endplate deformities are present at multiple mid and lower thoracic levels. Anterior wedging of the T11 vertebra is seen with approximately 20-25% loss of anterior and central vertebral body height. Milder wedging of the L1 vertebra is also noted. Incidental note is made of an osteoma within the T1 spinous process/right lamina. Central canal and foramina are patent. Anterior cervical fusion plate and screws are present at C6-7. A 2-3 mm nonobstructing left intrarenal calculus (image #72) is noted. Radiodense material is seen within the esophagus below the carina.

IMPRESSION:

1. Mild thoracic scoliosis.
2. Lower cervical anterior disc fusion.
3. Multiple endplate deformities within the thoracic spine. T11 and L1 a wedge compression deformities.
4. Osteoma in the T1 posterior elements.
5. Left intrarenal calculus.
6. Radiodense material within the esophagus.

Read By- STUART TINKLER M.D.
FINAL

Page 1

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6

SELF REGIONAL HEALTHCARE
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: LEOPARD, JOHN B Check-in Date: 05/01/10 2200
Unit Number: A000157622 Location: DIS - ED

Account # 1012100998 BD: 09/17/70 Age: 39Y Sex: M

Ordering Physician LOGAN, JOSEPH W Admit Phys: LOGAN, JOSEPH W

LOGAN, JOSEPH W
1325 SPRING ST

LOGAN, JOSEPH W
1325 SPRING ST

GREENWOOD SC

29649

GREENWOOD

SC 29649

Checkin-Exam Code Summary
1223538-70238, 1223539-70320

Released By- STUART TINKLER M.D.
Transcriptionist- STUART TINKLER M.D.
Released Date Time- 05/02/10 1141

FINAL

Page 2

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7

Preliminary Radiology Report
Vision Radiology (510) 683-9500 - Phone

Self Regional Healthcare

NAME: Leopard, John
Patient No: SRH000157622
Date of Birth: 09/17/1970

DATE OF EXAM: 05/01/2010
Physician: Logan^Joseph^W

Past Medical/Surgical History (entered by technologist):
Symptoms/Reason For Exam (entered by technologist):

Additional History (per Vision Radiologist): Back pain

NONCONTRAST CT THORACIC SPINE:

IMPRESSION:

No acute fractures. Incidental Schmorl's nodes/intravertebral disk herniations throughout the spine. Mild inferior endplate irregularity of the L1 vertebral body probably chronic. Alignment is unremarkable.

Anterior fusion C6-7. Sclerotic focus right T1 lamina probably a bone island measuring 10 x 9 mm.

Paraspinous soft tissues are unremarkable.

Punctate nonobstructing stone in the left kidney. No hydronephrosis or hydroureter.

Density within the esophagus probably ingested material.

Case discussed with Dr. Cook at 10:42 PM Eastern time

Nepenthe Fong, M.D.

This report has been electronically signed and verified by the Radiologist whose name is printed above.

DD: 05/01/2010/DT: 05/01/2010

PRINTED BY: E16055

52

7

Addressograph.



1012100998 000157622
LEOPARD, JOHN B 09/17/70 - M
Rm: -

Initial History

Self Regional Healthcare



1HX4580

Form # N-83AECC/ 9-09/Single/Page 1 of 1

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Respiratory: ☐ N/A ☐ No distress noted EFFORT ☒ Non-labored ☐ SOB ☐ Retractions ☐ Stridor Breath Sounds R L Present ☐ ☐ Clear ☐ ☐ Wheezing/Rhonchi ☐ ☐ Diminished ☐ ☐ Crackles ☐ ☐ Chest Expansion: Symmetric/ Asymmetric Cough ☐ N/A ☐ Nonproductive ☒ Productive	CARDIAC ☒ N/A CARDIAC RHYTHM Patient on Monitor Y/N If Yes, alarms ☐ On Chest Pain Y/N ☐ Constant ☐ Tightness ☐ Intermittent ☐ Sharp ☐ Heaviness ☐ N/V ☐ Diaphoresis CAPILLARY REFILL ☐ Absent ☐ less than 2 sec ☐ greater than 2 sec PULSE Regular / Irregular Radial R ☐ L ☐ Pedal R ☐ L ☐	NEUROLOGY ☐ N/A ☒ Alert ☐ Playful ☐ Oriented x3, x2, x1 ☐ Unresponsive ☐ Consolable ☐ Confused * ☐ Slurred Speech ☐ aphasic ☐ Appropriate for Age ☐ Verbal Stimuli ☐ Combative ☐ Painful Stimulation ☐ Headache ☐ Anxious ☐ Drowsy * ☐ Dizziness * Gait: Steady/ <u>Unsteady</u> Weakness * Hand Grips: Equal/Unequal ☐ Decreased Sensation *If marked: ☐ placed Fall Risk sticker on chart Pupil Size ☐ N/A <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Size</td> <td>R</td> <td>L</td> </tr> <tr> <td>React</td> <td>R</td> <td>L</td> </tr> </table> Size: Reaction: P=Pinpoint B=Brisk N=Normal S=Sluggish D=Dilated N=Nonreactive U=Unobtainable See pupil scale below	Size	R	L	React	R	L	EYES/ENT ☒ N/A Eyes ☐ Asymptomatic ☐ For. Body ☐ R ☐ L ☐ Burning ☐ R ☐ L ☐ Pain ☐ R ☐ L ☐ Redness ☐ R ☐ L ☐ Discharge ☐ R ☐ L ☐ Injury ☐ R ☐ L Date Time Mechanism Ears ☒ Asymptomatic ☐ Drainage ☐ R ☐ L ☐ CSF ☐ R ☐ L ☐ Pain ☐ R ☐ L ☐ Injury ☐ R ☐ L Date Time Mechanism Nose ☒ Asymptomatic ☐ Epistaxis ☐ R ☐ L ☐ For. Body ☐ R ☐ L ☐ Congestion ☐ R ☐ L ☐ Drainage ☐ R ☐ L Oral ☒ Asymptomatic ☐ Sore Throat ☐ Dysphagia ☐ Drooling ☐ Broken Teeth	GI Abdomen ☒ N/A ☐ Soft ☐ Distended ☐ Rigid ☐ Non Tender ☐ Tender ☐ Bruised ☐ Guarding ☐ Pain ☐ N/V ☐ Diarrhea Bowel Sounds ☐ Present x Quads ☐ Absent ☐ Hypoactive ☐ Hyperactive Last BM Color GU ☒ N/A ☐ Flank Pain R L ☐ Incontinent ☐ Pain ☐ Hematuria ☐ Urgency ☐ Retention ☐ Burning ☐ Frequency ☐ Pressure Duration Urine Color ☐ Penile Discharge Color: Psych ☒ N/A Eye contact: Yes / No Affect ☐ Normal ☐ Flat Behavior ☐ Cooperative ☐ Violent ☐ Destructive ☐ Restless ☐ Agitated Mental Status ☐ Oriented ☐ Confused * ☐ Lethargic ☐ Unconscious ☐ See Seclusion Flowsheet N-2008 ☐ See Restraint Flowsheet N-150 Do you suspect this patient is suicidal? ☐ No ☐ Yes If yes, consult Director/ Nursing Supervisor for guidance.
Size	R	L								
React	R	L								
INFECTION CONTROL PRECAUTIONS: ☐ Infection not suspected ☐ Infection suspected & Precautions required until ruled out CONTACT: Chicken Pox, Small Pox, Scabies, Lice, SARS, Conjunctivitis, uncontained drainage or Diarrhea, C. difficile ☐ DROPLET: Flu, Meningitis, Pertussis ☐ AIRBORNE: TB, pandemic flu, SARS, Chicken Pox less than 6 yrs old, Contact & Droplet: Scarlet Fever, Grp A Strep, RSV, Bronchiolitis, Croup Precautions Initiated: Time: Initials:										
Completed By: <u>S. J. [Signature]</u> RN Date: <u>5/1</u> Time: <u>2000</u> RN Date: Time:										
Belongings (ONLY IF ADMITTED) Dentures/Partials Upper/Lower With Patient/ Family ☐ N/A Jewelry ☐ With Patient/ Family ☐ N/A Clothing: ☐ With Patient/ Family ☐ N/A Money/Valuables ☐ N/A ☐ Locked up Env. # Home Meds: ☐ N/A ☐ Sent Home ☐ In Pharmacy ☐ With Patient With Family (Name:) Belongings Completed By: Date: Time:										
Pupil Scale 1 ● 2 ● 3 ● 4 ● 5 ● 6 ● 7 ● 8 ●										



10/2100998 000157622
LEOPARD, JOHN B
Rm: 09/17/70 - M

Initial Systems Assessment
Self Regional Healthcare



1CNP4660
Form # N-83B/ 4-09/HTD Duplex/Side 1 of 2

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Future Use Only

IV SITE / FLUIDS ☐ See Attached DC'D = Discontinued													
DATE	TIME	IV #	IV-# OF ATTEMPTS	GAUGE	SITE	FLUIDS/MED.	BAG #	AMT.	RATE	PUMP	TIME DC'D	AMT INFUSED	INITIALS
				ga.				mL	mL/h	Y/N			mL
				ga.				mL	mL/h	Y/N			mL
				ga.				mL	mL/h	Y/N			mL
				ga.				mL	mL/h	Y/N			mL
				ga.				mL	mL/h	Y/N			mL

MEDICATIONS ☐ See Attached * If pain present, use the most appropriate scale and enter the number that best rates the intensity. If not appropriate to rate by scale, use S&S key. Pain S&S key: FB = Facial & Body Behaviors VS = Vital Signs VC = Verbal Cues ↑ = Increase ↓ = Decrease NC = No Change

DATE	TIME	MEDICATION	DOSE	ROUTE	SITE	RESPONSE	*PAIN RATING PRIOR	TIME/ *PAIN RATING AFTER	INITIALS
5/1	211	Td VIS _____ (date) Lot # _____	0.5 mL	IM					
		Oral Discharge Drug IN @ Deliberate					8	2145	6 m

BLOOD PRODUCTS ☐ See Attached

DATE	TIME	BLOOD PRODUCTS	UNIT #	IV #	GAUGE	SITE	RATE	PUMP	TIME DC'D	AMT INFUSED	INITIALS
					ga.		mL/h	Y/N			
					ga.		mL/h	Y/N			

VITAL SIGNS ☐ See Attached

DATE	TIME	B/P	P	R	T	C. MONITOR RHY.	PULSE OX.	GCS	COMMENTS	INITIALS
							%on L/Min O ₂ via			
							%on L/Min O ₂ via			
							%on L/Min O ₂ via			

GCS q 1 hour on Head Injury Patients

ADMISSION/DISCHARGE ASSESSMENT: REVIEW ABOVE INFORMATION, ASSESS PATIENT, DOCUMENT CHANGES

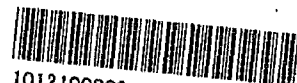
TRANSFER ☒ N/A ☐ Transfer Protocol	Vital Signs ☐ N/A BP _____ P _____ R _____ T _____
Via: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance ☐ Carry	Pain rating is <u>4</u> using Numeric (0-10) FACES FLACC NIPS
Condition: ☒ Stable ☐ Unstable ☐ Unchanged ☐ LWT ☐ LBTC ☐ AMA ☐ Morgue	☐ Condition unchanged from Initial Assessment ☐ Assessment Changes:
Admission Information: Room # _____	<u>pt given DR instructions</u>
Admitting Physician: _____	<u>pt gave no question</u>
Report To: _____	<u>all needs met pt DR</u>
Intake: _____ Output: _____	<u>driven - no call</u>
O ₂ Y/N _____ L/Min via _____	Patient/Family verbalizes issues/concerns at time of discharge? ☐ No ☐ Yes, see notes
Monitor Y/N Rhythm _____	☐ Instructed Pt/Family meds may cause drowsiness.
☐ See Patient Progress Notes (N-4005)	☐ Pt/Family verbalized understanding of Discharge instructions
☐ See Supplemental ECC Care Notes/ Procedures (N-83S)	Take home pack: _____ Lot # <u>0512273142</u>
☐ See Trauma Flow Sheet (N-83TF)	Take home pack: _____ Lot # _____
☐ See Code Blue/99 sheet (N-787)	Take home pack: _____ Lot # _____
Blood Bank Label	Initials: <u>NA</u> Date: <u>5/1</u> Time: <u>2345</u>
Diet ☐ N/A	Signature/Title: <u>Tanya Q. Harkin</u> <u>NA</u> Initials: <u>TQH</u>
Last Meal: ☐ Regular ☐ Diabetic ☐ Cardiac ☐ Low Fat	<u>no call</u>

Addressograph

ECC Care Notes/ Procedures
Self Regional Healthcare

INTENTIONALLY LEFT BLANK

Form # N-83C/ 4-09/HTDuxplex/Side 2 of 2



1012100998 000157622

LEOPARD, JOHN B

Rm: -

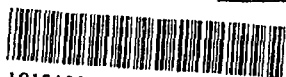
09/17/70 - M

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11

[illegible]

Address



1012100998 000157622
LEOPARD, JOHN B
Rm: - 09/17/70 - M

Patient Progress Notes

Self Regional Healthcare



1FS5120

Form # N-4005/9-03/HTDuplex/Side 1 of 2/FS-DateOrd

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DATE: 12/30/97 TIME: 2:00 ROOM: 31 EMS Arrival
HISTORIAN: patient spouse paramedics
_HX / _EXAM LIMITED BY:

HPI

chief complaint: Fall Injury to: <u>mid back</u>																													
occurred: last PTA today yesterday days PTA	where: home school neighbor's city park work street <u>home fire</u>																												
context: tripped / slipped / lost balance became dizzy / fainted alleged assault bicycle (helmet? Y N) fell from (standing position / from height) <u>gave myself my own head first into a fire</u> <u>at the house lower than expected - fell forward on</u> <u>hands - 4-5 feet - back twisted - with scapula</u>																													
location of pain / injuries: head face mouth neck chest abdomen <u>back upper mid lower</u> <u>radiating to R/L thigh / leg</u>	<table border="1"><thead><tr><th colspan="2">-right-</th><th colspan="2">-left-</th></tr><tr><th>shldr</th><th>hip</th><th>shldr</th><th>hip</th></tr></thead><tbody><tr><td>arm</td><td>thigh</td><td>arm</td><td>thigh</td></tr><tr><td>elbow</td><td>knee</td><td>elbow</td><td>knee</td></tr><tr><td>f-arm</td><td>leg</td><td>f-arm</td><td>leg</td></tr><tr><td>wrist</td><td>ankle</td><td>wrist</td><td>ankle</td></tr><tr><td>hand</td><td>foot</td><td>hand</td><td>foot</td></tr></tbody></table>	-right-		-left-		shldr	hip	shldr	hip	arm	thigh	arm	thigh	elbow	knee	elbow	knee	f-arm	leg	f-arm	leg	wrist	ankle	wrist	ankle	hand	foot	hand	foot
-right-		-left-																											
shldr	hip	shldr	hip																										
arm	thigh	arm	thigh																										
elbow	knee	elbow	knee																										
f-arm	leg	f-arm	leg																										
wrist	ankle	wrist	ankle																										
hand	foot	hand	foot																										
severity of pain: mild moderate <u>severe</u> <u>never enter</u> <u>Sigola</u> <u>pain is same</u>	associated symptoms: lost consciousness / dazed duration: remembers: impact coming to hospital seizure <u>from in hall & dressing</u>																												

ROS ☐ all systems neg except as noted loss feeling / power arms / legs headache double vision / hearing loss <u>no svr. to ur & rectal injury</u>	trouble breathing / chest pain nausea / vomiting loss of bladder function skin laceration recent fever / illness <u>no svr. to ur & rectal injury</u>
SOCIAL HX recent ETOH <u>smoker</u> drug abuse <u>Griffin</u>	

PAST HX negative
Griffin
Griffin
Griffin
Meds- none / see nurses note
Allergies- NKDA / see nurses note

Addressograph

07303-00555
LEOPARD, JOHN B
HISCELLANEOUS, HISC
H 09/17/1970 000157622
SURGERY DATE-

© 1996 - 2004 T-System, Inc.
Circle or check affirmatives, backslash (\) negatives.
EMERGENCY PHYSICIAN RECORD
Emergency Care Center
SELE REGIONAL
HEALTHCARE



IECTS600

08-04 / t-sheet / Page 1 of 2

19 Fall (5)

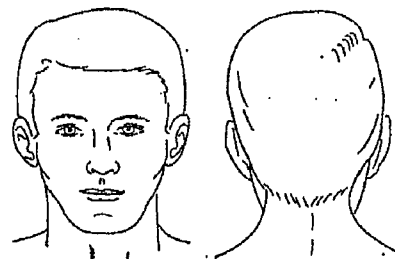
☐ Nursing Assessment Reviewed ☐ Vitals Reviewed ☐ Tetanus Immun. UTD

PHYSICAL EXAM

General Appearance collar (PTA / in ED) / backboard
no acute distress mild / moderate / severe distress
alert anxious / lethargic
IV / splint
see diagram
Battle's sign / Raccoon Eyes

HEAD
no evidence of trauma

NECK
non-tender see diagram
painless ROM vertebral point-tenderness
trachea midline muscle spasm / decreased ROM
pain on movement of neck



EYES
PERRL unequal pupils R- mm L- mm
COMI EOM entrapment / palsy
subconjunctival hemorrhage

ENT
nmI external hemotympanum
inspection TM obscured by wax
no dental injury clotted nasal blood
dental injury / malocclusion

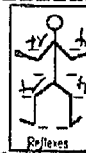
RESP / CVS
chest non-tender see diagram (on reverse)
breath sounds nmI decreased breath sounds
heart sounds nmI wheezing / rales
splinting / paradoxical movements

ABDOMEN
non-tender see diagram (on reverse)
no organomegaly tenderness / guarding / rebound
mass / organomegaly

GENITAL / RECTAL
perineal hematoma
nmI genital exam blood at urethral meatus
nmI vaginal exam decreased rectal tone
nmI rectal exam
heme negative stool

NEURO / PSYCH
oriented x3 confusion / disorientation
mood & affect nmI EOM palsy / anisocoria
CN's nmI facial asymmetry
as tested unsteady / ataxic gait
sensation & motor nmI sensory / motor deficit
uncomfortable reflexes blunted during exam

SKIN
intact see diagram
warm, dry crepitus / diaphoresis



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13

BACK

no CVA
tenderness
no vertebral
tenderness

EXTREMITIES

atraumatic
pelvis stable
hips non-tender
no pedal edema
DNT ROM

see diagram

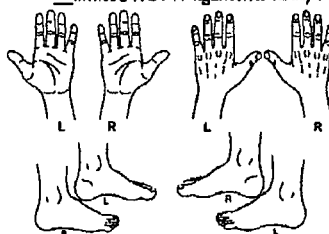
vertebral point-tenderness
CVA tenderness
muscle spasm / limited ROM

see diagram

bony point-tenderness
painful / unable to bear weight
pulse deficit

Joint Exam:

limited ROM / ligaments laxity / joint effusion



PROCEDURES:

Wound Description / Repair

length cm location
superficial *subcut. *muscle linear stellate irregular
clean contaminated moderately / *heavily
distal NVT: neuro & vascular status intact no tendon injury
anesthesia: local digital block mL
lidoc 1% 2% epi / bicarb marcalne .25% .5% LET
prep:
Hibiclen / Betadine / H2O2 debrided
irrigated / washed w/ saline minimal / *mod. / *extensive
minimal / mod. / *extensive undermined
foreign material removed minimal / mod. / *extensive
partially completely *wound margins revised
minimal / mod. / *extensive wound explored

repair: Wound closed with: wound adhesive / steri-strips
SKIN- # -0 nylon / prolene / staples / ethilon
*SUBCUT-# -0 vicryl
*may indicate intermediate repair *may indicate complex repair

XRAYS

☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist

C-Spine D-Spine LS-Spine

nm / NAD reversal / straightening of cerv. lordosis
no fracture DJD / spondylosis / spurring
nm alignment
soft tissues nm

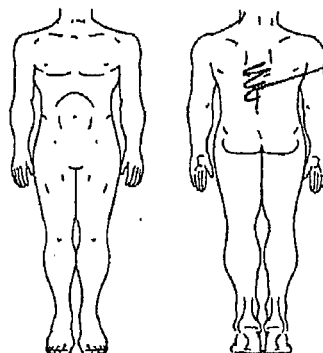
CXR

nm / NAD rib fracture
no infiltrates infiltrate / atelectasis
nm heart size
nm mediastinum

OTHER ☐ See separate report

Addressograph

07303-00553
LEOPARD, JOHN B
MISCELLANEOUS, MISC
H 09/17/1970 000157622
GERY



Tms 3

T=Tenderness
PT=Point Tenderness
S=Swelling
E=Eccymosis
Lac=Laceration
A=Abrasion B=Burn
(B=without m=mild
mod=moderate
sv=severe)
Try = Tenderness on
palpation (severe)

PROGRESS:

Time unchanged improved re-examined

Accurately reviewed - 10/23/03. C-Spine XRAY ->
C5/6 vert. bilat. transverse process fracture C6-7
distal clavicle = nondisplaced comminuted fracture
10/23/03 - 10/24/03 - 10/25/03 - 10/26/03 - 10/27/03 - 10/28/03 - 10/29/03 - 10/30/03 - 10/31/03 - 11/01/03 - 11/02/03 - 11/03/03 - 11/04/03 - 11/05/03 - 11/06/03 - 11/07/03 - 11/08/03 - 11/09/03 - 11/10/03 - 11/11/03 - 11/12/03 - 11/13/03 - 11/14/03 - 11/15/03 - 11/16/03 - 11/17/03 - 11/18/03 - 11/19/03 - 11/20/03 - 11/21/03 - 11/22/03 - 11/23/03 - 11/24/03 - 11/25/03 - 11/26/03 - 11/27/03 - 11/28/03 - 11/29/03 - 11/30/03 - 12/01/03 - 12/02/03 - 12/03/03 - 12/04/03 - 12/05/03 - 12/06/03 - 12/07/03 - 12/08/03 - 12/09/03 - 12/10/03 - 12/11/03 - 12/12/03 - 12/13/03 - 12/14/03 - 12/15/03 - 12/16/03 - 12/17/03 - 12/18/03 - 12/19/03 - 12/20/03 - 12/21/03 - 12/22/03 - 12/23/03 - 12/24/03 - 12/25/03 - 12/26/03 - 12/27/03 - 12/28/03 - 12/29/03 - 12/30/03 - 12/31/03 - 01/01/04 - 01/02/04 - 01/03/04 - 01/04/04 - 01/05/04 - 01/06/04 - 01/07/04 - 01/08/04 - 01/09/04 - 01/10/04 - 01/11/04 - 01/12/04 - 01/13/04 - 01/14/04 - 01/15/04 - 01/16/04 - 01/17/04 - 01/18/04 - 01/19/04 - 01/20/04 - 01/21/04 - 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Date: <u>10/30/09</u>	Time	Additional Orders	Physician Orders	Staff Initials/Time
2125		Morphine 4mg IV now) prior to xray Dilaudid 30mg IV	☐ Old Records	
		may repeat Morphine 4mg IV if pain	☐ FSBS	
			☐ CBC ☐ Hemogram	
			☐ Basic Metabolic Profile	
			☐ Comp Metabolic Profile	
			☐ Liver Profile	
			☐ Amylase ☐ Lipase	
2220		Morphine 4mg IV now	☐ PT ☐ PTT	
		Dilaudid 30mg IV	☐ CKI ☐ w/Troponin	
		prednisone 60mg po	☐ Cardiac Labs	
		Flexaid 10mg po	☐ Trauma Labs	
			☐ Blood Culture x	
			☐ Rapid Strep	
			☐ Drug Levels	
			☐ U/A void/cath	
			☐ Urine Culture	
			☐ UCG ☐ hCG	
			☐ Quantitative HCG	
			☐ Urine Drug Screen	
			☐ GC/Chlamydia	
			☐ Wet Prep	
			☒ CXR ☐ Port	
			☐ C-Spine ☐ Port	
			☐ Pelvis ☐ Port	
			☐ Abd Series	
			☐ IVP	
			☐ CT	
			☐ U/S	
			☒ Xrays: Dorsal spine	
			☐ ECG	
			☐ ABG	
			☐ Monitor ☐ Pulse Ox	
			☒ IV	
			☐ O2 at Lpm via	
			☐ Trauma Alert called at	
			☐	
			☐	
			☐	

Signature

Signature

Addressograph

07303-00555

LEOPARD, JOHN B

HISCELLANEOUS, MISC

M 09/17/1970 000157622

SURGERY DATE-

Emergency Physician Orders
Self Regional Healthcare

1EP0708

Form # N-859/ 4-06/Single/Page 1 of 1

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15

SELF REGIONAL HEALTHCARE
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: LEOPARD, JOHN B
Unit Number: A000157622Check-in Date: 10/30/07 2212
Location: DIS - ED

Account # 0730300555

BD: 09/17/70 Age: 37Y

Sex: M

Ordering Physician CAIN, BIBB R

Admit Phys: CAIN, BIBB R

CAIN, BIBB R
1325 SPRING STCAIN, BIBB R
1325 SPRING ST,

GREENWOOD SC

19646

GREENWOOD

SC 19646

Chk-in #	Order	Exam	
874812	0001	68847	XR CHEST PA AND LAT Ord Diag: BACK PAIN
874813	0001	68973	XR DORSAL SPINE 2 VIEWS Ord Diag: BACKPAIN

PA AND LATERAL CHEST 10/30/07

INDICATION: Back pain.

FINDINGS: Cardiomedial silhouette is within normal limits.
Pulmonary vascularity is normal. Lungs are clear.

IMPRESSION: Unremarkable chest radiograph.

DORSAL SPINE 10/30/07

INDICATION: Back pain.

FINDINGS: Frontal and lateral views are made. No fracture or
subluxation is identified. Alignment and vertebral body heights are
adequately maintained. There are mild degenerative changes at the lower
thoracic disc spaces, with some disc space narrowing and end plate
osteophyte formation. A swimmer's view also is included, demonstrating
mild changes of osteoarthritis at the C6/7 level.

IMPRESSION:

FINAL

Page 1

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17

SELF REGIONAL HEALTHCARE
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: LEOPARD,JOHN B Check-in Date: 10/30/07 2212
Unit Number: A000157622 Location: DIS - ED

Account # 0730300555 BD: 09/17/70 Age: 37Y Sex: M

Ordering Physician CAIN,BIBB R Admit Phys:CAIN,BIBB R

CAIN,BIBB R
1325 SPRING ST

CAIN,BIBB R
1325 SPRING ST,

GREENWOOD SC

19646

GREENWOOD

SC 19646

Checkin-Exam Code Summary
874812-68847,874813-68973

Mild osteoarthritis affecting the lower cervical and lower thoracic
levels. No acute skeletal abnormality.

Read By- JOHN W MCALHANY JR M.D.
Released By- CHRISTOPHER KNOX M.D.
Transcriptionist- ANN HOLLIDAY
Released Date Time- 10/31/07 2324

FINAL

Page 2

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18

FOR ECC ONLY



Triage classification
☐ V
☒ IV
☐ III
☐ II
☐ I

Date: 10/21/07 Time: 1044
 Sex: M ☐ F
 Name: Leopard, John
 DOB: 9/17/70 Age: 36
 Wt: 226 (Act/Est/lbs/kgs)
 Ht: _____
 Head Circum. (≤ 13 mos) _____

FOR ECC ONLY

MD: Hill, B. (None)

Arrival: ☒ Amb ☐ W/C ☐ Carry ☒ Stretcher
☐ Police ☐ Private Auto ☒ Ambulance - Unit # _____
☐ County of Injury _____
 Accompanied by wife
 Transferred from: N/A
 Prior Treatment: ☐ None ☒ EMS

B/P: 181/89 (R/L) 90 R/L: 99/70 (Oral/Rectal/Tympanic)
 Sit/Stand/Lying Pulse Ox 98 % on RA L/Min O2 Via _____

Work Related? Yes/No

GCS: 15 ☒ N/A RTS: N/A ☒ N/A

LMP _____

ECC & Peds ONLY

IMMUNIZATIONS: ☒ N/A ☐ Unknown ☐ UTD ☐ Last 3 wks Y/NLast Td: UTD ☐ Unknown: ☐ N/AMEDS: ☐ Home Med List (N-647) ☐ No MedsALLERGIES: ☐ NKA (Medication, food, latex, tape, dye, etc.)

Allergies

Symptoms/Reactions

Dermoidskin crawlNeospineswelling - localizedCHIEF COMPLAINT Info from ☐ See narrative notesfell from house firemid back

Onset/Time of Illness/Injury _____

Mechanism of Injury _____ ☐ N/AMEDICAL HISTORY: (Check if applicable) ☐ Denies Hx ☐ Not Available☐ Lung Disease ☐ CVA ☐ Cancer ☒ GI ☐ GU ☐ GYN☐ Diabetes-- Add Adult Hypoglycemia Protocol N-719 to chart.☐ Hepatic/Renal ☐ Hypo/Hyper tension☐ Heart Disease ☐ Psych _____☐ TB (Treated Y/N) ☐ Seizures ☐ Sickle Cell Disease☐ Alcohol ☐ Controlled Substances/Street Drugs? _____Smoked within last 12 months ☐ Yes ☐ No☐ If yes, Smoking Cessation form# N-933 given. ☐ Refused information☐ Other tobacco _____

Other/Surgeries: _____

INFECTION CONTROL PRECAUTIONS:

☐ Checked Face sheet for staff alert and labs☒ Infection not suspected☒ Infection suspected and Precautions required until ruled out

CONTACT:

1. High Risk for MRSA/VRE: STAFF ALERT; ileostomy/colostomy, dialysis, foley greater than 1 month, resident of acute care, LTC, prison or an institution

2. Chicken Pox, Small Pox, Scabies, Lice, SARS, Conjunctivitis, uncontained drainage or Diarrhea, C. difficile

☐ DROPLET: Flu, Meningitis, Pertussis☐ AIRBORNE: TB, pandemic flu, SARS, Chicken Pox

less than 6 yrs old, Contact & Droplet: Scarlet Fever, Grp A

Strep, RSV, Bronchiolitis, Croup

Precautions Initiated: TIME: _____ INITIALS: _____

PAIN: ☐ Denies If pain present, use the most appropriate scale and enter the number that best rates the intensity 6

Pain scale used: (circle) Numeric

(0-10) FACES FLACC NIPS

Location mid backQuality: ☐ Burning ☒ Dull ☐ Pressure☐ Heavy ☐ Sharp ☐ Cramping

Other _____

Duration: Pain is: ☒ Continuous or☐ Intermittent

Aggravating & Alleviating Factors:

What makes the pain better?

What makes the pain worse? backboardABUSE: Do you suspect this patient has been abused? Yes ☒ No ☐

If yes, patient has the following

unexplained Conditions:

(CHECK ALL THAT APPLY)

☐ Bruising ☐ Welts☐ Burns ☐ Puncture Wounds☐ Lacerations ☐ Fractures☐ Apparent lack of needed medical attention☐ Overly protective mate or refuses

To see mate

If admitted, consult

Director/Nursing Supervisor for guidance.

FOR ECC ONLY EMS TREATMENT

☐ N/A ☐ NoneSpinal Precautions: ☐ C-Collar ☐ Longboard☐ Straps ☐ Tape ☐ Head Block ☐ Splinting☐ Other MS 2mg IVMast Suit: ☐ In Place ☐ Inflated ☐ Deflated☐ Abdomen ☐ R Leg ☐ L LegAirway: ☐ Oropharynx ☐ NasopharynxE.T.T. ☐ Oral ☐ Nasal ☐ ET Size: _____Oxygen: ☐ L/Min ☐ NC ☐ Mask ☐ AmbuFluid: GA SITE AMT Infused PTA ☐ INJECT1. NS 18 LFA 200 30 ☐ Y/N

2. _____

FOR ECC ONLY Standing Orders

☒ N/A☒ Dressing☐ Ice/Elevate☐ FSBS☐ Meds (See Meds Section)☐ Other _____☐ Urine Specimen Obtained☐ UA Sent / Held ☐ C&S Held☐ UCG ☐ Positive / NegativeVisual Acuity: ☐ Correct / NonLeft 20/ 3 Right 20/ 3Both 20/ 3Completed By: [Signature]

FOR ECC ONLY TREATMENT AREA

Room: 31 Time: 07☐ AMB ☒ Stretcher ☐ W/C ☐ Carry

Pt. request MD _____

Notified: _____

Posted: _____

Initials: [Signature]

Safety

☒ 1D Band On☐ Bed low & locked ☐ Chair☐ Call Light in Reach

Addressograph

LEOPARD, JOHN B
 MISCELLANEOUS, RISC
 M 09/17/1970 000157622
 SURGERY DATE: _____

Initial History
 Self Regional Healthcare

White: Chart

Yellow: Pharmacy



1HX4580

Form # N-83AECC/ 7-07/NCR/ Page 1 of 1

RESPIRATORY: ☐ N/A ☒ Denies Complaint EFFORT ☒ Non-labored ☐ SOB ☐ Retractions ☐ Stridor Breath Sounds Present ☒ R ☒ L Clear ☒ ☒ Wheezing/Rhonchi ☒ ☒ Diminished ☐ ☐ Crackles ☐ ☐ Chest Expansion: Symmetric/Asymmetric Cough ☒ N/A Productive/Nonproductive	CARDIAC ☐ N/A CARDIAC RHYTHM Patient on Monitor ☒ Y ☒ N If Yes, alarms ☐ On Chest Pain ☒ Y ☒ N ☐ Constant ☐ Tightness ☐ Intermittent ☐ Sharp ☐ Heaviness ☐ N/V ☐ Diaphoresis CAPILLARY REFILL ☐ Absent ☒ less than 2 ☐ greater than 2 PULSE Regular / Irregular Radial R ☐ L ☐ Pedal R ☐ L ☐	NEUROLOGY ☐ N/A ☒ Alert ☐ Playful ☒ Oriented x3 x2, x1 ☐ Unresponsive ☐ Consolable ☐ Confused * ☐ Slurred Speech ☒ Appropriate for Age ☐ Verbal Stimuli ☐ Combative ☐ Painful Stimulation ☐ Headache ☐ Anxious ☐ Drowsy * ☐ Dizziness * Gait: Steady/Unsteady * ☐ Weakness * Hand Grips: Equal/Unequal ☐ Decreased Sensation	EYES/ENT ☐ N/A Eyes ☒ Denies Complaint ☐ For. Body ☐ R ☐ L ☐ Burning ☐ R ☐ L ☐ Pain ☐ R ☐ L ☐ Redness ☐ R ☐ L ☐ Discharge ☐ R ☐ L ☐ Injury ☐ R ☐ L Date _____ Time _____ Mechanism _____ Ears ☒ Denies Complaint ☐ Drainage ☐ R ☐ L ☐ CSF ☐ R ☐ L ☐ Pain ☐ R ☐ L ☐ Injury ☐ R ☐ L Date _____ Time _____ Mechanism _____ Nose ☒ Denies Complaint ☐ Epistaxis ☐ R ☐ L ☐ For. Body ☐ R ☐ L ☐ Congestion ☐ R ☐ L ☐ Drainage ☐ R ☐ L Oral ☒ Denies Complaint ☐ Sore Throat ☐ Dysphagia ☐ Drooling ☐ Broken Teeth	GI Abdomen ☐ N/A ☒ Soft ☐ Firm ☐ Rigid ☒ Non Tender ☐ Tender ☐ Bruised ☐ Guarding ☐ Pain ☐ N/V ☐ Diarrhea Bowel Sounds ☐ Present x _____ Quads ☐ Absent ☐ Hypoactive ☐ Hyperactive Last BM _____ Color ☐ Normal ☐ Abnormal GU ☐ N/A ☐ Flank Pain R ☐ L ☐ Incontinent ☐ Pain ☐ Hematuria ☐ Urgency ☐ Retention ☐ Burning ☐ Frequency ☐ Pressure Duration _____ Urine Color _____ ☐ Penile Discharge Color _____ Psych ☐ N/A Eye contact: Yes/No Affect ☐ Normal ☐ Flat Behavioral ☒ Cooperative ☐ Violent ☐ Agitated ☐ Restless Mental Status ☐ Oriented ☐ Confused * ☐ Lethargic ☐ Unconscious ☐ Harmful to Self/ Others ☐ See Restraint Flowsheet					
Skin/Circulation ☐ Moist ☒ Dry ☒ Warm ☐ Cool ☒ Hot ☐ Diaphoretic Color ☐ N/A ☐ Pink ☐ Pale ☐ Cyanotic ☐ Mottled ☒ Jaundice ☐ Flushed ☒ Normal for patient Edema ☒ Absent ☐ Present Location _____ Rash ☒ Absent ☐ Present Location _____ ☒ Skin Intact, if not _____ ☐ See Wound Status FS (Form# N-417A)	OB/GYN ☒ N/A ☐ Denies Complaint ☐ Pregnant: Y/N/Unknown ☐ LMP _____ ☐ FHT _____ Site _____ ☐ Gravida _____ ☐ Para _____ ☐ Ab _____ ☐ Vaginal D/C Color _____ ☐ Duration _____ ☐ Vaginal Bleeding Amount _____ ☐ Duration _____ FOR ECC ONLY Blood Bank Label	Pupil Size ☐ N/A <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Size</td> <td style="width: 30%;">R</td> <td style="width: 30%;">L</td> </tr> <tr> <td>React</td> <td>R</td> <td>L</td> </tr> </table> Size: _____ Reaction: _____ P=Pinpoint B=Brisk N=Normal S=Sluggish D=Dilated N=Nonreactive U=Unobtainable See pupil scale below FOR ECC ONLY DIET ☐ N/A Last Meal: _____ ☐ Regular ☐ Diabetic ☐ Cardiac ☐ Low Fat ☐ Other	Size	R	L	React	R	L	FOR ECC ONLY * If marked: ☐ placed Fall Risk sticker on chart
Size	R	L							
React	R	L							

Completed By _____

RN

e: 10/31

Time: 2045

RN Date:

Times:

Belongings (ONLY IF ADMITTED)

Dentures/Partials Upper/Lower With Patient/ Family ☐ N/A

Jewelry

With Patient/ Family ☐ N/A

Clothing:

With Patient/ Family ☐ N/A

Money/Valuables ☐ N/A

☐ Locked up Env. #

Belongings Completed By:

Date:

Time:

Pupil Scale

1 2 3 4 5 6 7

Addressograph 303-00555
LEOPARD, JOHN B
MISCELLANEOUS, MISC
M 09/17/1970 000157
SURGERY DATE-

Initial Systems Assessment



1CNP4660

Form # N-83B/3-06/HTDuplex/Side 1 of 2

IV SITE / FLUIDS ☐ See Attached DC'D = Discontinued												
TIME	IV #	IV # OF ATTEMPTS	GAUGE	SITE	FLUIDS/MED.	BAG #	AMT.	RATE	PUMP	TIME DC'D	AMT INFUSED	INITIALS
PTA	1	unk	18 ga.	LAC	NS	1	100mL	160 mL/h	Y/N	2345	— mL	JA
			ga.				mL	mL/h	Y/N		mL	
			ga.				mL	mL/h	Y/N		mL	
			ga.				mL	mL/h	Y/N		mL	
			ga.				mL	mL/h	Y/N		mL	
			ga.				mL	mL/h	Y/N		mL	

MEDICATIONS ☐ See Attached * If pain present, use the most appropriate scale and enter the number that best rates the intensity. If not appropriate to rate by scale, use S&S key. Pain S&S key: FB = Facial & Body Behaviors VS = Vital Signs VC = Verbal Cues ↑ = Increase ↓ = Decrease NC = No Change

TIME	MEDICATION	DOSE	ROUTE	SITE	RESPONSE	*PAIN RATING PRIOR	TIME/ *PAIN RATING AFTER	INITIALS
	dr/Manuf. Lot #	0.5 mL	IM					
2135	Morphine	4mg	IV	CB		10/10	10/10	JA
2135	Propofol	30mg	IV	CB				JA
2340	Morphine	4mg	IV	CB		10/10		JA
2340	Lorazepam THP x1							JA
2340	Prednisone	60mg	PO					JA
2340	Fentanyl	10mg	PO					JA

BLOOD PRODUCTS ☐ See Attached

TIME	BLOOD PRODUCTS	UNIT #	IV #	GAUGE	SITE	RATE	PUMP	TIME DC'D	AMT INFUSED	INITIALS
				ga.		mL/h	Y/N			
				ga.		mL/h	Y/N			
				ga.		mL/h	Y/N			

VITAL SIGNS ☐ See Attached

TIME	B/P	P	R	T	C. MONITOR RHY.	PULSE OX.	GCS	COMMENTS	INITIALS
2340	109/84	81	16	—	—	99% on RA L/Min O ₂ via	15	family @ bedside	JA
						%on L/Min O ₂ via			
						%on L/Min O ₂ via			
						%on L/Min O ₂ via			
						%on L/Min O ₂ via			
						%on L/Min O ₂ via			

GCS q 1 hour on Head Injury Patients

Notes: (2044) Initial contact & pt aidet. rec'd pt from EMS. (2120) MD @ bedside for eval, pt removed from LSP/C collar. (2140) Pt to XR. (2210) Pt returned from XR via stretcher. (2310) D/C inst w/ given to pt/wife. verbalized understanding. 2?/concerns. RX/THP provided. pt amb w/ unit.

ADMISSION/DISCHARGE ASSESSMENT: REVIEW ABOVE INFORMATION, ASSESS PATIENT, DOCUMENT CHANGES

TRANSFER ☒ N/A ☐ Transfer Protocol

Vital Signs ☐ N/A BP _____ P _____ R _____ T _____

Pain rating is 10 using Numeric (0-10) FACES FLACC NIPS

☒ Unchanged from Initial Assessment ☐ Assessment Changes:

Via: ☒ Ambulatory ☐ Wheelchair ☐ Stretcher
☐ Ambulance ☐ Carry

Condition: ☒ Stable ☐ Unstable ☐ Unchanged
☐ LWT ☐ LBTC ☐ AMA ☐ Morgue

Admission Information: Room # _____

Admitting Physician: _____

Report To: _____

Intake: _____ Output: _____

O₂ Y/N _____ L/Min via _____

Monitor Y/N Rhythm _____

☐ See Patient Progress Notes (N-4005)
☐ See Supplemental ECC Care Notes/ Procedures (N-83S)
☐ See Trauma Flow Sheet (N-83TF), I.
☐ See Code Blue/99 sheet (N-787)

Signature/Title: _____ Initials: _____

Family verbalized understanding of Discharge instructions
 Initials: 68 Date: 10/30 Time: 2340

Addressograph
 07303-00555
 LEOPARD, JOHN B.
 MISCELLANEOUS, HISC
 H 09/17/1970 000157622
 SURGERY

ECC Care Notes/ Procedures
 Self Regional Healthcare

INTENTIONALLY LEFT BLANK

Form # N-83C/3-06/HTDuplex/Side 2 of 2

PRINTED BY: E16055

REPORT NO. 0354072337

PATIENT CARE FORM

Trip No. 00003338

PATIENT IDENTIFICATION									
LAST NAME		FIRST NAME		MI	STREET		CITY	STATE	ZIP CODE
Leopard		John		B	712 Stillwell Rd		Greenwood	SC	29646
SEX Male		RACE White		DOB: 09/17/1970		AGE 37 YRS.		SSN: 247-63-1193	
TYPE OF INCIDENT		DISPOSITION		PATIENT STATUS			INCIDENT LOCATION		
TRAUMA MEDICAL		01 TREAT / NO TRAN		TO SCENE ON SCENE FROM SCENE			Street or Highway ; Name or Number		
1 MVA 1 ENVIRON		02 DOA AT SCENE		X Emergent X Urgent X Urgent			Hwy 34 Fire Dept		
2 MC 2 BEHAV		03 X HOSPITAL ER		Nonemergent Non Urgen Non Urgen			City State County		
3 BIKES 3 OB/GYN		04 HOSP. DIR. ADMIT		Code: 3 Code: 1			Greenwood SC 24		
4 PED 4 RESP		06 PATIENT'S HOME					Location Zip Coc 29646 (Rural)		
5 ASSAULT 5 CARDIAC		07 NURSING HOME					SAFETY EQP SITE OF INCIDENT		
6 FALL 6 INTERFAC		08 DR.'S OFFICE					Seatbel Childseat Roadway Recreational		
7 FIRE 7 X OTHER		09 OUTPATIENT					Helmet None Residence Agricultural		
8 INTERFAC		10 PT. REFUSED TREA					Airbags Unknown Industrial Other		
9 OTHER		11 EMS TRANSFER							
PRELIMINARY IMPRESSIONS									
003 Seizure 024 Multitrauma/Shock 074 Respiratory Distress									
004 Diabetic 030 Head Injury 080 Coronary Problems									
011 Abrasion/Contusion 032 Spinal Injury 083 Cardiac Arrest									
013 Laceration 084 Stroke									
023 Fracture 051 GI Problems 106 OTHER OTHER									
ICD9 CODE ADVANCED PROCEDURES									
724.5 1 X EKG Monitored Rhythm S-Tach Time 20:13									
Back Pain 2 First Defib Attempted Watt Sec. Time									
Post Defib Rhythm									
3 Second Defib Attempted Watt Sec. Time									
Post Defib Rhythm									
4 Third Defib Attempted Watt Sec. Time									
Post Defib Rhythm									
Intubate 5 Size									
6 External Pacing RSI 16 LMA 17 Crico									
7 Blood Drawn Dextrose BGL 081									
8 X IV Started/Gauge 18 Solution N/S									
Rate KVO IV Time 20:31 IV Volume 250 ml									
9 IV Started/Gauge Solution									
Rate IV Time IV Volume									
14 X IV Attempted Total 1									
10 Pleural Decompression Time									
11 Intraosseous									
12 Automatic Defib.									
13 Patient Assisted Meds									
2 Ordering Physician									
SITE OF TRAUMA									
1 Head									
2 Face									
3 Neck									
4 Chest									
5 Abdomen									
6 Hip/Pelvis									
7 Upper Extr.									
8 Lower Extr.									
9 X Back									
EXPOSURE TO PT'S BODY FLUIDS? 1. YES 2. X NO									
1ST Responder 1. YES Name 2. X NO									
COMMENTS (CHIEF COMPLAINTS, OBSERVATIONS, RESPONSE OF STIMULI)									
0730300555									
Patient Care Form Left In: X ED ICU OTHER									
TIME RECORD									
RUN DATE 10/30/2007									
Call Received: 20:09 District: 30									
Call Dispatched: 20:09									
Departed Base: 20:10 Unit: Medic 30									
Arrive Scene: 20:13									
Depart Scene: 20:32									
Arrive Destination: 20:45									
CAUSE OF DELAY No Delays									
DHEC PERMIT NO. 03508									
RECEIVING AGENCY 2016									
SENDING AGENCY									
PROVIDER TIME									
MICS 1050 (07/1988)									
ATTENDANT'S SIGNATURE & CERTIFICATION NO.									
Ricketts, L H 83543									
Primary Attendant									
Parrish, J 93844									
2nd Attendant/Driver									
3rd Attendant/Drive									
Jodee Rn									
Receiving Nurse or Physicia									

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22

REPORT NO. 0354072337

PATIENT CARE FORM

Trip No. 00003338

PATIENT IDENTIFICATION						
LAST NAME	FIRST NAME	MI	STREET	CITY	STATE	ZIP CODE
Leopard	John	B	712 Stillwell Rd	Greenwood	SC	29646
SEX Male	RACE White	DOB: 09/17/1970	AGE 37 YRS.	SSN: 247-63-1193		
37 Yr. old White Male. Patient complains of pain, moderate in quality, to back. Patient presents without signs to lower back, midline. PT complains of to lower back, midline. PT complains of pain, moderate pain localized. Spinal immobilization via Cervical Collar, Headblocks, Long Spine Board & Straps. 20:13 - EKG monitored, showing Sinus Tach. 20:16 - PT Assessment #1: PT alert. Airway is patent. PT breathing unlabored. Lung Sounds present and clear bilaterally. Oxygen administered via nasal cannula at a flow rate of 4 lpm. Initial O2 sat. 96%. Pulse - strong. BP present. No JVD noted. Skin warm/dry. 20:31 - I.V. #1 access established left antecubital, with 18 gauge jelco. Normal Saline running at a KVO rate. 250 ml infused. 20:32 - Transport initiated to Self Regional HealthCare. 20:36 - BGL = 81 mg/dl. 20:37 - PT administered Morphine Sulfate - 2mg, IV Bolus (Push) moderate relief. 20:40 - PT Assessment #2: PT alert. Airway remains stable. PT breathing unlabored. Follow up O2 sat. 98%. Pulse - strong. BP present. Skin warm/dry. 20:43 - PT administered Morphine Sulfate - 2mg, IV Bolus (Push) moderate relief. Patient with previous medical history of: Musculoskeletal Problems. Patient without prescribed medications. Patient without known drug allergies. No Delays. *** ADDITIONAL COMMENTS: on arrival fd above pt alert with patent airway pt had fell through a roof approx 5 ft and twisted his back he had some pain in his thoracic region of his back pt rem alert pt stated the pain was a 8 on scale pt lg sds were clear and equal bilat abdomen tender with no pain noted sensations present all extremities pt rem alert i called for morphine orders and Dr Givens gave me orders for 2 mg and repeat at 2 mg for comfort rep called to rn in 31						

0730300555

Patient Care Form Left In: ☒ ED ☐ ICU ☐ OTHER		Page 2	
TIME RECORD		DHEC PERMIT NO.	
RUN DATE	10/30/2007	03508	
Call Received:	20:09	RECEIVING AGENCY	
Call Dispatched:	20:09	2016	
Departed Base:	20:10	SENDING AGENCY	
Arrive Scene:	20:13	PROVIDER TIME	
Depart Scene:	20:32	MICS 1050 (07/1998)	
Arrive Destination:	20:45	ATTENDANT'S SIGNATURE & CERTIFICATION NO.	
CAUSE OF DELAY No Delays		Ricketts, L H 83543	
District: 30		Primary Attendant	
Unit: Medic 30		Parrish, J 93844	
		2nd Attendant/Driver	
		3rd Attendant/Driver	
		Jodee Rn	
		Receiving Nurse or Physician	

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23

Call Received:

Date: 10/31/07

Time:

Caller: Mrs. Leppard

Phone #: 227 87034 992-2724

Patient: Leppard, Mrs. B.

ER #:

Service Date: 10/30/07

RE: ☐ Prescription☐ Lab☐ X-Ray☒ Work Excuse☐ Other, Specify:Message: Wife states that Mr. Cain didn't give
them an excuse.

Per:

jt

(signature)

RN/LPN/Sec (circle one)

Call Returned or Patient Returned

Date:

Time:

Documentation/Directions:

11/1/07 1515 10/31-11/2 I forgot - please apologize
for me.

S. Cain.

No So
written

Per:

Renee (Doreen) A

(signature)

MD/RN/LPN/Sec (circle one)

Completed by:

(signature)

RN/LPN/Sec (circle one)

Addressograph

Patient Call Back
ECC
Self Regional Healthcare

1ECC7732

Form # N-911/ 5-04/Single/Page 1 of 1

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24

John Leopard

AUG 13 2010

229

1401100

3

Severe back pain

neck fusion (lat) 2 years ago
titanium

Name -
BLD - neg
*BIL + 9 umol/L
URO +- norm
KET - neg
PRO - neg
MIT - neg
GLU - neg
p.H 6.0
S.G 1.020
LEU - neg
COL LT. Yellow
CLA Clear

T12
L1
hyperreflexic
& up
since this
AM

JOHN LEOPARD

08/13/10

#22673

Patient was at home, going to get up and upon getting up had sudden severe pain into his mid to low back and dropped to the floor. Since that time, besides persistent pain, he has noticed burning and tingling into both legs. Feels he is not urinating quite as much since that occurred. That was earlier this morning. Historically he has had cervical spine fusion several years ago. In 2007 he suffered a traumatic vertebral compression fracture according to patient was thoracic spine. He is in distress today. Walks in of his own free will. Abdomen soft, no masses. No signs of enlarged bladder at this point. No rebound tenderness. No numbness. Cervical area with no point tenderness. No numbness to arms or hands. Motor skills to arms and hands are normal. Speech and balance normal. When you walk down his spine, T12-L3 has areas of point tenderness over spinous processes. He is extremely hyperreflexic and checking reflexes brought on extreme pain. SLR did not aggravate pain. Low back is in spasm as well. He is followed by pain therapy because of compression fracture in thoracic area. He is 40 years old. Concerned about compression fracture in low back or cord compression going on with hyperreflexia. Did not have a fall. No trauma. Was on a riding lawnmower yesterday but does not claim any sudden jolt or anything where he jarred his back. He did some fishing several days ago. Again, did not hit a hard wave or anything that would make one think about compression fracture to back. UA clear. Discussed case with radiology and will work in for urgent MRI from T10-lumbosacral area to make sure we are not dealing with acute disc symptoms or compression fracture. Stable to walk at this point. This was a very complicated case and we will follow him closely and hopefully get call reports in the very near future to assess further. MAB/rmb

Date: 08/19/10
Time: 1102

SELF REGIONAL HEALTHCARE
Abstract Summary Form

Page : 1
Report: EPABFA

Patient: LEOPARD, JOHN B

Address: 712 STILLWELL RD

DOB: 09/17/70

Fin Class: BLUE CROSS GROUP

GREENWOOD

Sex: MALE

Ins. Plan: BLUE CROSS

SC, 29646

Guarantor: SELF

Phone #: (864) 227-8763

Adm Date: 08/13/10

Adm Source: NON HEALTH FACILITY

Acct. #: 1022500297

Adm Time: 11:54

Adm Type: ELECTIVE

Unit. #: 000157622

Dis Date: 08/13/10

Trans From:

Pt. Type: OUTPATIENT

Dis Time: 23:59

Service: OUTPATIENT VISIT

Trans To:

LOS: 1

Dis Status: HOME OP

Coder: BP

Admitting DR: BARTZ, MARK A

Referring DR: MISCELLANEOUS, MIS

Attending DR: BARTZ, MARK A

Discharge DR:

ER Physician:

Primary DR: HILL, JOSEPH B

DRG: 552 MEDICAL BACK PROBLEMS W/O MCC

Admit Diagnosis: 724.3

SCIATICA

Principal Diagnosis: 721.2

THORACIC SPONDYLOSIS

POA:

Secondary Diagnoses/POA:

Reason for Visit:

Principal Procedure:

Date:

Primary Surgeon:

Secondary Procedures:

HCPCS:

Modifiers:

Date:

Surgeon:

Pre APC:

Consultants:

Date:

Specialty:

End of Report

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26

SELF REGIONAL HEALTHCARE
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: LEOPARD, JOHN B

Check-in Date: 08/13/10 1202

Unit Number: A000157622

Location: OP

Account # 1022500297

BD: 09/17/70 Age: 39Y

Sex: M

Ordering Physician BARTZ, MARK A

Admit Phys: BARTZ, MARK A

BARTZ, MARK A
1506 SPRING STREETBARTZ, MARK A
1506 SPRING STREET

GREENWOOD SC

29646-0000

GREENWOOD

SC 29646

Chk-in #	Order	Exam
1263253	0001	69827 MRI LUMBAR WO CONTRAST
Ord Diag: BACK PAIN		

Findings: Multiple T1 and T2-weighted MR images of the lumbar spine were obtained without contrast in axial and sagittal planes. Axial images were acquired from the level of T8 through the level of the S1. Vertebral body bone marrow signal demonstrates no acute abnormality. Numerous Schmorl's nodes are seen throughout the endplates of the lower thoracic spine and the lumbar spine along with a few anterior compression deformities of vertebral bodies, particularly at the T10, T11, and L1 vertebral bodies. The overall appearance is most compatible with that of Scheuermann's disease. At the T10/T11 level, posteriorly directed broad-based disc bulging and mild degree is present resulting in anterior thecal sac effacement, without resultant spinal canal or neural foraminal stenosis. At the T11/T12 level, a leftwardly prominent broad-based disc bulging of moderate degree is present resulting in anterior thecal sac effacement without frank spinal canal or neural foraminal stenosis. All other vertebral body levels have a fairly normal appearance. No level of frank disc protrusion or herniation is identified. No level of significant spinal canal or neural foraminal stenosis is appreciated. No soft tissue mass is identified.

Impression: Numerous Schmorl's nodes seen throughout the endplates of the lower thoracic and upper lumbar spine along with a few anterior compression deformities of the vertebral bodies which have a chronic appearance at the T10, T11, and L1 vertebral bodies. No overall appearance is most compatible with Sherman's disease. Broad-based disc bulging at the T10/T11 and T11/T12 levels does result in anterior thecal sac effacement but there is no evidence of spinal canal or neural foraminal stenosis at these or at any other levels in the lumbar spine. No level of frank disc protrusion or herniation is appreciated.

FINAL

Page 1

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27

SELF REGIONAL HEALTHCARE
Greenwood, S.C.

DEPARTMENT OF RADIOLOGY

Patient Name: LEOPARD,JOHN B Check-in Date: 08/13/10 1202
Unit Number: A000157622 Location: OP

Account # 1022500297 BD: 09/17/70 Age: 39Y Sex: M

Ordering Physician BARTZ,MARK A Admit Phys:BARTZ,MARK A

BARTZ,MARK A
1506 SPRING STREET

BARTZ,MARK A
1506 SPRING STREET

GREENWOOD SC

29646-0000

GREENWOOD

SC 29646

Checkin-Exam Code Summary
1263253-69827

Read By- CHRISTOPHER KNOX M.D.
Released By- CHRISTOPHER KNOX M.D.
Transcriptionist- CHRISTOPHER KNOX M.D.
Released Date Time- 08/13/10 1327

FINAL

Page 2

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28

John Leopard

Aug. 4, 2010 doctor's notes on previous page.

JOHN "BEANIE" LEOPARD

#22673

08/04/10

- S: 39 YOM presents today for refill of his medications. He says his stress seems to be well controlled with Lexapro. History of high cholesterol. He is planning to have a CPX with his fire dept with complete labs in the next few weeks. Denies chest pain or shortness of breath. No n/v. No fever, chills.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Back chronic pain at baseline. Otherwise, neurologic exam nonfocal. Skin no rashes.
- A/P: 1. **Hypercholesterolemia.** Continue with Simcor 750/20 q.d. Check fasting lipid panel, ALT when he has his CPX with the fire department.
2. **Hypertriglyceridemia.** Low-fat diet, Omega-3 fatty acids. Trilipix 135 mg. Refills given.
3. **Anxiety.** Stable with Lexapro 20 mg. Decrease life stressors. Avoid caffeinated products. Practice proper sleep hygiene.
4. **Health maintenance.** Patient has chronic back pain following a worker's comp claim where he fell through a roof while working at the fire dept and had compression fractures in his dorsal spine. He is followed by Dr. Shallcross. He takes Zanaflex 4 mg q.i.d., Lortab 10 mg p.r.n., tramadol 50 mg q.i.d., Neurontin 300 mg t.i.d. generic. In addition, patient would like to stop smoking. Consider a trial of Chantix in the future. Wish him well and return as instructed, sooner if needed.

JBH/rmb

DB

John Leopard
JAN 21 2010 Cancel

FEB 03 2010 226.8 120/80 ALT chol

TRG=189
TC=125 ALT=28
HDL=15 AST=22
LDL=72 AST/ALT=0.8
VLD=38
TC/HDL=8.2

KAPIDEX 60mg

Simcor 750/20

22/4

1/4

JOHN LEOPARD

#22673

02/03/10

- S: 39 YOM presents today for check of cholesterol. Needs refill of Kapidex. Denies headache or visual changes. No chest pain, shortness of breath or orthostasis. No myalgias.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Extremities full range of motion. Pulses palpable throughout. Neurologic exam nonfocal.
- AP: 1. **Hypercholesterolemia**. Total cholesterol 125, HDL 15, ratio 8.2, LDL 72. Remains in a very disturbing level. However, his ratio was 16.4. No side effects from current Simcor. Increase to Simcor 750/20 and recheck lipid ALT on return visit.
2. **Hypertriglyceridemia**. Total triglycerides 189. Improved with Trilipix 135 mg, refills given. Low-fat diet, omega-3 fatty acids. Will monitor.
3. **GERD**. Stable with Kapidex 60 mg. Refills given. Continue to avoid spicy and caffeinated products. Return as scheduled, sooner if needed.

JBH/rmb

JUN 03 2010 N5

AUG 04 2010 231.6 122/80 refill meds

Dr. Shallcross Pass Mary

Deviant 60y
Lipitor 20y
Simcor 750/20y
Trilipix 135y

Dr. Hill

W.C. Fire Royal Spring
Chapin Cousin PA
Disc

Chapin / TCD only

CPT to Fire Ref

Dr. Shallcross
Zanaflex 4mg
Hydrocodone APAP 10-500mg
Framadol Hct 50 x 100
Neurontin 300 mg 100
generic

LEV 10, Sing
Chato but
PA to Call

John Leopard

NOV 18 2009 recheck

11/20

Mo LO

CP / Sars / all
Sts Test x42k
Suthe
✓ 32

JOHN LEOPARD

#22673

11/18/09

- S: 39 YOM presents today for recheck of coughing and reflux type symptoms. He had a barium swallow revealing some mild esophageal dysmotility along with reflux. He states his biggest concern now is he is short of breath, especially when he climbs a flight of stairs, usually on exertion, improves at rest. Also reports he has discovered mold in his house.
- O: HEENT nasal congestion, watery eyes, oropharynx moist mucous membranes without lesions. Neck supple. No LA. Lungs CTA bilaterally. No wheezing, good air movement. Heart RRR without MRG. Abdomen soft, NT, nondistended, positive bowel sounds. Neurologic exam nonfocal.
- A/P: 1. **Chest pain.** Patient has numerous risk factors, including family history and considerable dyslipidemia. In light of his current symptoms will need to proceed with Cardiolite stress test to further evaluate.
2. **Shortness of breath.** PFTs at the Fire Dept. were normal. Appears he has DOE, which warrants further cardiac workup. Await results of stress test and manage as indicated. Avoid activities that would worsen symptoms.
3. **Allergies.** Mold at home may be a chronic contributor to his cough. Continue with Kapidex for reflux. Provide samples of Xyzal and Singulair and re-evaluate in 2-3 weeks. Avoid environmental irritants. He is working on mold abatement. Return as scheduled, sooner if needed.

JBH/rmb

DEC 03 2009

BP 138/80

3 wk re ✓

John's Cell
#864-554-6069

Divid

CP / Sars / all
Sts Test x42k
Suthe
✓ 32

JOHN LEOPARD

#26673

12/03/09

- S: 39 YOM presents today for recheck of cough. He says he thinks it was all due to mold. He feels much better after mold abatement in his home. Almost completely finished with that job. He is pleased. Recent stress test because of intermittent chest pain and shortness of breath.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. No wheezing, good air movement. Neurologic exam nonfocal.
- A/P: 1. **Cough.** Essentially resolved. Cardiolite stress test normal.
2. **Hypercholesterolemia.** Continue with current meds. Low-cholesterol diet and exercise. Will recheck fasting lipid panel and ALT on return visit. No myalgias. Follow-up sooner if needed.

JBH/rmb

John Leopard

OCT 26 2009 PPP My

x Walgreen's All: Neosporin-
Sinus drip- 5T

Zithrom 500, 12
#5 det
on madi 4: 100
mg

NOV 05 2009

recheck -
Pain Mgmt CML
TRAMADOL
ZANAFLEX

BACK → 418 lb on 1 yr
T.P. f CA
LEX 20 mg PR
allergy
PPD ⊕

① Hem DTC
↓
Hem Sy '04
HFA & good 3 PFT's?
@ work
① HFA

Cy2 / CFM / allergy
T.P. Pain Smlh
Kytril

JOHN LEOPARD

#22673

11/05/09

S: 39 YOM presents today for recheck of cough.

O: Workup has been unremarkable thus far, including a negative PPD, negative pertussis, normal CXR and sinus films. Has spirometry scheduled at his worksite; he is a firefighter.

A/P: 1. GERD. Improved with Kapidex. Patient has gained 18 pounds over the past year due to back pain. He is followed by Pain Management in Greenville. Takes tramadol and Zanaflex. Recommend weight loss. Exercise as tolerated. Proceed with barium swallow for possible esophageal lower sphincter.

2. Allergies. Samples of Xyzal 5 mg. Avoid environmental irritants.

3. Health maintenance. Refill Lexapro 20 mg. Currently stable. He said HFA albuterol inhaler was of no benefit. Return as instructed, sooner if needed.

JBH/rmb

John Leopard

10-9-09 a. re -

O₂ sat - 98
p - 84

(D/H/12)

500/Bt
Re 10 / St 15 62

CXR @ Alt HFA

JOHN LEOPARD #22673 10/09/09

S: 39 YOM presents today for recheck of bronchitis with bronchospasm. Has had shortness of breath. No chest pain.
O: HEENT nasal congestion. Moist mucous membranes, otherwise unremarkable. Neck supple. No LA. Lungs with rhonchi bilaterally. Slight expiratory wheeze noted. Heart RRR. Overall good air movement.
A/P: 1. **Shortness of breath.** CXR negative. O₂ sat 98%. Treat with Decadron 10 mg IM. Sterapred DS 6 day taper. Albuterol HFA inhaler.
2. **Bronchitis.** Continue with Cipro as instructed. Out of work today. Return for recheck, sooner if symptoms worsen or not improved.

JBH/rmb

OCT 22 2009 229.8

chole
ALT
Re 3m
(D/H/12)

TRG=197
TC=251
HDL=15
LDL=196
VLD=39
TC/HDL=16.4

ALT=23
AST=23
AST/ALT=1.0

Tal/Cor Cough
(D/H/12)

✓BW/PRO Sin XRAY
B. Lute Kipides W/uh

TRIPLEX 135.
Sinus 500/20

JOHN BENNY LEOPARD #22673 10/22/09

S: 39 YOM presents today for check of cholesterol. Continues to have cough in spite of several treatments, normal CXR, etc.
O: HEENT unremarkable. Lungs CTA bilaterally. Good air movement. Heart RRR. Neurologic exam nonfocal. Skin no rashes.
A/P: 1. **Hypercholesterolemia.** Total cholesterol 251, HDL 15, ratio 16.4, LDL 196. Awful! Patient has been noncompliant with meds. Restart Simcor 500/20. Recheck lipid panel in 3 months. ALT normal at 23. Low-cholesterol diet and exercise.
2. **Hypertriglyceridemia.** Total triglycerides 197. Much improved with Trilipix 135 mg. Refills given. Continue low-fat diet, Omega-3 fatty acids.
3. **Cough.** Patient is a smoker. Declines smoking cessation therapy. Will place PPD. Check for pertussis along with CBC and ESR. Proceed with sinus film x-rays. Samples of Kapidex for possibly reflux induced for cough/bronchitis. Re-evaluate in 2 weeks. Afebrile at this time. Return as directed, sooner if needed.

JBH/rmb

10-28-09. PPP Done/mbs (B) For arm will return monday for results

33

John Leopard

OCT 01 2009 5'9 232.2 34.3 122/82

3/2/03

cc. ST/cough v temp 98.0

Aug 875
Dec 5.
Dallergy
2/2 Ac prn

JOHN LEOPARD

10/01/09

#22673

DOB: 9/17/1970

Sore throat, cough. Temp okay. Physical exam shows sinus with posterior drainage. Normal ears. Normal neck. No nodes present. No thyromegaly. Chest clear. CV no MG. Sinusitis with pharyngeal redness and drainage. Augmentin 875 b.i.d. Decadron 5 IM. Dallergy b.i.d. for drainage and congestion. Polytussin AC q4h p.r.n. cough. MB
MAB/rmb

OCT 07 2009 congestion ^{130/100} still on meds from 10-1-09

(11/10)

Rx - Rn / CA
X Cyn / Pse / Medl n 10/9

JOHN LEOPARD

#22673

10/07/09

S: 39 YOM presents today complaining of productive cough, yellowish sputum. Symptoms no better after a round of Augmentin.
O: HEENT nasal congestion. Moist mucous membranes, otherwise unremarkable. Neck supple. No LA. Lungs with rhonchi bilaterally. Slight expiratory wheeze. Heart RRR.
A/P: 1. **Bronchitis.** Increase hydration.
2. **Bronchospasm.** Medrol Dosepak.
3. **Cough.** Polytussin AC. Return for recheck on 10/09/09, sooner if needed.

JBH/rmb

John Leopard

JUL 06 2009

4-5'9" 69" wt-229.0

R7 Meds
BMI 33.8 B/P 128/70

(17/8)

CHOL/CRP/ALT
✓ RRR

OMEPRAZOLE 20mg

Lex 20 Simcor 500/20
x Lovaza at 12/20

JOHN LEOPARD #22673 07/06/09

- S: 38 YOM presents today for a refill of his Lexapro and Simcor and his omeprazole. He did not get his cholesterol checked and he is not fasting.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Extremities full range of motion. Pulses palpable throughout. Neurologic exam nonfocal.
- A/P: 1. **Hypercholesterolemia.** Will continue with Simcor 500/20. Samples given. Check lipid, ALT. Adjust dose if needed. Patient stopped Lovaza. That was an AMA decision. Will review his triglycerides.
2. **GERD.** Omeprazole 20 mg. Refills given. Avoid spicy and caffeinated products.
3. **Anxiety.** Stable with Lexapro 20 mg. Continue to decrease life stressors. Avoid caffeinated products. Return for recheck, sooner, if any other symptoms arise.

JBH/rmb
B

AUG 10 2009 recheck 233.2 134/80

(18/12)

TRILIPIX 135mg
TC/CRP/ALT (S&U)
✓ 8LH

JOHN LEOPARD #22673 08/10/09

- S: 38 YOM presents today for review of recent lipid panel. Says his reflux symptoms are stable. Patient stopped taking Lovaza.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Extremities full range of motion. Pulses palpable throughout. Neurologic exam nonfocal.
- A/P: 1. **Hypertriglyceridemia.** Total triglycerides 433. Actually improved. Immediately proceed with Trilipix 135 mg, low-fat diet, Omega-3 fatty acids.
2. **Hypercholesterolemia.** Total cholesterol 197, HDL 20. Actually improving with Simcor 500/20. ALT normal at 37. Continue with low-cholesterol diet and exercise, MVI. Will monitor.
3. **GERD.** Currently stable with omeprazole 20 mg. Avoid spicy and caffeinated products. Return as directed, sooner if needed.

JBH/rmb
B

35

John Leopard

AN 08 2009 - chol, AST

222 130/80

TRG=304 ALT=25
TC=166 AST=29
HDL<15 AST/ALT=1.2
LDL=N/A
VLD=61
TC/HDL=N/A

DAP CAD stent (50%)

Simcor 500/20
Lex 20

(01/90) CHOL/TG/GERD
EGD

JOHN BENNY LEOPARD

#22673

01-08-09

- S: 38 YOM presents today for check of his cholesterol. Continues to have reflux type symptoms where he has difficulty swallowing some foods and then has battery-acid taste in his mouth.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Abdomen soft, nondistended, mild discomfort in the mid epigastric region. No rebound tenderness or guarding. Negative psoas. No organomegaly. Back no CVA tenderness.
- A/P: 1. **Hypercholesterolemia.** Total cholesterol 166. Improved. It was 215. Very concerned about a low HDL. Patient's father had CAD and stents placed at age 58. Strict compliance with Simcor 500/20. Samples given along with prescription. Low-cholesterol diet and exercise. Recheck lipid panel on return visit.
2. **Hypertriglyceridemia.** Total triglycerides were 393; they are down to 304. Continue with ~~Lovaza~~, low-fat diet. Will recheck.
3. **GERD.** Unresponsive to omeprazole 20 mg. Continue to Avoid spicy and caffeinated products. Proceed with EGD.
4. **Health maintenance.** Refill Lexapro 20 mg. Continue to decrease life stressors. Avoid caffeine. Follow-up sooner if needed.

JBH/mb
B

JAN 27 2009 ^{LP} cancel

36

John Leopard

NOV 17 2008 22/12/60 cough congestion

(11/20) Rx /Ch /CFM
Rx AUG PAC 12/12 2 ELO?

JOHN LEOPARD

#22673

11-17-08

S: 38 YOM presents today complaining of productive cough, yellowish sputum, reflux type symptoms over the past week.

O: HEENT nasal congestion. Moist mucous membranes, otherwise unremarkable. NECK supple, no LA. Lungs central rhonchi noted bilaterally. Good periphery. Heart RRR. Abdomen soft, NT, nondistended, positive bowel sounds. No rebound tenderness or guarding. Negative psoas. No organomegaly.

AP: 1. **Bronchitis.** Augmentin. Increase hydration. Decadron IM.

2. **Cough.** Polytussin AC.

3. **GERD.** Omeprazole 20 mg. Avoid spicy and caffeinated products. Return in two weeks for recheck. May consider EGD if warranted.

JBH/mb

R

DEC 01 2008

DEC 11 2008

DEC 19 2008

NS LTP (11/20)

37

John Leopard

AUG 20 2008 - chol, ALT

222 120/60

TRG=262
TC=185
HDL=20
LDL=112
VLD=52
TC/HDL=9.1

mg/dL
mg/dL
mg/dL
mg/dL
mg/dL
ALT=24
AST=31
AST/ALT=1.3

U/L
U/L

8/20/08

Δ Simcor 500/20

(25/12)

Chol/TC/ALT
Lex 10
1/2mg
Lex 10

JOHN LEOPARD

#22673

08-20-08

- S: 37 YOM presents today for check of his cholesterol and says he has lost a few pounds. He is trying to diet and exercise. Reports that his stress has recurred. He would like to restart Lexapro.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Extremities full ROM. Pulses palpable throughout. Neurologic exam nonfocal. Skin no rashes.
- A/P: 1. **Hypercholesterolemia.** Total cholesterol 185, HDL 20. That is awful. Immediately start Simcor 500 / 20. Samples given. Low-cholesterol diet handouts provided. Exercise. ALT normal at 24. Return for fasting lipid panel as directed.
2. **Hypertriglyceridemia.** Total triglycerides 262. Recommend low-fat diet. Omega-3 fatty acids. Recheck on follow-up visit.
3. **Anxiety.** Restart Lexapro 10 mg. Samples provided. Other meds include AcipHex 20 mg.

JBH/mb

OCT 23 2008 chol, ALT

216 120/80

TRG=393
TC=215
HDL=15
LDL=N/A
VLD=79
TC/HDL=N/A

mg/dL
mg/dL
mg/dL
mg/dL
mg/dL
ALT=21
AST=25
AST/ALT=1.2

U/L
U/L

(25/12)

OMEPRAZOLE 20mg

Chol/TC/CGM

Simcor 500/20

repeat
TRG=368
TC=207
HDL=17
LDL=117
VLD=74
TC/HDL=12.4

mg/dL
mg/dL
mg/dL
mg/dL
mg/dL

DAO - "CAD" "Stents"

1/6 ch

JOHN LEOPARD

#22673

10-23-08

- S: 38 YOM presents today for check of triglycerides and cholesterol. Needs a refill of his reflux medication, something cheaper. No myalgias with Simcor.
- O: HEENT unremarkable. Lungs CTA bilaterally. Heart RRR. Extremities full ROM. Pulses palpable throughout. Neurologic exam nonfocal.
- A/P: 1. **Hypercholesterolemia.** Total cholesterol 207, HDL 17, ratio 12.4. LDL 117. Awful! HDL only improved slightly since starting Simcor 500 / 20. Says he has not taken it every day. Samples are provided. Take OTC niacin. Exercise. MVI. Very concerned because his dad has CAD and required stents.
2. **Hypertriglyceridemia.** Total triglycerides 368. He has eaten pork the last two days. Recommend low fat diet, Omega-3 fatty acids. Will obviously need Tricor or Lovaza. Recheck in six weeks.
3. **GERD.** Omeprazole 20 mg. Avoid spicy and caffeinated products. Return sooner if needed.

JBH/mb

John Leopard

OCT 01 2007 follow up 227- 152/80

ca
(D) An Rnd / MS Rnd (Cher)
NUS @ Up 24M SP MS 61
N3-1

JOHN LEOPARD

#22673

10-01-07

- S: 37 YOM presents today c/o right arm pain, numbness. Denies trauma. Says he has a muscle strain in his upper back that is aggravating. History of high cholesterol. Denies chest pain or shortness of breath.
- O: HEENT unremarkable. Neck supple. Mild paracervical muscular discomfort on the right with subjective radiculopathy into the arm. Good ROM. No impingement sign. Negative Tinel's and Phalen's. Back mild discomfort in the right upper rhomboid muscle region without radiculopathy. Abdomen soft, NT, nondistended, positive bowel sounds. Skin no rashes. Neurologic exam nonfocal otherwise.
- A/P: 1. **Right cervical radiculopathy.** Will proceed with NCS to further evaluate. Avoid activities that worsen symptoms.
2. **Muscle strain (right upper back).** Zanaflex, Sterapred DS, ice, moist heat, stretching exercises. Avoid activities that worsen symptoms.
3. **Hypercholesterolemia.** No myalgias since starting Vytorin. Return as scheduled for fasting lipid panel. ALT. Will review NCS and manage as indicated. Return sooner if needed.

JBH/rmb

B

OCT 22 2007 Cancel

NOV 02 2007

WT: 226 BP: 138/88

cc: Hurt back (b/t shoulder blades)
pinched nerve (neck)

LEXAPRO 20
(Preferred list)?

ca Rnd / MS Rnd / Cher

BR WC 10/30/07
fell head Paul/Lott
Montgomery, AL

(D) 11/13

JOHN LEOPARD

#22673

11-1-07

- S: 37 YOM presents today for recheck of right cervical radiculopathy. Recent MRI of his cervical spine revealing stenosis at C6/7, worse on the right. Patient has been referred to Dr. Lal. However, reports he had a work-related injury on 10-30-07. He is a fireman. States he had to climb head-first through a gable vent and fell 5-6 feet onto his head and shoulders. Seen in the ER. No x-rays done. Given prednisone and Lortab 7.5. He has been followed up with WC at the Montgomery Center and continues to have some mid back pain and discomfort.
- O: HEENT unremarkable. Continues to have mild paracervical muscular discomfort worse on the right with radiculopathy into the right arm and paraspinal muscle discomfort in the neck. Lungs CTA bilaterally. Heart RRR. Otherwise, neurological exam nonfocal.
- A/P: 1. **Cervical radiculopathy.** As noted, MRI showed significant foraminal stenosis. Follow-up with Dr. Lal on 11-14-07 as directed. Continue meds as scheduled. Work as tolerated.
2. **Neck strain.** Continue with Zanaflex, ice, moist heat. May consider soft cervical collar.
3. **GERD.** AcipHex 20 mg, refill given along with samples. Avoid spicy and caffeinated products.
4. **Health maintenance.** Continue with Lexapro 20 mg. Samples and refill given. Review patient's preferred medication list and manage as indicated. Incidental note: patient has some paraspinal muscle discomfort in lumbar region. He is to follow with his WC doctor as directed. Follow instructions and advice. Return as directed for recheck, sooner if needed.

JBH/rmb

PAGE 16/50

FAMILY PHYS OF GMD

2271924 10:19 03/15/2011

Montgomery Center For Family Medicine

155 Academy Avenue Greenwood, SC 29646
(864) 725-4865 Fax: (864) 725-4725
www.selfpatient.org

October 6, 2010

Page 1

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

006060094

Home: (864) 227-8763
Ins: GREENWOOD (2) Grp: CLAIM5700002

12/21/2007 - Office Visit: Multiproblem Visit

Provider: Dan Divilbiss, MD

Location of Care: Montgomery Center For Family Medicine

Acute Visit

Vital Signs

Weight: 229 pounds **Temperature:** 97.6 degrees F (oral) **Respirations:** 16 **Pulse rate:** 100 /min **Pulse rhythm:** regular **Pain Level:** 5 **Pain Loc:** back **Chief Complaint:** Recheck back pain

Blood Pressure

Blood Pressure: 130/80 mm Hg

Large cuff

Vitals Taken by: Linda Speach, LPN

Workability/Return to Work Report

FOLLOW-UP REPORT

Date of injury/illness: 10/30/2007

Employee: JOHN LEOPARD **DOB:** 09/17/1970

Employer: Greenwood county

Work related: Yes.

Chemical or toxic compounds involved? No

Are findings and diagnosis consistent with patient's account of injury or illness? Yes

Is there any other current condition that will impede or delay patient's recovery? Yes - see below

There are no known pre existing conditions noted.

Prognosis On schedule

*
*
*

Patient is a 37 Year Male.

Chief Complaint: Recheck back pain

Pt reports that the pain is relatively stable. Still located in same area. No s/s of radiculopathy. No new injuries. He is working some, with no lifting over 20 lbs unless it is with assistance. This is working OK for patient right now. Here for MRI results. There are reviewed with the patient and his spouse.

Past History

Past Medical History

40

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October 6, 2010

Page 2

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOO (2) Grp: CLAIM5700002

PAIN IN THORACIC SPINE (ICD-724.1)

CONTUSION (ICD-924.9)

* PARASPINOUS SPASM OF BACK

Medications

reviewed - no changes

ULTRACET 37.5-325 MG TABS (TRAMADOL-ACETAMINOPHEN) 1-2 tabs PO every 6 hours PRN
breakthrough pain

Allergies

NKA NKA

Social History (reviewed - no changes required): Volunteer firefighter.

Review of Systems**Musculoskeletal:**

Complains of back pain, muscle cramps, muscle weakness, stiffness, arthritis.

General Medical Physical Exam:**Musculoskeletal:**

Gait/station: normal gait; no ataxia
Digits/nails: no cyanosis, clubbing, or petechiae
Head/neck: normal alignment and mobility
Trunk: TTP over the mid thoracic region today, around t5-t8. This is over the spinous processes. There is mild TTP over the right paraspinous musculature as well. Pain with rightward flexion as well.
RUE: normal range of motion and strength
RLE: no pain or paresthesia with SLR
LUE: normal range of motion and strength
LLE: no pain or paresthesia with SLR

ASSESSMENT AND PLAN**Problem #1**

Problem: PAIN IN THORACIC SPINE (ICD-724.1)

Status of Problem: Unchanged

Other Plan: With MRI that shows disc bulge with mild compression of the cord, we will send patient to Dr. Lal. This compression of the cord is at several different levels.

41

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October 6, 2010

Page 3

Chart Document

JOHN B LEOPARD

Male DOB:09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOO (2) Grp: CLAIM5700002

Signed by Dan Divilbiss, MD on 12/22/2007 at 1:52 AM

Signed by Gary A. Goforth, MD on 12/22/2007 at 1:56 PM



6060094

OUTSIDE STUDY INTERPRETATION

**GREENVILLE
RADIOLOGY**

1210 W. Farls Rd.

Greenville, SC 29608

864-296-4410

CHARLES GRAY, MD
102 GREGOR MENDEL CIR
LAKELANDS ORTHO
GREENWOOD, SC 29646-

In reference to your recent referral of:

JOHN B LEOPARD MRN:
712 STILLWELL RD
GREENWOOD, SC 29646-
DOB: 09-17-70

LAKELANDS ORTHOPAEDIC
MRI Spine Thoracic w/o Contrast

Date Of Service: 12-19-07

REPORT:**MRI THORACIC SPINE 12/19/07:**

CLINICAL HISTORY: Thoracic pain in a 37 year old male. Assess for fracture.

TECHNICAL: Sagittal T1 weighted, sagittal fast spin echo T2 weighted images, sagittal inversion recovery images of the entire thoracic spine. Axial T1 weighted, sagittal inversion recovery, sagittal fast spin echo T2 weighted images of the entire thoracic spine. Axial T1 weighted images of T6-7 and T10 to L1.

FINDINGS: Endplate irregularity is present throughout the entire thoracic spine, particularly noted distally where multiple Schmorl's nodes are evident. Changes of desiccation are present at all levels.

T6-7, a small central HNP is present which lies up against the anterior margin of the cord. The foramina are patent.

At T10-11, mild central disc bulge is present with minimal flattening of the anterior margin of the thoracic cord. Foramina are patent.

At T11-12, a disc bulge is present, mildly asymmetric towards the right with minimal flattening of the anterior margin of the cord. The foramina are patent.

There is no evidence for an occult fracture and no malalignment.

No definite abnormal MR signal changes within the cord.

Page #: 1 Of 2 (JOHN B LEOPARD)

OUTSIDE STUDY INTERPRETATION

**GREENVILLE
RADIOLOGY**

1210 W. Faris Rd.

Greenville, SC 29605

864-295-4410

IMPRESSION:

1. MULTILEVEL SCHMORL'S NODES, PARTICULARLY DISTALLY. SUPERIMPOSED EARLY DEGENERATIVE CHANGES AT MULTIPLE LEVELS. AT T10-11, THERE IS BORDERLINE IMPINGEMENT UPON THE ANTERIOR ASPECT OF THE CORD. AT T11-12, ASYMMETRIC DISC BULGES TOWARDS THE RIGHT WITH BORDERLINE IMPINGEMENT UPON THE CORD. AT T6-7, THERE IS ALSO MINIMAL DISC BULGE LYING UP AGAINST THE ANTERIOR MARGIN OF THE CORD.

Kathleen Oxner, M.D.

KATHLEEN OXNER MD, MD

TRANSCRIBED: 12-19-2007 04:48:52 PM

DICTATED BY: KATHLEEN OXNER MD 12-19-2007 04:48:52 PM

RELEASED BY: KATHLEEN OXNER MD 12-19-2007 04:58:17 PM

KGO/HW

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October 6, 2010

Page 1

Chart Document

JOHN B. LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

12/14/2007 - Office Visit: Multiproblem Visit**Provider: Dan Divilbiss, MD****Location of Care: Montgomery Center For Family Medicine****Acute Visit****Vital Signs****Weight:** 224 pounds**Temperature:** 97.6 degrees F (oral) **Respirations:** 16 **Pulse rate:** 72/min **Pulse rhythm:** regular**Pain Level:** 6 **Pain Loc:** back **Chief Complaint:** workers comp

follow up

Blood Pressure**Blood Pressure:** 130/86 mm Hg**Vitals Taken by:** Debbie Edmunds, LPN**Patient is a 37 Year Male.****Chief Complaint:** workers comp follow up

Pt here for f/u. He had a CT of the thoracic spine looking for any occult fractures. None were seen. They did note that there was the chance of some disk protrusion at multiple levels of the T spine. Here today for referral for MRI. The pt continues to have pain in the mid thoracic spine. It is there with twisting and bending forward. No better or worse since last visit.

Patient Data:**Patient Name:** LEOPARD, JOHN B**Date of Birth:** 09/17/1970**Social Security Number:** 247-63-1193**Date of Injury:** 10/30/2007**Work Status:****Modified Duty from:** 12/14/2007**Modified duty to:** 12/26/2007**List ANY restrictions/Job limitations:** no lifting over 20 lbs with out assistance**Next Follow up Appt:** 1 week or so**Past History****Past Medical History**

PAIN IN THORACIC SPINE (ICD-724.1)

CONTUSION (ICD-924.9)

* PARASPINOUS SPASM OF BACK

Medications

reviewed - no changes

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Page 2

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JOHN B LEOPARD

Male DOB: 09/17/1970 006060094 Ins: GREENWOO (2) Grp: CLAIM5700002 Home: (864) 227-8763

ULTRACET 37.5-325 MG TABS (TRAMADOL-ACETAMINOPHEN) 1-2 tabs PO every 6 hours PRN

breakthrough pain

FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL) 1 tab po TID prn spasm

Allergies

NKA NKA

Social History (reviewed - no changes required): Volunteer firefighter.

Review of Systems**General:**

Denies anorexia.

Musculoskeletal:

Complains of back pain, stiffness.

General Medical Physical Exam:**Musculoskeletal:**

Gait/station: normal gait; no ataxia

Digits/nails: no cyanosis, clubbing, or petechiae

Head/neck: normal alignment and mobility

Trunk: TTP over the mid thoracic region today, around t5-t8. This is over the spinous processes. There is mild TTP over the right paraspinal musculature as well. Pain with rightward flexion as well.

RUE: normal range of motion and strength

RLE: pain in back with SLR

LUE: normal range of motion and strength

LLE: no pain or paresthesia with SLR

ASSESSMENT AND PLAN**Problem #1**

Problem: PAIN IN THORACIC SPINE (ICD-724.1)

Other Plan: Will obtain MRI of the D-spine. F/u in one week or so. ultracet and flexeril for pain.

Prescriptions:

FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL) 1 tab po TID prn spasm #30 x 1

Entered and Authorized by: Dan Divilbiss, MD

Signed by: Dan Divilbiss, MD on 12/14/2007

Method used: Print then Give to Patient

ULTRACET 37.5-325 MG TABS (TRAMADOL-ACETAMINOPHEN) 1-2 tabs PO every 6 hours PRN breakthrough pain #28 x 1

Entered and Authorized by: Dan Divilbiss, MD

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October 6, 2010

Page 3

Chart Document

JOHN B LEOPARD

Male DOB:09/17/1970

Home: (864)227-8763

006060094 Ins: GREENWOO(2) Grp: CLAIM5700002

Signed by: Dan Divilbiss, MD on 12/14/2007

Method used: Print then Give to Patient

Signed by Dan Divilbiss, MD on 12/15/2007 at 1:54 PM

Signed by Rob J Tiller, MD on 12/16/2007 at 10:17 PM



2120 East Greenville Street
Anderson, SC 29621
Telephone (864) 225-6286
Fax (864) 231-6738

PATIENT: Leopard, John
DOB: 9/17/1970
MRN: 538576
PHYSICIAN: Dan Divilbiss, MD
DATE: 12/11/2007

EXAM: CT THORACIC SPINE WITH RECONSTRUCTIONS

HISTORY: Mid back pain after a fall six weeks ago.

TECHNIQUE: Thin section helical CT exam was performed from lower C7 level through the L1 level with sagittal and coronal reconstructions performed. Source and reconstruction images are reviewed on both bone and soft tissue windows.

FINDINGS: There is mild dextroscolliosis with the apex near the T7-T8 level. There are no findings of anterior or posterior subluxation. In the upper thoracic spine, there is an area of sclerosis in the right T1 lamina, which is probably benign and related to a bone island or other sclerotic focus. There is no bone destruction. There is mild to moderate diffuse disc space narrowing in the upper thoracic discs from T1-T2 through T7-T8. No posterior disc protrusion or herniation or canal compromise is evident. There are multifocal chronic-appearing Schmorl's node endplate defects at T3, T5, T6 and T7. No acute fractures are indicated.

There is vacuum disc change in a moderately to markedly degenerated disc anteriorly at T8-T9 and T9-T10. There are moderate-sized chronic Schmorl's nodes and endplate defects inferiorly and superiorly at T8 and T9 and superiorly at T10. There is posterior chronic-appearing disc protrusion or bulging at T10-T11 in addition to marked disc narrowing. There is some overlying osteophytic spur. There is ventral thecal sac effacement and a mild degree of canal stenosis is induced. At T11-T12, moderate to diffuse posterior disc protrusion is evident with osteophytic spurs causing moderate canal narrowing and thecal sac effacement. I cannot include some degree of cord effacement. MRI evaluation is recommended. Additionally, there is an irregular curvilinear appearance to the superior and inferior T11 endplates consistent with Schmorl's nodes, but I cannot exclude a recent subacute fracture on the left side at T11. Chronic Schmorl's nodes are seen at T12 and L1 with chronic degenerative disc disease at the adjacent discs. No cord or canal compromise at these levels. The foramina appear to remain patent. There is no identified paraspinal mass. The imaged portions of the lung show chronic lung disease changes, but no findings of acute disease. No paraspinal mass or hematoma. No fractures involving the imaged portions of the posterior medial ribs. There are two small calcifications in the upper pole left kidney that could represent small renal calculi which are nonobstructing.

IMPRESSION:

1. Mild flattened configuration of the central and left sides of T11 vertebral body, which could be on the bases of advanced chronic degenerative disc disease, but I cannot exclude some subacute fracture on the left side of the T11 vertebral body. No posterior bony retropulsion if there is a fracture present.
2. Moderate degenerative disc disease and posterior disc protrusion and osteophytes at T10-T11 at T11-T12 appearing to cause ventral thecal sac effacement and possible cord effacement. This would be best assessed with MRI and MRI of the thoracic spine is recommended. The presence or absence of a fracture at T11 could also be assessed utilizing this technique. If this cannot be performed, then a bone scan might be considered to exclude a fracture at the T11 level. CT myelography would then be necessary to evaluate the degree of thecal sac compromise due to the disc disease changes if MRI cannot be performed.
3. Multilevel moderate degenerative disc disease in the upper, mid and lower thoracic spine with no other areas of apparent disc protrusion or canal stenosis of significance.

Patient: Leopard, John
MRN: 538576
Exam: CT THORACIC SPINE WITH RECONSTRUCTIONS

4. Vacuum disc degenerative changes at T8-T9 and T9-T10 anteriorly.

Thank you for this consultation.

Charles E. Parke, MD
CP/lb

DD: 12/11/2007
DT: 12/11/2007
Job: 5295139

This document has been electronically reviewed and signed.



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October 6, 2010

Page 1

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

006060094

Home: (864) 227-8763
Ins: GREENWOOD (2) Grp: CLAIM5700002

12/06/2007 - Office Visit: Multiproblem Visit

Provider: Dan Divilbiss, MD

Location of Care: Montgomery Center For Family Medicine

Acute Visit

Vital Signs

Weight: 227.5 pounds

Temperature: 98.6 degrees F (oral) Respirations: 16 Pulse

rate: 80 /min Pulse rhythm: regular

Pain Level: 6 Pain Loc: back Comments: workers

comp re check

Chief Complaint: workers comp re check

Blood Pressure

Blood Pressure: 140/80 mm Hg

large cugg left arm

Vitals Taken by: Debbie Edmunds LPN

Patient is a 37 Year Male.

Chief Complaint: workers comp re check

Here for f/u of back injury. He had been doing well with PT, but has plateaued in relation to his mid back pain. This has not improved while everything else has gotten much better. It was quite a concern for his PT and she actually called me a few days ago requesting recheck in clinic. there was some concern for needing an MRI.

He does not complain of radicular symptoms - no weakness, numbness or tingling. He has no bowel or bladder dysfunction. He has been back to work with mostly light duty, getting assistance with any heavy lifting.

The pain is in the mid back. It is sharp and point specific. It does not radiate. Nothing helps it. It is worse with twisting or moving.

Past History

Past Medical History

PAIN IN THORACIC SPINE (ICD-724.1)

CONTUSION (ICD-924.9)

* PARASPINOUS SPASM OF BACK

Medications

reviewed - no changes

Allergies

NKA NKA

Social History: Volunteer firefighter.

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October 6, 2010

Page 2

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

006060094

Home: (864) 227-8763
Ins: GREENWOOD (2) Grp: CLAIM5700002**Patient Data:**

Patient Name: LEOPARD, JOHN B

Date of Birth: 09/17/1970

Social Security Number: 247-63-1193

Date of Injury: 10/30/2007

Work Status:

May Return to Normal Duty on: 12/06/2007

Modified Duty from: 12/06/2007

Modified duty to: 12/13/2007

List ANY restrictions/job limitations: Cannot lift over 20 pounds

Next Follow up Appt: 1 week

Review of Systems**Musculoskeletal:**

Complains of back pain.

Denies joint pain, joint swelling, muscle weakness, stiffness, arthritis.

Neurologic:

Denies transient paralysis, weakness, paresthesias.

General Medical Physical Exam:**General Appearance:**

Well developed, well nourished, in no acute distress

Musculoskeletal:

Gait/station: normal gait; no ataxia

Digits/nails: no cyanosis, clubbing, or petechiae

Head/neck: normal alignment and mobility

Trunk: TTP over the mid thoracic region today, around t5-t8. This is over the spinous processes. There is mild TTP over the right paraspinous musculature as well.

RUE: normal range of motion and strength

RLE: no pain or paresthesia with SLR

LUE: normal range of motion and strength

LLE: no pain or paresthesia with SLR

Neurological:

Cranial N: II - XII grossly intact

Reflexes: 2+ and symmetric with no pathological reflexes

Sensory: intact to touch in ble

Other: neg slr bilaterally

Problems:

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October 6, 2010

Page 3

Chart Document

JOHN B LEOPARD

Male DOB:09/17/1970

Home: (864)227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

Medical Problems Added:

1) Dx of Pain in Thoracic Spine (ICD-724.1)

ASSESSMENT AND PLAN**Problem #1****Problem:** PAIN IN THORACIC SPINE (ICD-724.1)**Status of Problem:** Unchanged**Medication Plan:** Add new medicine(s)

Other Plan: This pain does not seem to be new or worse, but is persistent when the remainder of his pain is gone. With no radicular sx's, CT will be better at showing bony anatomy than MRI. It does not appear to be bulging disk. Plan for light duty and then f/u with me in one week or one-two days after the thoracic CT is done.

Signed by Dan Divilbiss, MD on 12/07/2007 at 11:55 AM

Signed by Harvey F Hatcher, MD on 12/07/2007 at 4:01 PM

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October 6, 2010

Page 1

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

006060094

Home: (864)227-8763
Ins: GREENWOOD (2) Grp: CLAIM5700002

11/20/2007 - Office Visit: workers comp

Provider: Dan Divilbiss, MD

Location of Care: Montgomery Center For Family Medicine

Acute Visit

VITAL SIGNS

Entered weight: 224 lb.

Calculated Weight: 224 lb.

Pulse rate: 72

Pulse rhythm: regular

Respirations: 16

Vitals entered by: Debbie Edmunds, LPN

Blood Pressure: 122/84 mm Hg - taken by: Debbie Edmunds, LPN

Patient has no complaint of pain today.

Patient reports current tobacco use to nurse.

Patient is a 37 Year Male.

Chief Complaint: workers comp recheck

Review of Old Problems:

Problem: * PARASPINOUS SPASM OF BACK

Quality: Improving

Duration: 3 weeks

Severity: Mild

Comment: much better today. Has been able to lift children who weigh about 30 pounds. Has been able to make it to PT several times and this is going very well. He will have several more sessions of therapy.

Patient Data:

Patient Name: LEOPORD, JOHN B

Date of Birth: 09/17/1970

Social Security Number: 247-63-1193

Date of Injury: 10/30/2007

Work Status:

May Return to Normal Duty on: 12/03/2007

Modified Duty from: 11/26/2007

Modified duty to: 11/30/2007

Out of Work from: 11/20/2007

Out of work to: 11/25/2007

List ANY restrictions/job limitations: Cannot lift over 50 lbs for one week and then may advance to full duty, must continue with rehab.

Next Follow up Appt: 5-6 wks

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October 6, 2010

Page 2

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

Past Medical History

CONTUSION (ICD-924.9)

* PARASPINOUS SPASM OF BACK

Medications

reviewed - no changes

FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL) 1 tab po TID prn spasm

Allergies

NKA NKA

Review of Systems**Musculoskeletal:**

Complains of stiffness.

Denies back pain, joint pain, muscle weakness, arthritis.

Neurologic:

Denies transient paralysis, weakness, paresthesias.

General Medical Physical Exam:**General Appearance:**

Well developed, well nourished, in no acute distress

Musculoskeletal:

Gait/station:	normal gait; no ataxia
Digits/nails:	no cyanosis, clubbing, or petechiae
Head/neck:	normal alignment and mobility
Trunk:	normal alignment and mobility; no deformity
RUE:	normal range of motion and strength
RLE:	no pain or paresthesia with SLR
LUE:	normal range of motion and strength
LLE:	no pain or paresthesia with SLR

ASSESSMENT AND PLAN**Problem #1**

Problem: * PARASPINOUS SPASM OF BACK

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October 6, 2010

Page 3

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

Status of Problem: Improved**Medication Plan:** Continue Present medicine(s)**Other Plan:** Much better. Finish PT. Return to work progressively over the next 2 weeks. Plan for f/u with me in 4-6 weeks when PT is done for final recheck.**Problem #2****Problem:** CONTUSION (ICD-924.9)**Other Plan:** resolved.**Prescriptions:****FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL)** 1 tab po TID prn spasm #15 x 0

Entered and Authorized by: Dan Divilbiss, MD

Signed by: Dan Divilbiss, MD on 11/20/2007

Method used: Print then Give to Patient

Signed by Dan Divilbiss, MD on 11/21/2007 at 10:35 AM

Signed by Floyd Hatcher, MD on 11/21/2007 at 10:50 AM

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October 6, 2010

Page 1

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

11/06/2007 - Office Visit: Multiproblem Visit

Provider: Dan Divliliss, MD

Location of Care: Montgomery Center For Family Medicine

Acute Visit**VITAL SIGNS**

Entered weight: 224 lb.

Calculated Weight: 224 lb.

Pulse rate: 84

Pulse rhythm: regular

Respirations: 16

Vitals entered by: Debbie Edmunds, LPN

Blood Pressure: 130/94 mm Hg - taken by: Debbie Edmunds, LPN

Patient complains of 6 out of ten pain.

Patient denies tobacco use to nurse.

Patient is a 37 Year Male.

Chief Complaint: workers comp

Review of Old Problems:

Problem: * PARASPINOUS SPASM OF BACK

Quality: Improving

Duration: weeks

Severity: Moderate

Comment: pt feels better. Pain is more of a sharp, pointing pain. The large "knot" is better. He has not been to PT as of yet. Still unable to bend or lift with back.

Past Medical History

CONTUSION (ICD-924.9)

* PARASPINOUS SPASM OF BACK

Medications

reviewed - no changes

FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL) 1 tab po TID prn spasm

LORTAB 5 5-500 MG TAB (ACETAMINOPHEN-HYDROCODONE) 1 tablet q 4-6 hours prn pain

PREDNISONE 20 MG TAB (PREDNISONE) 2 tabs po daily x 3 days, then 1 tab po daily x 3 days

Allergies

56

Montgomery Center For Family Medicine

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October 6, 2010

Page 2

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

006060094

Home: (864) 227-8763
Ins: GREENWOOD (2) Grp: CLAIM5700002

NKA NKA

Patient Data:

Patient Name: LEOPARD, JOHN B

Date of Birth: 09/17/1970

Social Security Number: 247-63-1193

Date of Injury: 10/30/2007

Work Status:

Out of Work from: 10/30/2007

Out of work to: 11/19/2007

List ANY restrictions/job limitations: Cannot lift

Next Follow up Appt: 2 weeks

Review of Systems**General:**

Denies fatigue, malaise.

Musculoskeletal:

Complains of back pain, stiffness.

Denies joint swelling, muscle cramps, muscle weakness.

General Medical Physical Exam:**Musculoskeletal:**

Gait/station:	stiff when walking
Head/neck:	normal alignment and mobility
Trunk:	TTP around T10-12, no spasm palpable.
RUE:	normal range of motion and strength
LUE:	normal range of motion and strength

Lymphatic:

Neck:	no cervical adenopathy
-------	------------------------

Neurological:

Cranial N:	II - XII grossly intact
Reflexes:	2+ and symmetric with no pathological reflexes
Other:	neg slr bilaterally

ASSESSMENT AND PLAN**Problem #1**

Problem: * PARASPINOUS SPASM OF BACK

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October 6, 2010

Page 3

Chart Document

JOHN B. LEOPARD

Male DOB:09/17/1970

Home: (864)227-8763

006060094 Ins: GREENWOO (2) Grp: CLAIM5700002

Status of Problem: Improved

Other Plan: pt will start PT on Thursday. he is unable to bend and lift for work right now. We will have him work with PT and then slowly increase activity. Hope to have him f/u in 2 weeks, but if he's feeling better sooner, then he will call back and we will reassess his ability to return to work.

Signed by Dan Divilbiss, MD on 11/08/2007 at 10:39 PM

Signed by Mark Van Swol, MD on 11/13/2007 at 3:51 PM

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October 6, 2010

Page 1

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

10/31/2007 - Office Visit: workers comp

Provider: Dan Divilbiss, MD

Location of Care: Montgomery Center For Family Medicine

Acute Visit

VITAL SIGNS

Entered weight: 223 lb.

Calculated Weight: 223 lb.

Pulse rate: 80

Pulse rhythm: regular

Respirations: 16

Vitals entered by: Debbie Edmunds, LPN

Blood Pressure: 140/84 mm Hg - taken by: Debbie Edmunds, LPN

Patient Data:

Patient Name: LEOPORD, JOHN B

Date of Birth: 09/17/1970

Social Security Number: 247-63-1193

Date of Injury: 10/30/2007

Work Status:

Out of Work from: 10/31/2007

Out of work to: 11/08/2007

List ANY restrictions/job limitations: out of work until next week

Next Follow up Appt: one week

Patient complains of 6 out of ten pain.

Patient reports current tobacco use to nurse.

Patient is a 37 Year Male.

Chief Complaint: fall injury

Problem

The patient complains of pain in mid back. This has been present for 12-18 hours. This is located mid-inferior D-spine. Its quality is described as tight, sharp, pain. Its severity is described as severe. Each episode lasts all day long, worse with any movement. This generally improves when nothing has helped. The symptoms are generally exacerbated by moving. The symptoms seem to be associated with the patient fell when entering a burning home and landed awkwardly. He twisted his back during the fall. The patient also states that he fell forward and landed awkwardly. He was seen in the ED last night and told he might has a pinched nerve. Apparently, the patient has had a pinched nerve in his neck in the past.

Past Medical History

Montgomery Center For Family Medicine

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October 6, 2010

Page 2

Chart Document

JOHN B LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

CONTUSION (ICD-924.9)

* PARASPINOUS SPASM OF BACK

Medications

reviewed - no changes

FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL) 1 tab po TID prn spasm
LORTAB 5 5-500 MG TAB (ACETAMINOPHEN-HYDROCODONE) 1 tablet q 4-6 hours prn pain
PREDNISONE 20 MG TAB (PREDNISONE) 2 tabs po daily x 3 days, then 1 tab po daily x 3 days

Allergies

NKA NKA

Review of Systems**General:**

Complains of see HPI.

Musculoskeletal:

Complains of back pain, stiffness.

Denies joint pain, joint swelling, arthritis.

Neurologic:

Denies transient paralysis, weakness, paresthesias.

no bowel or bladder dysfunction

General Medical Physical Exam:**General Appearance:**

WD/WN male in mild distress/discomfort

Musculoskeletal:

Gait/station: normal gait; no ataxia

Digits/nails: no cyanosis, clubbing, or petechiae

Head/neck: normal alignment and mobility

Trunk: Spasm over left latissimus, TTP over the lower thoracic vertebrae paraspino

muscles, some TTP over the lower rhomboids bilaterally as well.

RUE: cuff intact bilaterally

RLE: pain in back with SLR

LUE: cuff intact bilaterally

LLE: pain in back with SLR

Neurological:

Cranial N: II - XII grossly intact

Reflexes: 2+ and symmetric with no pathological reflexes

Sensory: intact to touch in ble

60

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October 6, 2010

Page 3

Chart Document

JOHN B. LEOPARD

Male DOB: 09/17/1970

Home: (864) 227-8763

006060094 Ins: GREENWOOD (2) Grp: CLAIM5700002

Problems:**Medical Problems Added:**

- 1) Dx of Confusion (ICD-924.9)
- 2) Dx of Paraspinous Spasm of Back ()

ASSESSMENT AND PLAN**Problem #1****Problem:** * PARASPINOUS SPASM OF BACK**Status of Problem:** New**Medication Plan:** Add new medicine(s)

Other Plan: pt to fill rx from ED for flexeril, lortab and prednisone. This should help with inflammation and spasm. Advised to use lortab only if motrin does not help. Understanding voiced. Start PT asap. Pt to be out of work for one week. Plan for recheck next week, midweek. Forms completed for work. Encouraged to follow through with PT as this may improve his symptoms much more quickly.

Problem #2**Problem:** CONTUSION (ICD-924.9)**Status of Problem:** New**Medication Plan:** Add new medicine(s)**Prescriptions:****LORTAB 5 5-500 MG TAB (ACETAMINOPHEN-HYDROCODONE)** 1 tablet q 4-6 hours prn pain #20 x 0

Entered and Authorized by: Dan Divilbiss, MD

Signed by: Dan Divilbiss, MD on 11/01/2007

Method used: Print then Give to Patient

FLEXERIL 10 MG TAB (CYCLOBENZAPRINE HCL) 1 tab po TID prn spasm #30 x 1

Entered and Authorized by: Dan Divilbiss, MD

Signed by: Dan Divilbiss, MD on 11/01/2007

Method used: Print then Give to Patient

Signed by Dan Divilbiss, MD on 11/01/2007 at 12:08 AM

Signed by Floyd Hatcher, MD on 11/01/2007 at 7:06 AM

661

SELF REGIONAL HEALTHCARE

PHYSICAL THERAPY DISCHARGE REPORT

Date: 1/15/08 Re: John Leopard
Referring MD: Dr. Wilbriss DOB: 9/17/70
DX: Back strain

We have completed treatment of your patient per your referral. See status report below.

STATUS REPORT

Frequency of treatments: 3x week
of treatments received: 8 land (~) missed appointments 2
_____ aquatic

Treatments:

Therex for ROM and strengthening, Massage, Ultrasound
Ultrasound/esthm combo, MHP, manual therapy, Interferential

Patient's current status/complaints:

Still had 4-5/10 @ resting and 8-9/10 @ exercises/work

Progress/Goals:

pt. met 9/5 goals for therapy 2° pt. limited by pain.

Recommendations:

pt. was put on hold from therapy to return to MD.

pt. has not returned for PT is to be p/c'd 2° expired script.

Thank you for your referral,

Caroline Evans, DPT

Caroline Evans, DPT
OPTIMUM LIFE CENTER
115 Academy Avenue
Greenwood, South Carolina 29646
Phone: (864) 725-7066
Fax: (864) 725-7063

Leopard, John
07311-00350

25 Spring Street • Greenwood, South Carolina 29646-3875 • 864-725-4111

PRINTED BY: E8946

62

Optimum Life Center
Of Self Regional Healthcare
115 Academy Avenue
Greenwood, SC 29646
Phone (864) 725-4183
Fax (864) 725-5757

PATIENT: LEOPARD, JOHN B
THERAPIST: CAROLINE EVANS, PT

ACCT: 0731100350
DICTATED: 11/08/2007
TRANS DT: 11/08/2007

PHYSICAL THERAPY
INITIAL EVALUATION

AGE: 37
SEX: M
DOB: 09/17/1970

DATE OF INITIAL EVALUATION:
November 7, 2007

PHYSICIAN:
Daniel D Divilbiss, MD

MEDICAL DIAGNOSIS:
Back strain

TREATMENT DIAGNOSIS: 724.5

MD APPT:
1 Week

LENGTH OF REFERRAL:
Not stated

SUBJECTIVE:

PATIENT COMMENTS:

Patient works as a volunteer fire fighter for Greenwood County. Patient states he was going into the eave of a roof to go into the attic to fight a fire. Patient states he fell into the attic on his hands, twisted, and then landed on his back. Patient states this happened on 10/30/2007. Following the accident, patient reports he was able to get up and walk back to the truck and walk into the fire department. Patient states he laid down for a while and when he went to get back up is when he had increased pain. Patient then went to the doctor on 10/31/07. Patient states it feels like there is a knot in his

Leopard, John
07311-00350

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63

PATIENT: LEOPARD, JOHN B
THERAPIST: CAROLINE EVANS, PT

ACCT: 0731100350

PAGE 2

back between his shoulder blades. Patient states he has difficulty sleeping and tends to constantly change positions. Patient states the pain is worse when he is sitting versus standing. Patient reports the pain is more in the center, mid-back (pointing to his mid-thoracic along his spine). Patient states he also has a pinched nerve in his neck, C6/7, but this is not related to his accident. Patient states following his accident and his doctor visit he had an x-ray that showed no fracture. Patient is right handed. Patient stated he was given pain killers and muscle relaxers and prednisone by his physician. Patient states the muscle relaxers seem to help a lot with his pain. Patient reports that muscle relaxers and warm showers help him to relax more, which allows him to decrease his pain. Patient also works maintenance for ATS.
PAIN RATING: Patient reports a 5/10 pain in sitting.
PAIN DESCRIPTION: Patient states pain is worse with increased sitting, feels like there is a huge knot between his shoulders right along his thoracic spine.

OBJECTIVE & PHYSICAL FINDINGS:

GAIT: COMMENTS (assistive device): Patient ambulates independently with no assistive device with no obvious gait deviations.

POSTURE/GENERAL APPEARANCE: Within functional limits.

STRENGTH/MUSCLE TONE: Manual muscle testing: Patient reports pain with resisted upper extremity flexion, in abduction, and resisted scapular adduction. Lower extremity strength is within functional limits; however, pain reported with resisted hip flexion. Upper extremity strength is within functional limits with manual muscle testing.

ROM:

C/spine: Within functional limits, except for pain reported with full cervical flexion.

L/spine: Within functional limits, except for pain with lumbar flexion at 80 percent. Pain with rotation and sidebending.

UE: Within functional limits.

LE: Not tested.

BALANCE:

Sitting: Independent.

Standing (Static): Independent.

Dynamic: Independent.

Leopard, John
07311-00350

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64

PATIENT: LEOPARD, JOHN B
THERAPIST: CAROLINE EVANS, PT

ACCT: 0731100350

PAGE 3

RADICULAR SYMPTOMS: Patient reports numbness and tingling in his right arm and hand secondary to pinched nerve in his cervical spine; however, not related to current injury.

SENSATION: Intact.

REFLEXES: Not tested.

ENDURANCE: Not tested.

EDEMA/WOUNDS: Patient has minimal edema along the thoracic paraspinals.

PALPATION: Patient reports increase pain with palpation over the thoracic spine between T5 and T11. Patient also reports pain with palpation over paraspinal muscle bellies in the same thoracic region.

SPECIAL TESTS: Patient has increase pain with thoracic PAs.

ASSESSMENT:

Patient is a 37 year old male that presents for physical therapy for evaluation and treatment of a thoracic back sprain. Patient presents today with primary symptoms of increased pain that is affecting his ADLs and work and painful range of motion and manual muscle testing with strengthening. Patient will benefit from physical therapy to decrease his pain so that he may return to full duty at work and ADLs, full pain free range of motion and strength. Patient has a good rehabilitation potential.

SHORT TERM GOALS:

To be set for 4 weeks.

1. Patient will subjectively report a decrease in pain to 0/10 at worst.
2. Patient will be able to report to full duty at work with a 0/10 pain.
3. Patient will be able to demonstrate pain free range of motion within normal limits for upper extremity, cervical and lumbar spine.
4. Patient will be able to demonstrate pain free manual muscle testing of the upper extremity and hip flexion.
5. Patient will be independent with a home exercise program to improve trunk range of motion and strength.

Leopard, John
07311-00350

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65

PATIENT: LEOPARD, JOHN B
THERAPIST: CAROLINE EVANS, PT

ACCT: 0731100350

PAGE 4

LONG TERM GOALS:

None set at this time.

PATIENT'S GOAL: To decrease has pain.

PLAN:

TODAY'S TREATMENT: Evaluation. Manual therapy (4 minutes), moist hot pack times 20 minutes, interferential electrical stimulation times 15 minutes at 12 intensity (with moist hot back) over thoracic paraspinals while prone. Patient reported a decrease in pain after interferential and moist hot pack.

TREATMENT PLAN: Patient will benefit from Therex to improve range of motion and strength to upper extremity and trunk, modalities to include moist hot pack, cold pack, interferential, ultrasound, traction, iontophoresis etc., massage, manual therapy etc., and home exercise program.

TREATMENT FREQUENCY: 3 times a week times 4 weeks.

Caroline Evans, DPT

Caroline Evans, DPT

CE/kp

Job #: 2006370/303321991

PHYSICIAN SIGNATURE IS REQUIRED FOR ALL MEDICARE PATIENTS:

I certify that the above named patient is under my care and supervision and that the above described care is reasonable and necessary for this patient. I certify that I have reviewed and/or developed the above plan of care and that this plan of care is appropriate for this patient and will be reviewed every 30 days or more often if the condition warrants. I recommend that this patient receive treatment as described in the above plan of care and signature here will serve as written prescription for that care.

PHYSICIAN SIGNATURE: _____

DATE: _____

Leopard, John
07311-00350

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66

PROGRESS NOTES	
DATE	NOTES
11/12/07	S: "It feels a little better today" but reports it was sore when driving this past weekend. O: Pt. performed ⁵⁰NuStep x 11 min @ L2. Pt. performed mid thoracic stretch by sitting on his heels w/ hands out front, to R side & then (L) side 2x each for 20H. Pt. ^{PM} received massage to thoracic paraspinals x 12 min while prone - noted muscle spasm tender to palpation on (R) thoracic musculature inferior to the scapula. Pt. received IFC @ 13 int. x 15 min to (R) thoracic paraspinals while prone w/ MHP to his back. Total treatment time 50 min. A: Pt. reports ↓'d pain p treatment P: Reassess pain + cont = POC ————— <i>Caroline Evans, DPT</i>
11/14/07	S: Pt. reports (P) in (R) thoracic paraspinals. Reports ↑'d (P) in sitting & supine position. O: Pt. rec'd US/Estim combo to (R) thoracic paraspinals x 8 min. @ an intensity of 20. Pt. then rec'd STM to same area x 10 min in prone. Tx. ended early 20 to Dr.'s appt. A: Pt. @ slight ↑'d soreness p treatment. P: Cont POC. ————— <i>Paulsell, PT</i>
11/16/07	Pt. no show for appt. Called later today he mixed up appt. times w/ Monday's appt. ————— <i>Caroline Evans, DPT</i>
11/19/07	S: Pt. reports he had a good weekend w/ ↓'d pain. O: Pt. performed NuStep x 9 min @ L3. Pt. performed therex to ↑ trunk ROM: SKTC, DKC, LTR, HSS, bowing on heels (↑, ↗, ↘) x 20H 3 times each. Performed STM to (R) thoracic paraspinals while prone + side lying x 5 min total. Received IFC to (R) thoracic paraspinals

Addressograph

Leopard, John
07311-00350

Progress Notes
Self Regional Healthcare



1PPN680

Form# 4014/4-04/Single/Page 1 of 1/Date Order

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67

PROGRESS NOTES	
DATE	NOTES
11/19/07	while prone on mat x 15 min @ 16 int $\bar{c}$ MHP over back.
(cont.)	Total treatment time 40 min.
	A: Pt. $\bar{c}$ good progress in $\downarrow$ pain but still working towards goals.
	P: cont POC Caroline Evans, DPT
11/21/07	Pt. no show for appt. Called $\bar{c}$ no answer + no machine Caroline Evans, DPT
11/26/07	S: "I have a spot that burns right in the middle of my back"
	O: Manual massage to $\textcircled{B}$ paraspinals (thoracic) x 15 min, manual prone LE flexion x 10 reps (2x), Cat-a-camel x 10, Prayer stretch x 3 (L + R), "Superman" x 10 in prone - U.S. @ 1.4 w/cm ^{2} 100%, 1 mhz x 8 min to $\textcircled{R}$ Paraspinal - Ice x 5 min - Review of posture, chaitucks, and comban support
	A: pt had very limited extension $\bar{c}$ Cat-a-camel
	P: Cont $\bar{c}$ POC DPTA
11-28-07	S: Pt. reports $\textcircled{P}$ 6/10. Pt. reports US estim helps the most, no $\bar{c}$ P IFC.
	O: Pt. reviewed proper performance of ex's: SKC, DKT, POE, POH, alt UE for multifidus. Pt. rec'd massage $\bar{c}$ MFR to back focusing on $\textcircled{R}$ mid back all while prone (mins) Attempted PA's but painful. Pt. rec'd US-estim combo @ 1.5 w/cm ^{2} @ int 8-12 x 8 min.
Addressograph	(cont.)

Leopard, John
07311-00350

Progress Notes
Self Regional Healthcare



1PPN680

Form# 4014/4-04/Single/Page 1 of 1/Date Order

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68

PROGRESS NOTES	
DATE	NOTES
11-28-07	(Cont'd) Pt. encouraged to drink water to ↓ soreness p deep tissue and to try Biofreeze. (65 mins tx) A: Pt. educated on proper sleeping positioning A: Pt. c tenderness to palpation, ↓'d p tx. ① Musculature raised compared to ②. P: Cont per POC ———— LOurth PTA
11-30-07	S: Pt. reports ↓'d ② today, ↓'d tenderness. Pt. reports he had taken muscle relaxers (Flexeril) on Tues pm. Pt. reports working on outlets but s c/o's. O: Pt. rec'd MFR to full back c deep tissue on QL area while prone x 25 mins. Pt. rec'd e-stim- US combo @ 1.5 W/cm ² x 8 mins to ② mid back. Pt. performed ther ex's per f/s. for postural muscles and scapular stabilization. Attempted scap. depression on lat. pull down but ↑'d discomfort. (Tx time 55 mins) A: Pt. c weakness on scap. area. No ↑'d discomfort c ex's & X scap depression. Pt's ② ↓'d today and progressing to strengthening P: Cont per POC ———— LOurth PTA
12/3/07	S: Pt. reports he has returned to light duty at work but still has 4-5/10 just sitting and 8-9/10 c some exercises and c palpation. O: Pt. received MHP to back while prone x 15 min while discussing work duties. Pt. instructed on body mechanics & body awareness while at work. Pt. palpated p Moist heat and still 8/10 pain over thoracic spine (T7) and thoracic paraspinals (T6-T10). Total tx time 20 min. (no charge) A: Feel further testing/imaging is necessary 2° pt. not made much progress thus far c therapy. P: Plan to put pt. on hold. To see MD next week, Caroline Gamm OPT

Addressograph

Leopard, John
07311-00350Progress Notes
Self Regional Healthcare

1PPN680

Form# 4014/4-04/Single/Page 1 of 1/Date Order

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69

July 15, 2008

Bengy Hill, M.D.
Family Physicians of Greenwood

RE: John Leopard
ID: 247-63-1193

Dear Bengy,

I am releasing Mr. Leopard from our service today. He is post anterior cervical discectomy and fusion doing well.

Thank you,



Sumeer Lal, M.D.

SL/dkh



*Diplomate of the American Board of Neurological Surgery (Board Certified)

*Fellow of the Royal College of Surgeons of Canada (Board Certified)

303-C West Alexander Avenue • Greenwood, SC 29646 • Phone: (864) 943-1267 • (800) 611-0823 • Fax: (864) 943-1860

April 15, 2008

Bengy Hill, M.D.
Family Physicians of Greenwood

RE: John B. Leopard
ID: 247-63-1193

Dear Dr. Hill,

I saw Mr. Leopard today in our office on 04-15-08.

Interim History: Last seen on 03-13-08, 02-14-08 and he had an operation done, a single anterior cervical discectomy and fusion on 01-16-08.

Presentation Today: Feeling well. Ready to go back to work.

PE/Radiographic: Incision well healed. No neuro deficit.

Treatment/Plan: Back to work. Follow-up in three months with x-rays.

Thank you,

Sumeer Lal

Sumeer Lal, M.D.

SL/dkh

13/12

[†] Diplomate of the American Board of Neurological Surgery (Board Certified)

^{*} Fellow of the Royal College of Surgeons of Canada (Board Certified)

303-C West Alexander Avenue • Greenwood, SC 29646 • Phone: (864) 943-1267 • (800) 611-0823 • Fax: (864) 943-1860

March 13, 2008

Bengy Hill, M.D.
Family Physicians of Greenwood

RE: John B. Leopard
ID: 247-63-1193

Dear Dr. Hill,

Interim History: Mr. Leopard was seen in office follow-up today after last being seen by Dr. Lal on 02-14-08. At this time he is now two months post C6/7 ACDF and continues to do well postoperatively.

Presentation Today: Patient presents today regarding return to work.

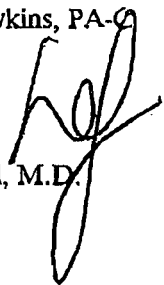
PE/Radiographic: Patient has no notable weakness in his upper extremities and little to no pain with range of motion in his neck.

Treatment/Plan: Patient is scheduled to return to work on 04-18-08 and will follow-up with Dr. Lal before this date.

If you have any concerns, please do not hesitate to give us a call.

Thank you,


Carrie Hawkins, PA-C
CH/dkh


Sumeer Lal, M.D.
SL/dkh

[†] Diplomate of the American Board of Neurological Surgery (Board Certified)

^{*} Fellow of the Royal College of Surgeons of Canada (Board Certified)

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February 14, 2008

Bengy Hill, M.D.
Family Physicians of Greenwood

RE: John B. Leopard
ID: 247-63-1193

Dear Dr. Hill,

Mr. Leopard is really doing well after his surgery. He is very pleased with his surgical outcome. Follow-up appointment in our office at a later date. If you have any concerns, please do not hesitate to give us a call.

Thank you,

Sumeer Lal

Sumeer Lal, M.D.

SL/dkh

[†] Diplomate of the American Board of Neurological Surgery (Board Certified)

^{*} Fellow of the Royal College of Surgeons of Canada (Board Certified)

303-C West Alexander Avenue • Greenwood, SC 29646 • Phone: (864) 943-1267 • (800) 611-0823 • Fax: (864) 943-1860

January 10, 2008

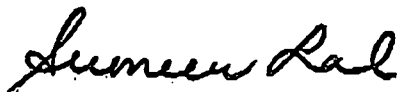
Bengy Hill, M.D.
Family Physicians of Greenwood

RE: John B. Leopard
ID: 247-63-1193

Dear Dr. Hill,

Mr. Leopard had a recent fall and has thoracic pain. The imaging shows degenerative changes but really no acute findings in the thoracic spine and I agree with the report describing the levels of where there are some disc bulges, but there is no cord compression. His neck pain is still there and he has still periodic pain in his arm. He has decided he would like to proceed with an anterior cervical discectomy decompression and fusion. Risks were detailed at length. If you have any concerns, please do not hesitate to give us a call.

Thank you,



Sumeer Lal, M.D.

SL/dkh

BA

†Diplomate of the American Board of Neurological Surgery (Board Certified)

*Fellow of the Royal College of Surgeons of Canada (Board Certified)

November 14, 2007

Bengy Hill, M.D.
Family Physicians of Greenwood

RE: John B. Leopard
ID: 247-63-1193

Dear Dr. Hill,

Thank you for requesting consultation on Mr. Leopard.

REASON FOR CONSULTATION: He is a very pleasant 37-year-old male with a five month history of neck pain with radiation to the right shoulder, upper arm and hand, which had increased until approximately a month ago when he began a leave of absence from work secondary to a low back injury. Patient states that his pain now has stabilized and improved slightly. Patient denies associated symptoms such as headaches, fatigue or clumsiness, or problems with sleep secondary to pain. He states that he does have paresthesias in his right hand, shoulder and upper arm, as well as weakness in his right hand at times. Patient's pain is palliated by manipulation and is exacerbated by exercise. Patient's pain is qualified as a throb ache and is quantified as a 2/10 at this time and intermittent in frequency. Patient has sought no treatment to date.

PAST SURGICAL HISTORY: Inguinal hernia repair, knee scope.

PAST MEDICAL HISTORY: Arthritis, hypercholesterolemia, stomach disorders.

MEDICATIONS: Vytorin, Aciphex, Lexapro, Lortab, Flexeril.

ALLERGIES: Neosporin.

SOCIAL/FAMILY HISTORY: Smokes but does not state how much and drinks alcohol on occasion. Family history is positive for diabetes and cancer.

PHYSICAL EXAMINATION: No upper motor neuron signs. Deep tendon reflexes are intact bilaterally in his upper extremities. Strength and sensation are intact bilaterally in his upper extremities. Patient has no pain with full range of motion in his shoulder bilaterally.

RADIOGRAPHIC EVALUATION: Demonstrates disc herniation at C6/7 to the right with some foraminal stenosis bilaterally.

BP

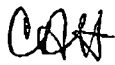
† Diplomate of the American Board of Neurological Surgery (Board Certified)

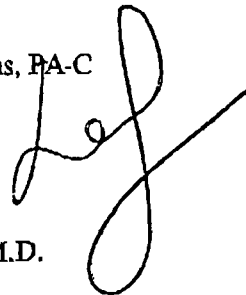
*Fellow of the Royal College of Surgeons of Canada (Board Certified)

RE: John B. Leopard
ID: 247-63-1193
Page 2

PLAN: Consideration for possible ACDF. Risks were detailed at length. He is going to decide if that is something he would like to do or not. If you have any concerns, please do not hesitate to give us a call.

Thank you,


Carrie Hawkins, PA-C
CH/dkh


Sumeer Lal, M.D.
SL/dkh

JOHN B. LEOPARD Patient ID: 247-63-1193

DOB: 17.Sep.1970 (38) Male

Visit Date: 23.Mar.2009

PRESENT ILLNESS INFORMATION

Chief Complaint: WC INJURY 10/30/07. Follow up on upper back pain. Patient states pain score today is a 5. Patient returns with Thoracic MRI done at GRPA 3/12/09. Patient states the Flexeril is helping him. Medications reviewed with patient, appropriate updates made.

HPI:

S1: Follow-up on thoracic pain.

Location: upper back below the level of the shoulder blades in the midline. There was no referral of pain to other locations.

This has been a recurring problem.

Status of the pain since last visit: changed. **Severity:** somewhat less severe.

Previous associated manifestations:

- insomnia - unchanged.

New associated manifestations: none identified.

Tests or diagnostic procedures since the last visit:

- Thoracic spine MRI: Date - 3/12/09. Test location - GRPA.

REVIEW OF SYSTEMS

Constitutional Symptoms: no details provided.

Gastrointestinal: heartburn or indigestion.

Musculoskeletal: back pain.

The following systems are negative: Cardiovascular, Eyes, Genital/Urinary, Hematological/Lymphatic, Immunologic, Integumentary, Nervous, Psychiatric, Respiratory.

PAST, FAMILY AND SOCIAL HISTORY

Current Meds: Aciphex (20 MG), daily, prescribed by Dr. Hill

EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID for 30 days (quantity: 60), subs OK, refills: 2, prescribed on 09.Mar.2009 by Philip J. Hodge, M.D.

Flexeril (Cyclobenzaprine HCl Tab 10 MG), 1 tid prn for muscle spasm (quantity: 45), subs OK, refills: 2, prescribed on 09.Mar.2009 by Philip J. Hodge, M.D.

Lexapro (20 MG), daily, prescribed by Dr. Hill

Vytorin (uncertain of dosage), daily, prescribed by Dr. Hill

Med Allergies: Demerol: "makes skin crawl"

Neosporin: "swell up"

Non-Med Allergies: No non-medication allergies.

Past Health History: **Childhood Diseases:** negative.

Eyes: negative.

Ears: negative.

Cardiovascular: negative.

Respiratory: negative.

Gastrointestinal: reflux diagnosed in 1998.

Neurologic: negative.

Endocrine: negative.

Hematologic and Lymphatic: negative.

Surgeries and Hosp: **Problems with anesthesia:** none.

Previous surgery:

- **Abdominal and gastrointestinal:** hernia repair in 2002

- **Musculoskeletal:** "right knee - 2005" spine surgery - "cervical fusion on 01/16/08 in Greenwood, SC".

Previous non-surgical hospitalizations: infection in left knee.

Serious Injuries: **Back Injury:** cervical spine injury; and lumbar injury of the back on 30.Oct.2007.

Family History: **Problems with anesthesia:** negative.

Cardiovascular: Hypertension - father, mother, and brother(s).

Respiratory: negative.

Musculoskeletal: Arthritis - father and mother.

Neurologic: negative.

Hematologic/Lymphatic: negative. Specifically, no bleeding, clotting, or bruising problems.

Social History: **Most recent occupation:** Maintenance.

Marital status: married.

Current tobacco usage:

- Cigarettes - Started smoking cigarettes in 1986. Currently smokes an average of 1/2 pack per day.

Current use of alcoholic beverages: Drinks beer, an average of 6 cans or bottles (1 six-pack) per week; started in 1989.

Second-hand smoke exposure: is exposed to second-hand smoke.

Hand dominance: right.

Home living situation and relationships: Lives with spouse and children.

Other comments: Dr. Hill - PCP; Dr. Sameer Lal - neck surgery.

Provider has reviewed PFSH/ROS information

OBJECTIVE

CONSTITUTION: Blood pressure: Left arm - sitting 163/105 mm Hg. **Radial Pulse:** 112 bpm. **Temperature:** 97.4 F (oral). Weight: 231.0 pounds.

General appearance: Well developed, well nourished and groomed. No apparent acute or chronic distress.

Ability to communicate: normal.

NEUROLOGIC:

Level of consciousness: awake and alert.

Level of orientation: normal to time, place, person and situation.

Judgment and insight: normal.

Mood and affect: normal and appropriate to the situation.

Language: intact for receptive and expressive functions.

Deep tendon reflexes: Knee reflex *bilaterally* 3+. Ankle reflex on the right normal (2+); *on the left* 3+.

Pathologic reflexes: Ankle clonus is absent.

Cerebellar function including coordination: Romberg with eyes closed fails to reveal any trunk ataxia. Tandem gait is normal.

Gait: Normal.

Station: Normal.

TESTS AND PROCEDURES

PERFORMED IN THE PAST

72146 MRI, spinal canal and contents, thoracic; without contrast material

Date: 12.Mar.2009; Location: GRPA

- 23.Mar.2009 T10-11 mild degenerative disc bulge with mild flattening of cord. At T11-12 central disc protrusion that rotates the cord to the left.

72146 MRI, spinal canal and contents, thoracic; without contrast material

Date: 19.Dec.2007

- 19.Feb.2008 Broad base degenerative disc bulge at T11-12 with minimal flattening of cord. T10-11 mild degenerative disc bulge with mild flattening of cord. Mild compression deformity at T11 on the left.

ASSESSMENT

CURRENT PROBLEMS

724.1 Pain, Thoracic

Status: unstable

PLAN

Medical Advice: Patient's questions were answered.

Consults and referrals: Referral request: Pain Management for evaluation and management.

Comments: CD wioth patient.

Impression: Mr. Leopard returns to review his thoracic spine MRI which shows some stenosis in the lower thoracic region. He has mildly increased reflexes but no other symptoms of myelopathy. He has back pain that has worsened since our last evaluation but I do not feel that this warrants surgery. His rating and restrictions remain the same and I recommend pain management.

Philip J. Hodge, M.D.

AllMeds

ICD CODE SUMMARY

724.1 Pain, Thoracic

CPT CODE SUMMARY

99214 Established Patient: Level 4

NON-BILLABLE CPT CODES

72146 MRI, spinal canal and contents, thoracic; without contrast material

72146 MRI, spinal canal and contents, thoracic; without contrast material



13:16 MAR 13, 2009 ID: GREENVILLE RADIOLOGY FAX NO: 2207457

#59508 PAGE: 1/2

H 247631193
3/23
3:40



**GREENVILLE
RADIOLOGY**

1210 W. Faris Rd.

Greenville, SC 29605

864-295-4410

STEPHEN GARDNER, MD
200 PATEWOOD DRIVE
BLDG B SUITE 260
GREENVILLE, SC 29615-

In reference to your recent referral of:

JOHN B LEOPARD
712 STILLWELL RD
GREENWOOD, SC 29646-
DOB: 09-17-70 *

GREENVILLE RADIOLOGY

MRI Spine Thoracic w/o Contrast

Date Of Service: 03-12-09

REPORT:

HISTORY: 38-year-old male approximately 18 months following back injury presents with mid back pain and reported muscle spasm.

MRI THORACIC SPINE 3/12/09

Sagittal and axial images were obtained using multiple pulse sequences. No prior studies are presently available for direct comparison.

Relatively subtle thoracic scoliosis is noted. Mild, chronic endplate compression is identified involving the superior and inferior aspect of the T5 vertebral body. Multiple Schmorl's nodes are identified throughout the mid and lower thoracic spine and mild, chronic anterior wedge deformity is identified at the T10, T11, and T12 levels. No marrow signal to suggest an acute osseous abnormality is noted. Multilevel disc degeneration is present with mild disc space narrowing.

At the T4-5 level, shallow central disc herniation is identified which subtly effaces the anterior aspect of the cervical cord. No central canal stenosis or cord compression is identified.

At the T6-7 level, a shallow central disc herniation is identified producing subtle flattening of the anterior surface of the cervical cord. No evidence of central canal stenosis, cord compression, or foraminal narrowing is identified.

At the T10-11 level, central disc herniation and spondylosis are present which produces central canal stenosis which mildly compresses the distal thoracic cord. No evidence of significant foraminal stenosis is noted.

At the T11-12 level, central and left posterolateral disc herniation and spondylosis are present which efface and rotate the distal thoracic cord. No foraminal stenosis is noted.

79A



**GREENVILLE
RADIOLOGY**

1210 W. Faris Rd. Greenville, SC 29605 864-295-4410

No intrinsic abnormality of the thoracic cord is noted. The visualized paravertebral soft tissues demonstrate no significant abnormality.

IMPRESSION:

1. **MINOR THORACIC SCOLIOSIS: CONSIDERING PATIENT AGE, FINDINGS ARE PRESENT WHICH STRONGLY SUGGEST THE PRESENCE OF SCHEUERMANN'S DISEASE. NO ACUTE OSSEOUS ABNORMALITY IS NOTED.**
2. **A COMBINATION OF DISC HERNIATION AND SPONDYLOSIS PRODUCES CENTRAL CANAL STENOSIS AT THE T10-11 LEVEL AND MILDLY COMPRESSES THE THORACIC CORD. SIMILAR CHANGES TO A SOMEWHAT LESSER DEGREE ARE PRESENT AT T11-12 AND THIS EFFACES AND ROTATES THE THORACIC CORD WITHOUT OBVIOUS COMPRESSION. NO INTRINSIC ABNORMALITY OF THE THORACIC CORD IS NOTED.**
3. **NO EVIDENCE OF FORAMINAL STENOSIS IS VISUALIZED WITHIN THE THORACIC SPINE.**

/tr

L. Chase Allen Jr MD

L CHASE ALLEN JR MD, MD

TRANSCRIBED: 03-13-2009 09:15:38 AM

Dictated by: L CHASE ALLEN JR MD 03-13-2009 09:15:38 AM

RELEASED BY: L CHASE ALLEN JR MD 03-13-2009 01:10:20 PM

LCA/TR

JOHN B. LEOPARD Patient ID: 247-63-1193
 DOB: 17.Sep.1970 (38) Male
 Visit Date: 09.Mar.2009

PRESENT ILLNESS INFORMATION

Chief Complaint: WC INJURY 10/30/07. Patient returns after phone call, last seen in office 5/12/08, NO NEW TESTING. Follow up on upper back pain. Patient states pain score today is a 7. Patient states pain is worse than at last visit. Medications reviewed with patient, appropriate updates made.

HPI:

SA: Follow-up on thoracic pain.

Location: upper back below the level of the shoulder blades in the midline. There was no referral of pain to other locations.

This has been a recurring problem.

Status of the pain since last visit: changed. **Severity:** somewhat more severe.

Previous associated manifestations:

- insomnia - unchanged.

New associated manifestations: none identified.

REVIEW OF SYSTEMS

Constitutional Symptoms: no details provided.

Gastrointestinal: heartburn or indigestion.

Musculoskeletal: back pain.

The following systems are negative: Cardiovascular, Eyes, Genital/Urinary, Hematological/Lymphatic, Immunologic, Integumentary, Nervous, Psychiatric, Respiratory.

PAST, FAMILY AND SOCIAL HISTORY

Current Meds: Aciphex (20 MG), daily, prescribed by Dr. Hill
 EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID for 30 days (quantity: 60), subs OK, refills: 2, prescribed on 17.Apr.2008 by Philip J. Hodge, M.D.
 Lexapro (20 MG), daily, prescribed by Dr. Hill
 Vytarin (uncertain of dosage), daily, prescribed by Dr. Hill

Med Allergies: Demerol: "makes skin crawl"
 Neosporin: "swell up"

Non-Med Allergies: No non-medication allergies.

Past Health History: **Childhood Diseases:** negative.
 Eyes: negative.
 Ears: negative.
 Cardiovascular: negative.
 Respiratory: negative.
 Gastrointestinal: reflux diagnosed in 1998.
 Neurologic: negative.
 Endocrine: negative.
 Hematologic and Lymphatic: negative.

Surgeries and Hops: **Problems with anesthesia:** none.
Previous surgery:
 • Abdominal and gastrointestinal: hernia repair in 2002.
 • Musculoskeletal: "right knee - 2005" spine surgery - "cervical fusion on 01/16/08 in Greenwood, SC".

Serious Injuries: **Previous non-surgical hospitalizations:** infection in left knee.
Back Injury: cervical spine injury; and lumbar injury of the back on 30.Oct.2007.

Family History: **Problems with anesthesia:** negative.
 Cardiovascular: Hypertension - father, mother, and brother(s).
 Respiratory: negative.
 Musculoskeletal: Arthritis - father and mother.
 Neurologic: negative.
 Hematologic/Lymphatic: negative. Specifically, no bleeding, clotting, or bruising problems.

Social History: **Most recent occupation:** Maintenance.
Marital status: married.
Current tobacco usage:
 • Cigarettes - Started smoking cigarettes in 1986. Currently smokes an average of 1/2 pack per day.
Current use of alcoholic beverages: Drinks beer, an average of 6 cans or bottles (1 six-pack) per

week; started in 1989.

Second-hand smoke exposure: is exposed to second-hand smoke.

Hand dominance: right.

Home living situation and relationships: Lives with spouse and children.

Other comments: Dr. Hill - PCP; Dr. Sameer Lal - neck surgery.

Provider has reviewed PFSH/ROS information

OBJECTIVE

CONSTITUTION: Blood pressure: Left arm - sitting 157/96 mm Hg. Radial Pulse: 94 bpm. Temperature: 98.7 F (oral). Weight: 221.8 pounds.

General appearance: Well developed, well nourished and groomed. No apparent acute or chronic distress.

Ability to communicate: normal.

RESPIRATORY: Respiratory Effort normal. Auscultation: normal breath sounds.

CARDIOVASCULAR:

Auscultation: normal S1, S2, no murmurs or abnormal sounds.

NEUROLOGIC:

Level of consciousness: awake and alert.

Level of orientation: normal to time, place, person and situation.

Judgment and insight: normal.

Mood and affect: normal and appropriate to the situation.

Language: intact for receptive and expressive functions.

Motor examination:

- Muscle strength - Upper extremities, intact and symmetrical. Lower extremities intact and symmetrical.

- Muscle size - is normal and symmetrical in upper extremities; is normal and symmetrical in lower extremities.

Sensory examination for light touch intact and symmetrical in the lower extremities.

Deep tendon reflexes: Knee reflexes normal (2+) bilaterally. Ankle reflexes normal (2+) bilaterally.

Gait: Normal.

Station: Normal.

Spine examination:

Spine palpation:

- Thoracic spine: *Tenderness* off midline only on the right *in the paraspinous muscles*.

TESTS AND PROCEDURES

PERFORMED IN THE PAST

72146 MRI, spinal canal and contents, thoracic; without contrast material

Date: 19.Dec.2007

- 19.Feb.2008 Broad base degenerative disc bulge at T11-12 with minimal flattening of cord. T10-11 mild degenerative disc bulge with mild flattening of cord. Mild compression deformity at T11 on the left.

ASSESSMENT

CURRENT PROBLEMS

724.1 Pain, Thoracic

Status: unstable

MEDICATIONS

CHANGED

Flexeril (Cyclobenzaprine HCl Tab 10 MG), 1 tid prn for muscle spasm (quantity: 45), subs OK, refills: 2 , prescribed on 09.Mar.2009 by Philip J. Hodge, M.D.

REFILLED

EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID for 30 days (quantity: 60), subs OK, refills: 2 , prescribed on 09.Mar.2009 by Philip J. Hodge, M.D.

PLAN

Medical Advice: Contact the office if there are any problems. Home exercise: Exercise sheet given to patient. Focus on core stabilization. Patient's questions were answered.

Schedule Follow-up: in 2 weeks.

Impression: Mr. Leopard has thoracic back pain with muscle spasm after a work related injury in 2007. There is no associated weakness or numbness in his legs. I will order a new thoracic, adjust his medications and start home exercise

program. I will see him back in 2 weeks.

TESTS AND PROCEDURES

SCHEDULES

72146 MRI, spinal canal and contents, thoracic; without contrast material

Scheduled: 12.Mar.2009; Location: GRPA

- Arrive@5:00. RTO 3-23-09@3:40.

Scheduled through One Call Medical

Philip J. Hodge, M.D.

AllMeds

ICD CODE SUMMARY

724.1 Pain, Thoracic

CPT CODE SUMMARY

99213 Established Patient: Level 3

NON-BILLABLE CPT CODES

72146 MRI, spinal canal and contents, thoracic; without contrast material

72146 MRI, spinal canal and contents, thoracic; without contrast material

JOHN B. LEOPARD Patient ID: 247-63-1193
 DOB: 17.Sep.1970 (37) Male
 Visit Date: 12.May.2008

PRESENT ILLNESS INFORMATION

Chief Complaint: W/C injury on 10-30-07. Follow up on low back and thoracic pain. Patient continues with only thoracic pain which is unchanged from last visit. Patient states pain score is 4. Medications reviewed, no changes made.

HPI:

SI: Follow-up on low back pain.

Location: lumbar region of the back in the midline.

This has been a recurring problem.

Status of the pain since last visit: no change in location, quality, severity or timing.

Previous associated manifestations:

- insomnia - much improved.

New associated manifestations: none identified.

Response to other treatments or surgery: Prescription medication: Naprosyn (effectiveness: good).

REVIEW OF SYSTEMS

Constitutional Symptoms: no details provided.

Gastrointestinal: heartburn or indigestion.

Musculoskeletal: back pain.

The following systems are negative: Cardiovascular, Eyes, Genital/Urinary, Hematologic/Lymphatic, Immunologic, Integumentary, Nervous, Psychiatric, Respiratory.

PAST, FAMILY AND SOCIAL HISTORY

Current Meds: Aciphex (20 MG), daily, prescribed by Dr. Hill
 EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID for 30 days (quantity: 60), subs OK, refills: 2, prescribed on 17.Apr.2008 by Philip J. Hodge, M.D.
 Lexapro (20 MG), daily, prescribed by Dr. Hill
 Vytarin (uncertain of dosage), daily, prescribed by Dr. Hill

Med Allergies: Demerol: "makes skin crawl"
 Neosporin: "swell up"

Non-Med Allergies: No non-medication allergies.

Past Health History: **Childhood Diseases:** negative.
 Eyes: negative.
 Ears: negative.
 Cardiovascular: negative.
 Respiratory: negative.
 Gastrointestinal: reflux diagnosed in 1998.
 Neurologic: negative.
 Endocrine: negative.
 Hematologic and Lymphatic: negative.

Surgeries and Hosp: **Problems with anesthesia:** none.
Previous surgery:
 • Abdominal and gastrointestinal: hernia repair in 2002.
 • Musculoskeletal: "right knee - 2005" spine surgery - "cervical fusion on 01/16/08 in Greenwood, SC".

Serious Injuries: **Previous non-surgical hospitalizations:** infection in left knee.
Back Injury: cervical spine injury; and lumbar injury of the back on 30.Oct.2007.

Family History: **Problems with anesthesia:** negative.
 Cardiovascular: Hypertension - father, mother, and brother(s).
 Respiratory: negative.
 Musculoskeletal: Arthritis - father and mother.
 Neurologic: negative.
 Hematologic/Lymphatic: negative. Specifically, no bleeding, clotting, or bruising problems.

Social History: **Most recent occupation:** Maintenance.
Marital status: married.
Current tobacco usage:
 • Cigarettes - Started smoking cigarettes in 1986. Currently smokes an average of 1/2 pack per day.
Current use of alcoholic beverages: Drinks beer, an average of 6 cans or bottles (1 six-pack) per

week; started in 1989.

Second-hand smoke exposure: is exposed to second-hand smoke.

Hand dominance: right.

Home living situation and relationships: Lives with spouse and children.

Other comments: Dr. Hill - PCP; Dr. Sameer Lal - neck surgery.

Provider has reviewed PFSH/ROS information

OBJECTIVE

CONSTITUTION: Blood pressure: Left arm - sitting 136/84 mm Hg. Radial Pulse: 88 bpm. Temperature: 98.7 F (oral). Weight: 221.0 pounds.

General appearance: Well developed, well nourished and groomed. No apparent acute or chronic distress.

Ability to communicate: normal.

NEUROLOGIC:

Level of consciousness: awake and alert.

Level of orientation: normal to time, place, person and situation.

Judgment and insight: normal.

Mood and affect: normal and appropriate to the situation.

Language: intact for receptive and expressive functions.

Gait: Normal.

Station: Normal.

TESTS AND PROCEDURES

PERFORMED IN THE PAST

72146 MRI, spinal canal and contents, thoracic; without contrast material

Date: 19.Dec.2007

- 19.Feb.2008 Broad base degenerative disc bulge at T11-12 with minimal flattening of cord. T10-11 mild degenerative disc bulge with mild flattening of cord. Mild compression deformity at T11 on the left.

ASSESSMENT

CURRENT PROBLEMS

724.1 Pain, Thoracic

Status: stable

PLAN

Medical Advice: Patient's questions were answered.

Work Status: return to regular duty. MMI has been reached. Disability rating: 3% to the whole person for thoracic back soft tissue injury according to AMA Guide to the Evaluation of Permanent Impairment Fifth Edition.

Impression: Mr. Leopard is some what better on Naprosyn for his thoracic back pain. I feel that his injury is likely a soft tissue injury and has met maximum improvement. I feel that he can return to work without restriction although he may need intermittent antiinflammatories and physical therapy to function optimally.

COMMUNICATIONS

Follow-up visit

Johnny A. Goforth, III, M.D.; J Benjamin Hill, M.D.

Follow-up visit

Johnny A. Goforth, III, M.D.; J Benjamin Hill, M.D.

Philip J. Hodge, M.D.

AllMeds

ICD CODE SUMMARY

724.1 Pain, Thoracic

CPT CODE SUMMARY

99213 Established Patient: Level 3

NON-BILLABLE CPT CODES

72146 MRI, spinal canal and contents, thoracic; without contrast material

JOHN B. LEOPARD Patient ID: 247-63-1193
 DOB: 17.Sep.1970 (37) Male
 Visit Date: 17.Apr.2008

PRESENT ILLNESS INFORMATION

Chief Complaint: WC Injury on 10/30/07. Follow up on low back and thoracic back. Patient states pain score today is a 1. Patient states pain is now only in the thoracic spine. Patient states Dr. Lal told him not to take Aleve because it would slow down healing process of healing of the metal rod in neck, but patient is out of Naproxen which seemed to help him so he wants to ask questions about that. Medications reviewed with patient, appropriate updates made, summary given to patient.

HPI:

SI: Follow-up on low back pain.

Location: lumbar region of the back in the midline.

This has been a recurring problem.

Status of the pain since last visit: changed.

- **Location now:** Pain is referred to the same location as previously.
- **Severity:** resolved.

Previous associated manifestations:

- insomnia - much improved.

New associated manifestations: none identified.

REVIEW OF SYSTEMS

Constitutional Symptoms: no details provided.

Gastrointestinal: heartburn or indigestion.

Musculoskeletal: back pain.

The following systems are negative: Cardiovascular, Eyes, Genital/Urinary, Hematological/Lymphatic, Immunologic, Integumentary, Nervous, Psychiatric, Respiratory.

PAST, FAMILY AND SOCIAL HISTORY

Current Meds: Aciphex (20 MG), daily, prescribed by Dr. Hill
 EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID for 30 days (quantity: 60), subs OK, refills: 2, prescribed on 19.Feb.2008 by Philip J. Hodge, M.D.
 Lexapro (20 MG), daily, prescribed by Dr. Hill
 Vytarin (uncertain of dosage), daily, prescribed by Dr. Hill

Med Allergies: Demerol: "makes skin crawl"
 Neosporin: "swell up"

Non-Med Allergies: No non-medication allergies.

Past Health History: **Childhood Diseases:** negative.
 Eyes: negative.
 Ears: negative.
 Cardiovascular: negative.
 Respiratory: negative.
 Gastrointestinal: reflux diagnosed in 1998.
 Neurologic: negative.
 Endocrine: negative.
 Hematologic and Lymphatic: negative.

Surgeries and Hosp: Problems with anesthesia: none.

Previous surgery:

- Abdominal and gastrointestinal: hernia repair in 2002.
- Musculoskeletal: "right knee - 2005" spine surgery - "cervical fusion on 01/16/08 in Greenwood, SC".

Previous non-surgical hospitalizations: infection in left knee.

Serious Injuries: Back Injury: cervical spine injury; and lumbar injury of the back on 30.Oct.2007.

Family History: Problems with anesthesia: negative.

Cardiovascular: Hypertension - father, mother, and brother(s).

Respiratory: negative.

Musculoskeletal: Arthritis - father and mother.

Neurologic: negative.

Hematologic/Lymphatic: negative. Specifically, no bleeding, clotting, or bruising problems.

Social History: Most recent occupation: Maintenance.

Marital status: married.

Current tobacco usage:

- Cigarettes - Started smoking cigarettes in 1986. Currently smokes an average of 1/2 pack per day.

Current use of alcoholic beverages: Drinks beer, an average of 6 cans or bottles (1 six-pack) per week; started in 1989.

Second-hand smoke exposure: is exposed to second-hand smoke.

Hand dominance: right.

Home living situation and relationships: Lives with spouse and children.

Other comments: Dr. Hill - PCP; Dr. Sameer Lal - neck surgery.

Provider has reviewed PFSH/ROS information

OBJECTIVE

CONSTITUTION: Blood pressure: Left arm - sitting 144/93 mm Hg. Radial Pulse: 70 bpm. Temperature: 98.4 F (oral). Weight: 221.0 pounds.

General appearance: Well developed, well nourished and groomed. No apparent acute or chronic distress.

Ability to communicate: normal.

MUSCULOSKELETAL:

Thoracic spine: Active ROM.

NEUROLOGIC:

Level of consciousness: awake and alert.

Level of orientation: normal to time, place, person and situation.

Judgment and insight: normal.

Mood and affect: normal and appropriate to the situation.

Language: intact for receptive and expressive functions.

Sensory examination for light touch intact and symmetrical in the upper extremities; intact and symmetrical in the trunk; intact and symmetrical in the lower extremities.

Gait: Normal.

Station: Normal.

TESTS AND PROCEDURES

PERFORMED IN THE PAST

72146 MRI, spinal canal and contents, thoracic; without contrast material

Date: 19.Dec.2007

- 19.Feb.2008 Broad base degenerative disc bulge at T11-12 with minimal flattening of cord. T10-11 mild degenerative disc bulge with mild flattening of cord. Mild compression deformity at T11 on the left.

ASSESSMENT

CURRENT PROBLEMS

724.1 Pain, Thoracic

Status: stable

MEDICATIONS

REFILLED

EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID for 30 days (quantity: 60), subs OK, refills: 2 , prescribed on 17.Apr.2008 by Philip J. Hodge, M.D.

PLAN

Medical Advice: Contact the office if there are any problems.

Work Status: return to regular duty.

Schedule Follow-up: in 3 to 4 weeks after returning to work.

Impression: Mr. Leopard is doing better with his thoracic back pain. He will return to work and I will see him back in 1 month.

Philip J. Hodge, M.D.

AllMeds

ICD CODE SUMMARY

724.1 Pain, Thoracic

CPT CODE SUMMARY

99213 Established Patient: Level 3

NON-BILLABLE CPT CODES

72146 MRI, spinal canal and contents, thoracic; without contrast material

JOHN B. LEOPARD Patient ID: 247-63-1193
 DOB: 17.Sep.1970 (37) Male
 Visit Date: 19.Feb.2008

PRESENT ILLNESS INFORMATION

Chief Complaint: WC injury: 10/30/07. Patient seen in neurosurgical consultation for low back pain. he describes pain at the level of the shoulder blades radiating to chest wall. Thoracic MRI done 12/19/07. Medications reviewed with patient, appropriate updates made, summary given to patient.

HPI:

SI: Evaluation of thoracic pain.

Location: in the interscapular region in the midline.

Quality: gnawing and sharp.

Severity: The usual pain level is 6 (scale of 1-10). Functional impairment is moderate - when present it interferes only with some daily activities.

Timing: This has been a problem since 10/30/07.

Referred or radiating symptoms: pain -

- pain of the same quality as the thoracic back pain extending into the chest wall retrosternally.

Setting in which it first occurred: following trauma.

- Mechanism of injury: a fall.
- Timing of injury: 10/30/07.
- Locale where the injury occurred: in the workplace. The injury was reported to Workers' Compensation.

Aggravating factors:

- low back movements.

Relieving factors: The patient states that nothing seems to relieve the pain, including lying down, sitting, standing, walking, application of cold or heat.

Associated manifestations:

- insomnia. It starts after the onset of the thoracic back pain.

Previous tests/evaluations:

- Thoracic spine MRI: Date - 12/19/07. Test location - Lakeland Ortho.

Previous treatment related to the thoracic back pain:

- Prescription medication: Flexeril (effectiveness: negative), Ultracet (effectiveness: fair), Darvocet-N 100 (effectiveness: fair), Lortab (effectiveness: negative).
- Physical therapy: Response - fluctuating (sometimes better, sometimes worse).

REVIEW OF SYSTEMS

Constitutional Symptoms: no details provided.

Gastrointestinal: heartburn or indigestion.

Musculoskeletal: back pain.

The following systems are negative: Cardiovascular, Eyes, Genital/Urinary, Hematological/Lymphatic, Immunologic, Integumentary, Nervous, Psychiatric, Respiratory.

PAST, FAMILY AND SOCIAL HISTORY

Current Meds: Aciphex (20 MG), daily, prescribed by Dr. Hill
 Lexapro (20 MG), daily, prescribed by Dr. Hill
 Vytarin (uncertain of dosage), daily, prescribed by Dr. Hill

Med Allergies: Demerol: "makes skin crawl"
 Neosporin: "swell up"

Non-Med Allergies: No non-medication allergies.

Past Health History: **Childhood Diseases:** negative.

Eyes: negative.

Ears: negative.

Cardiovascular: negative.

Respiratory: negative.

Gastrointestinal: reflux diagnosed in 1998.

Neurologic: negative.

Endocrine: negative.

Hematologic and Lymphatic: negative.

Surgeries and Hxops: **Problems with anesthesia:** none.

Previous surgery:

- Abdominal and gastrointestinal: hernia repair in 2002.
- Musculoskeletal: "right knee - 2005" spine surgery - "cervical fusion on 01/16/08 in Greenwood,

SC.

Serious Injuries: Previous non-surgical hospitalizations: infection in left knee.
Back Injury: cervical spine injury; and lumbar injury of the back on 30.Oct.2007.

Family History: Problems with anesthesia: negative.
Cardiovascular: Hypertension - father, mother, and brother(s).
Respiratory: negative.
Musculoskeletal: Arthritis - father and mother.
Neurologic: negative.
Hematologic/Lymphatic: negative. Specifically, no bleeding, clotting, or bruising problems.

Social History: Most recent occupation: Maintenance.
Marital status: married.
Current tobacco usage:
 • Cigarettes - Started smoking cigarettes in 1986. Currently smokes an average of 1/2 pack per day.
Current use of alcoholic beverages: Drinks beer, an average of 6 cans or bottles (1 six-pack) per week; started in 1989.
Second-hand smoke exposure: is exposed to second-hand smoke.
Hand dominance: right.
Home living situation and relationships: Lives with spouse and children.
Other comments: Dr. Hill - PCP; Dr. Sameer Lal - neck surgery.
Provider has reviewed PFSH/ROS information

OBJECTIVE

CONSTITUTION: Blood pressure: Left arm - sitting 141/91 mm Hg. Radial Pulse: 93 bpm. Temperature: 97.7 F (oral).
 Weight: 225.8 pounds.
 General appearance: Well developed, well nourished and groomed.
 Ability to communicate: normal.

RESPIRATORY: Normal breath sounds.

CARDIOVASCULAR:

Auscultation: normal S1, S2, no murmurs or abnormal sounds.

MUSCULOSKELETAL:

Thoracic spine: Active ROM.

NEUROLOGIC: The patient is awake and alert. Oriented x 4. The judgment and insight of the patient is normal. The patient's immediate, recent, and remote memory seem normal. The mood and affect of the patient seem normal and appropriate to the situation. Language is intact for receptive and expressive functions. The fund of knowledge is within normal limits for age and educational background. Capacity for sustained mental activity and abstract thinking is within normal limits.

Motor examination:

- Muscle strength - Shoulder girdle bilaterally, intact and symmetrical. Proximal upper extremities bilaterally, intact and symmetrical. Distal upper extremities and hand bilaterally, intact and symmetrical. Lower extremities intact and symmetrical.
- Muscle size - is normal and symmetrical in upper extremities; is normal and symmetrical in lower extremities.

Sensory examination for light touch intact and symmetrical in the upper extremities; intact and symmetrical in the trunk; intact and symmetrical in the lower extremities.

Deep tendon reflexes: Biceps reflexes normal (2+) bilaterally. Brachioradialis reflex normal (2+) bilaterally. Triceps reflexes normal (2+) bilaterally. Knee reflex *bilaterally* 3+. Ankle reflexes normal (2+) bilaterally.

Pathologic reflexes: Hoffmann's response is negative bilaterally. Ankle clonus is absent.

Nerve and spinal cord tension-compression signs:

Gait: Normal.

Station: Normal.

Spine examination: Thoracic spine: *tenderness* off midline only on the left present in the paraspinous muscles.

TESTS AND PROCEDURES

PERFORMED IN THE PAST

72146 MRI, spinal canal and contents, thoracic; without contrast material

Date: 19.Dec.2007

- 19.Feb.2008 Broad base degenerative disc bulge at T11-12 with minimal flattening of cord. T10-11 mild degenerative disc bulge with mild flattening of cord. Mild compression deformity at T11 on the left.

ASSESSMENT

CURRENT PROBLEMS

724.1 Pain, Thoracic

Status: unstable

MEDICATIONS

NEW

EC-Naprosyn (Naproxen Tab EC 500 MG), 1 TAB BID (quantity: 60), subs OK, refills: 2 , prescribed on 19.Feb.2008 by Philip J. Hodge, M.D.

PLAN

Medical Advice:

Restrictions:

Work Status: return to regular duty.

Schedule Follow-up: in 1 month.

Comments: Films with patient.

Impression: Mr. Leopard has thoracic back pain after a fall thru the attic in 10/30/07. His MRI shows degenerative changes of his thoracic spine without fracture or disc herniation. I think his injuries are muscular or ligamentous in nature and will improve with time. I recommend Naprosyn and return to work without restriction. I will see him back in 1 month to measure his progress.

Philip J. Hodge, M.D.

AllMeds

ICD CODE SUMMARY

724.1 Pain, Thoracic

CPT CODE SUMMARY

99203 New Patient: Level 3

NON-BILLABLE CPT CODES

72146 MRI, spinal canal and contents, thoracic; without contrast material



**Upstate Medical
Rehabilitation**

David L. Shallcross, MD
Robert E. LeBlond, MD
James Reilly Keffer, DO
Theresa R. Little, PA-C
David E. Goldsmith, PA-C
Joe McTavish, PA-C
April Smith, PA-C

111 Doctors Drive
Greenville, SC 29605
(864) 797-7100
(864) 797-7105 Fax

February 2, 2011

Helena Stovall
Benefits Specialist, Advanced Technology Services
8201 N. University
Peoria, IL 61615-1858

RE: John Leopard - 9117170

Dear Ms. Stovall:

Thank you for your request for information regarding John Leopard. Through this office he receives a prescription for 12 Lortab a month so that he can take one when he has done work. This medicine should not affect his ability to be in a factory. He receives Tramadol 50 mg, up to four per day. Most patients are quite capable of functioning well on this medicine, although the only way to know for sure is to ask the patient, and if he feels he can work safely on this medicine, then the odds are that he can. In addition, he receives Zanaflex 4 mg, up to three times a day. This medicine occasionally makes people sleepy, but in general is safe to use in a workplace.

The patient is no longer on Neurontin. He receives other medicines through Dr. Hill and Dr. Sida. I am not aware of what those medications are. However, based on the medicines he is receiving through this office: Lortab several times a month, Tramadol 50 mg up to four times a day, and Zanaflex up to three times day – it should be safe for this patient to return to the job. This is a very subjective issue and if the patient feels unsafe on the medicines he should not work on them. If he feels safe on them and can be observed to be functioning fairly well on them when he returns to work, he should be allowed to perform his normal tasks with these medicines. Again, I cannot make any statement about any medications being prescribed through other offices.

Sincerely,

David L. Shallcross, M.D.

DLS/cta/pdm
TR #020111 UMR

UPSTATE MEDICAL REHABILITATION, P.C.

111 Doctors Drive

Greenville, SC 29605

Telephone: (864) 797-7100 Fax: (864) 797-7105

Robert E. LeBlond, M.D.
BL 4575215

James Reilly Keffer, D.O.
BK 8877308

David L. Shallcross, M.D.
BS 1616931

Name

John Leeper

Date

1/27/11

Address

R

Permanent work & c50/6

Max lift 6/100 - to waist

60/6

Max 6' for handle 50/6

☐ Label

Refill - 0-1-2-3-4-PRN

Frequent stretching, climbing, balancing,
kneeling, stooping, crouching, crawling

01/28/11

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

UPSTATE MEDICAL REHABILITATION

111 Doctors Drive
Greenville, SC 29605
(864) 797-7100

David L. Shallcross, M.D. L. Ashley Mullinax, M.D. Robert E. LeBlond, M.D. Jyoti Math, MD

LEOPARD, JOHN BENJAMIN 869665

OUTPATIENT FOLLOWUP 01/27/11

CC: Back pain following work related injury.

HISTORY: Since last visit John has finished up physical therapy. He still has pain in his midback. He has completed a functional capacity evaluation showing him capable of lifting 60 lbs from floor to waist, 50 lbs from waist to shoulder and limited lifting from floor to shoulder of 50 lbs. He can carry 100 lbs 25 feet. He can constantly sit and walk. He can frequently stand, stair climb, ladder climb, do desk level reaching, overhead reaching (needs to limit this with heavy weights), floor level reaching, balance, kneeling, stooping, crouching and crawling. These are listed as his permanent restrictions. He is at maximum medical improvement and there is no increased impairment rating based on his recent aggravation of pain. The patient is using Lortab 10mg about 12 times a month and he uses Tramadol 50mg four to five times a day. He also uses Zanaflex as needed.

PE: On examination he has not been on any antiinflammatory medicines.

IMP: His current job would require him to lift up to 100 lbs and he doesn't think that they would let him back on the job using the medications he is.

A note from his fire house boss states that he has only been out on a couple of fire calls and that he has been primarily the safety officer. I do not believe that he could use the heavy equipment necessary to be a fire fighter at this point.

PLAN: Patient is released from my care at maximum medical improvement with above listed restrictions. Begin Relafen on a p.r.n. basis.

Dictated not read

David L. Shallcross, M.D.

DLS/dfh

TR #012711 UMR

UPSTATE MEDICAL REHABILITATION

111 Doctors Drive
Greenville, SC 29605
(864) 797-7100

David L. Shallcross, M.D. J. Reilly Keffer, DO Robert E. LeBlond, M.D. Jyoti Math, MD

LEOPARD, JOHN B

869665

OUTPATIENT FOLLOWUP 12/16/10

INTERVAL: One month

CC: Midback pain

HISTORY: Since last visit Mr. Leopard has continued to have pain in the midback and low back. The low back is typically not problematic unless the midback is flared up and in fact he does not think he would be seeing a physician for the low back at this point if it were not for his midback problems. He has been turned down for functional capacity evaluation. He continues to do only a few calls with the volunteer fire department. He feels as though he has difficulty wearing full gear. He has been told not to return to work because he is on medications that they think may interfere with his ability to work. He is currently on Zanaflex 4mg three to four times a day, Tramadol 50mg q.i.d. and Lortab one q.d. He also takes Lexapro. He is currently off his Neurontin.

PE: He is alert, fluent and pleasant. He has slightly exaggerated thoracic kyphosis. He is very tender on the lower thoracic spine midline. His lumbar region is essentially pain free.

PLAN: Patient needs functional capacity evaluation. He has an aggravation of his midthoracic pain and needs to have this brought to a conclusion. It sounds as though he has lost his other job because of the medications he is on, but at this point the medications are very minimal and really likely do not cause any impact on his job.


David L. Shallcross, M.D.
DLS/dfh
TR #121610 UMR

Upstate Medical Rehabilitation

Name (Print Clearly) John Leonard SS # 9/17/70 Date 11/23/10
 Medicine Allergies: Penicillin, Neomycin New Allergies _____

List Current Pain Medications:

How much/often do you take the Medication?

1. Loratab 10/500 QHS
2. Tramadol 57 day
3. Zenadol 4/day

Does this medication impair your judgment, coordination or your ability to drive?

- ☒ Yes ☒ No _____ if yes, please explain. at night after taking
- ☒ Have you started any new meds since last seen by your doctor at UMR? no List: _____
- ☒ When did you take your last dose of your medication? this AM
- ☒ Are you experiencing any side effects? (Please circle any that apply.)
- Stomach upset Diarrhea Constipation Itching Rash Change in appetite he thinks he can do.
- Jittery sleepy Difficulty Breathing Other: _____
- ☒ Do you consume any alcohol? no If so, what & how much? _____
- ☒ Rate the pain you had before you began treatment: 0 (no pain) to 10 (unbearable)
- | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|
- ☒ Rate your pain since you began treatment: 0 (no pain) to 10 (unbearable)
- | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|
- ☒ List any changes in your activity level over the last month. try to walk
- ☒ Are you working now? ☐ Yes ☒ No is this a change? ☐ Yes ☒ No
- ☒ Who is your family doctor? Dr. Barton MD
- ☒ When is your next appointment with your doctor HERE? next month

I have reviewed Upstate Medical Rehabilitation's narcotics agreement.

I understand it and continue to agree to honor the agreement. I understand that failure to do so may result in my discharge from this medical practice. Below I give a daytime phone number where I should be able to be reached.

Patient Signature _____

Date _____

Daytime Phone Number (Mobile if possible) _____

DO NOT WRITE BELOW THIS LINE

Provider Comments:

pt having difficulty sleeping - to use OTC Benhyd. cat
meds, refills given, pt @ MMT - w/ach for FCE
pt to & med to possible
 Medical Provider Signature: [Signature] Date: 11/23/10 Incident to: DRS

95

UPSTATE MEDICAL REHABILITATION

111 Doctors Drive
Greenville, SC 29605
(864) 797-7100

David L. Shallcross, M.D. J. Reilly Keffer, DO Robert E. LeBlond, M.D. Jyoti Math, MD

LEOPARD, JOHN BENJAMIN 869665

OUTPATIENT FOLLOWUP 10/22/10

INTERVAL: One month.

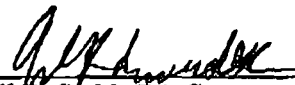
CC: back pain following work related injury.

HISTORY: Today Mr. Leopard reports that he is no longer seeing physical therapy. He states that he has not yet had an FCE. He states that he took the prescription given to him at his last visit to the physical therapy office but that Worker's Compensation had an affiliate that they would like for him to go see for this. He denies any change in the character or quality of his pain. He rates his pain as a 5/10. He denies any new numbness, weakness, bowel or bladder dysfunction though he does complain of some mild urinary retention with some "difficulty getting started". He is taking his Lortab 10 mg primary at h.s. He is allowed twelve of these per 30 days. He is utilizing Tramadol 50mg q.i.d. and Zanaflex 4mg t.i.d. He does complain of some sedation with the medications. He is currently smoking one pack of cigarettes and not attempting to decrease these. He denies alcohol use. He is currently not doing anything other than his at HEP for exercise.

PE: On examination this is an overweight Caucasian male in no acute distress. Alert and oriented x3. Mood and affect are appropriate. Gait is within normal limits. He is able to walk on toes and heels without difficulty. Thoracic and lumbar spine there is decreased lumbar flexion and extension. He is tender over the midthoracic region, midline and facets especially with facet loading.

IMP: This is a 40 y/o Caucasian male seen for management of his back pain following work related injury. He is stable on current medications. He has finished up physical therapy. He has not yet had his functional capacity evaluation. He is still out of work due to the sedation caused by his medications and states that he will not be allowed to return to work until he is no longer on the sedating medications. He shows me an email on his blackberry that is sent to him from somebody at work and gives me the number for an ATS safety manager, which is (309) 693-6311 for any questions to be answered.

PLAN: We will see him back for re-evaluation in one month and will hopefully have had his functional capacity evaluation by that time. I did speak with Ann today about this and she will call the provider on Monday. He is to continue current medications as prescribed and try to cut back on them as much as possible this month, utilizing TENS unit in place of Zanaflex and cutting back on the Tramadol as tolerated. He is instructed to increase his activity and to start at least a walking routine.


April D. Smith, PA-C

AS/dfh

TR# 102210 UMR

RECEIVED

10-5-10

UPSTATE MEDICAL REHABILITATION

111 Doctors Drive
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(864) 797-7100

David L. Shallcross, M.D. J. Reilly Keffer, DO Robert E. LeBlond, M.D. Jyoti Math, MD

LEOPARD, JOHN BENJAMIN 869665 OUTPATIENT FOLLOWUP 09/21/10

INTERVAL: Four months

CC: Back pain following work related injury.

HISTORY: Since last visit John has had a couple of episodes where pain shot through his back forcing him to feel weak at the knees. He has seen Dr. Sida a neurologist in the local area. He has been placed on Valium and he also temporarily put him on some Avinza. While on these medicines he was evaluated at work and they told him that Valium, Lortab, Zanaflex and Lexapro are medicines that may interfere with work performance and they do not want him to return to work unless he is off these medicines. Currently he takes Zanaflex t.i.d., Tramadol about q.i.d. He is on Neurontin 300mg t.i.d. He is not sure if that makes him sleepy. He does think the Lortab makes him sleepy. He has been placed in physical therapy. Traction was of no help. He is doing some exercises, TENS unit and some stretches. He has only been in therapy for about two weeks. He has been taken out of work. He is concerned about losing his job. He is having some straining of stool, which causes pain and he has some hesitancy of urination.

PE: On examination he is alert, fluent and pleasant. He is slightly overweight, but well muscled. Gait is stable including toe walking, heel walking and tandem walking. His shoulder ROM is normal. His lumbar ROM is well preserved. He has tenderness in the midline lower thoracic region where he has a slight increase in thoracic kyphosis. His lower extremity musculature is intact. He has extremely brisk reflexes at the knees, slightly less so at the patellar tendon.

IMP: Clinically I cannot see any true worsening in his patient's condition, but he is complaining of increase pain and I think at this point he is having an attorney help him decide on disability and out of work issues.

PLAN: I will keep him out of work while he goes through therapy for the next month. He will have a functional capacity evaluation at the end and if it doesn't look safe for him to return to the job then we will have to say so. Follow up in one month.

dictated not read

David L. Shallcross, M.D.

DLS/dfh

TR #092110 UMR



Received
Companion P&C Claims
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Medicare
58-223052

David L. Shallcross, M.D. James R. Keffer, D.O. Robert E. LeBlond, M.D.

LEOPARD, JOHN

869665

OUTPATIENT FOLLOWUP

07/26/10

INTERVAL: Two months.

CC: Mid-back pain, thoracic compression fracture and herniated disc.

HISTORY: Today, Mr. Leopard rates his pain as an 8.5/10. He reports that today he bent over and pain shot through his back and down his leg into his foot. He denies any new weakness or bowel or bladder dysfunction. He reports some numbness in the toes on the right foot described as intermittent especially when driving. He is unable to tell the difference in his pain level with Pennsaid. He is currently taking Tramadol 50 mg 5-6 daily, Zanaflex 4 mg 5-6 daily, Lortab 10/500 which lasted approximately two weeks. He does report some sedation with Lortab which impairs his ability to take this at work. He reports that he had left early several days from work, as he works maintenance and this does aggravate his pain. He is asking about obtaining FMLA as he is almost out of vacation time. He is currently smoking one pack per day and is trying to cut back on his smoking. He states that he does this by trying to put a candy in his mouth instead of smoking a cigarette. He denies any alcohol use. He denies any exercise.

PE: This is a Caucasian male in no acute distress. Alert and oriented x3. Mood and affect are appropriate. His gait is in normal limits. He is able to walk on his toes and heels without difficulty. The lumbar spine exhibits decreased flexion due to thoracic pain as well as pain with lateral bending. The thoracic spine is tender from the mid-thoracic down especially in the right musculature.

IMP: This is a 39-year-old, Caucasian male seen for management of his mid-back pain, thoracic compression fracture and herniated disc. Most recent MRI performed in May of 2010, did show this protrusion at T10-11 and T11-12 contributing to some relative central canal stenosis without cord compression as well as minimal disc bulging or protrusion of the midline at T4-5. The patient has failed injections per his report.

PLAN: The patient will F/U in two months for re-evaluation. We will add Neurontin 300 mg 3 times daily to see if this improves his pain. We may consider thoracic epidural steroid injection in the future if his symptoms become less wide-spread. The patient may submit FLMA paperwork and this will be discussed with Dr. Shallcross at that time.

April D. Smith, PA-C for
AS/cld

TR# 07/26/10 UMR

Robert E. LeBlond, M.D.
REL/cld

UPSTATE MEDICAL REHABILITATION

111 Doctors Drive
Greenville, SC 29605
(864) 797-7100

David L. Shallcross, M.D.

J. Reilly Keffer, DO

Robert E. LeBlond, M.D.

LEOPARD, JOHN

869665

OUTPATIENT FOLLOWUP 05/27/10

INTERVAL: One month.

CC: Mid back pain, thoracic compression fracture and herniated disk.

HISTORY: Since last visit, Mr. Leopard has had MRI scan of the thoracic spine. He has disk protrusions at T10/11 and T11/12 with no cord compression appreciated. He has some Schmorl's nodes involving the endplates. He had an episode of worsening pain and during which he could not work. He went to the emergency room and got some pain medications including Ativan and Lortab, and these made it impossible for him to stay on the job. Tramadol over the past few days has been beneficial. He is back at work. His Worker's Comp case has settled, and he gets lifetime care for it. He is worried about staying on a job.

PE: On examination, he is alert, fluent and pleasant. Gait is stable. Thoracic kyphosis remains the same. He has tenderness in the back.

IMP/PLAN: We have discussed various treatment options. I recommend he be given Pennsaid to the back about four times a day, and he will be given a dozen Lortab a month to supplement his other medications for pain. Follow up in two months.


David L. Shallcross, M.D.
DLS/lcb T: 06/01/10
TR# 052710 MTS

MEDICAL RECORD SCANNED

DATE: 6/3/10
INITIAL: ar

UPSTATE MEDICAL REHABILITATION

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David L. Shallcross, M.D.

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Robert E. LeBlond, M.D.

LEOPARD, JOHN

869665

OUTPATIENT FOLLOWUP 04/16/10

INTERVAL: Four months.

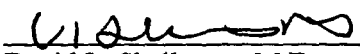
CC: Mid back pain with thoracic compression fracture and herniated disk.

HISTORY: Since last visit, Mr. Leopard continues to work at his regular job in maintenance. He has to get under machines and pull on pipes which cause a lot of pain. His job with the fire department is going well, but he does not do any heavy work and does not go into burning buildings. The Lidoderm patch has caused some breakout on his skin. Naprosyn has not been of much help. He is hoping to go to school, complete a bachelor's degree in worker's safety in the plant. He has developed some pain in the posterior right lower extremity which is a burning sensation which comes on on a daily basis one to two hours at a time, especially when the back hurts bad.

PE: On examination, he is alert, fluent and pleasant. He has normal thoracic contour. His lower extremity sensation is intact. He has quite brisk reflexes at patellar tendon, normal reflexes at the Achilles tendon. He has no clonus.

▸ **IMP:** Mechanical back pain but no evidence of true radiculopathy or myelopathy following thoracic compression fracture and herniated disk. The patient does need to be watched carefully because of risk of spinal cord injury.

PLAN: We will switch him back to the tramadol 50 mg four times a day. Continue Zanaflex. Follow up in two months.


David L. Shallcross, M.D.

DLS/lcb T: 04/20/10

TR# 041610 MTS

100

UPSTATE MEDICAL REHABILITATION

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David L. Shallcross, M.D.

J. Reilly Keffer, DO

Robert E. LeBlond, M.D.

LEOPARD, JOHN

869665

OUTPATIENT FOLLOWUP 10/08/09

INTERVAL: One month.

CC: Mid back pain.

HISTORY: John got a slight improvement from his last facet joint injections, but it only lasted for a couple of days. He is doing well using Zanaflex occasionally, Naprosyn occasionally and tramadol in the evening. He does not use this at work. He continues to volunteer as a firefighter. He can put on a 50 pound piece of equipment and work in the fires if necessary but, in general, he tries to avoid this and does most of the work on the outside. Review of his chart shows that he suffered a mild compression fracture at T12 as well as evidence of a bulging disk which flattened but did not displace or damage the spinal cord. He has been through all reasonable treatments and is not a surgical candidate. He shows no myelopathy. Pain is localized, mechanical and limited to the thoracic level.

IMP/PLAN: The patient is at maximum medical improvement. He may perform tasks of a volunteer fire department without restriction although, because of the pain, he may wish to avoid this. He has sustained a 25% spine impairment (25% whole person impairment). He is released from my care except for medication management and will follow up again in three to four months for medications. He will continue to use a TENS unit.


David L. Shallcross, M.D.

DLS/lcb T: 10/12/09

TR# 100809 MTS

Upstate Medical Rehabilitation

1003 Grove Road, Suite E
Greenville, South Carolina 29605
(864) 232-8417

David L. Shallcross, MD

Robert E. LeBlond, MD

PROCEDURE NOTE

Patient: John Leonard SSN: _____

Date: 9-1-09

Procedure: Facet Nerve/ Facet Joint Block

Indication(s): Spondylosis

Procedure: Risks and benefits of the procedure were explained to the patient and all questions regarding the same were answered. The patient gave written and verbal consent, and the decision was made to proceed.

The patient was placed in the prone position on the procedure table and was prepped and draped in the usual sterile fashion using Betadine which was allowed to dry. Using fluoroscopic guidance, I located the lumbosacral facet joints noting the greatest opening. The tissues overlying the identified facet joint(s) were anesthetized using 5 cc of 1% Lidocaine without epinephrine. After several minutes a 25 gauge needle was inserted and, using fluoroscopy, guided into the lumbosacral facet joint noting ligamentous feeling prior to entering the joint. Aspiration was negative. I placed 20 mg Depo Medrol and 1 cc of 1% Lidocaine without epinephrine. The needle was removed and pressure was applied for several minutes. The patient was cleansed, bandaged, and transported to recovery.

Complications: Ø

Patient tolerated procedure well.

Follow-up: The patient is to follow-up in two to three weeks, sooner if needed.

Discharge instructions, including review of possible signs and symptoms of infection, were given according to office procedure. Continue current meds.

[Signature]
Physician Signature

Upstate Medical Rehabilitation
1003 Grove Road, Suite C, Greenville, South Carolina 29605
Phone: (864) 232-8417 Fax: (864) 232-1511

After-Procedure Care

Patient Name: _____

It is normal to have some soreness at the site of the injection for several days after the procedure.

You may use ice over the area of injection as needed, but be sure to wrap the ice in a towel or washcloth. It should be applied for no more than twenty minutes and then removed. This can be repeated every hour if needed.

You may take your pain medications (and all other medications) afterwards, and you may resume a normal diet immediately after your procedure.

You may resume driving 3 to 4 hours after your procedure as long as you are not experiencing any problems.

We ask that you avoid any strenuous activity for 24 hours after the procedure.

Please call our office during business hours at (864) 232-8417 if you have problems, including signs/symptoms of infection such as fever, chills, redness or drainage at the site of the injection or an increase in pain.

Should you need to contact our office after hours you may reach our answering service by calling (864) 455-9330. The provider on call will contact you.

Your follow up appointment is scheduled with _____

Date: _____ Time: _____

Patient or Authorized Representative Signature: W. Dalton, CMS

Upstate Medical Rehabilitation Representative: * [Signature]

Date: 9-1-09

Revised 06.12.08

Upstate Medical Rehabilitation
1003 Grove Road, Suite E
Greenville, SC 29605-4626
Phone: (864) 232-8417 Fax: (864) 232-1511

Pre-Procedure History and Physical

Date: 7-1-09 Patient Name: John Leopard DOB: 9-17-70

Scheduled Procedure: Facet

Referring Physician: _____

Please list any Medication allergies: General Anesthetics

Are you allergic to Seafood? Yes _____ No X Iodine? Yes _____ No X

Please list your current medications:

Same

Are you receiving satisfactory pain relief from your pain medication? Yes (circled) No

Are you having any side effects from your pain medication? Yes (circled) No
If yes, please explain. _____

Are you taking any Blood Thinners? Aspirin Plavix Heparin Coumadin Anti-Inflammatory medications? (circled)
If yes, please list. _____

Do you have any of the following medical conditions? Please circle any that apply.

Diabetes Mellitus (circled) what was your AM Blood Sugar? _____

Heart Disease (circled) Respiratory Disease (circled)
(Specify) (Specify)

Are you pregnant: Yes _____ No X Are you currently ill? Yes _____ No X

Are you currently taking an Antibiotic? Yes (circled) No Describe: _____

Any changes in your medical condition? Please explain (circled)

Upstate Medical Rehabilitation
1003 Grove Road, Suite E
Greenville, SC 29605-4626

Upstate Medical Rehabilitation
1910 Commonwealth Lane
Anderson, SC 29621

David L. Shallcross, MD
Robert E. LeBlond, MD
James Reilly Keffer, DO
David E. Goldsmith, PA-C
Theresa R. Little, PA-C

CONSENT TO PROCEDURE UNDER FLUOROSCOPY

Are you Allergic to Dye? Yes _____ No X

Patient Name: John Leonard

S/S #: _____ DOB: 9-17-76 Account # 35643

The above-mentioned patient is scheduled for facet
to be performed under fluoroscopy, a specialized X-Ray technique to aid in pain relief.

There is no guarantee for successful pain relief as a result of having this procedure. In addition, there are inherent risks, up to and including death, involved with all medical procedures. Other possible risks for this procedure also include allergic reaction and anaphylaxis to the medications infection, bleeding, dural puncture/spinal tap and associated severe headaches, paralysis, dizziness, nausea and vomiting, transient hypotension and brief numbness and weakness in the legs, as well as a temporary increase in back or leg pain. There can also be reactions to the steroids and anesthetics used such as confusion, nystagmus, ringing in the ears, muscle twitching, insomnia, and mood swings. If you have any questions about any of these or other possible risks, you should discuss them with your physician prior to the procedure.

My signature below certifies that I fully understand the above consent to a procedure under Fluoroscopy and understand the benefits and risks.

Date: 9-1-09 Time: _____

Patient: [Signature]

Patient Representative: _____

Physician: _____

Witness/ UMR Employee: A. Dutton, CMA

Revised 06.12.08

UPSTATE MEDICAL REHABILITATION

1003 Grove Road, Suite E
Greenville, SC 29605
(864) 232-8417

David L. Shallcross, M.D.

J. Reilly Keffer, DO

Robert E. LeBlond, M.D.

LEOPARD, JOHN/WC

35643

OUTPATIENT FOLLOWUP 08/28/09

INTERVAL: One month.

CC: Persistent thoracic pain S/P work related injury.

HISTORY: Mr. Leopard received trigger point injections from Dr. Keffer on last visit. These did help with some muscular pain. They did not help with the deeper, dull, aching pain. He still is working full-time without formal restrictions although he does avoid putting on a heavy oxygen pack and avoids going into burning houses. He continues on Naprosyn 500 myofascial once or twice a day, tramadol 50 mg up to four a day and Zanaflex 4 mg three a day.

PE: On examination he is alert, fluent and pleasant. He is quite well muscled. His posture is good. He is tender in the lower thoracic paraspinals and over the facet joints of the thoracic spine.

PLAN: The patient will be brought back for thoracic facet injections on next visit. There are no other treatment options available. The patient does understand the risk of pneumothorax associated with injections.


David L. Shallcross, M.D.

DLS/mbm T: 09/01/09

TR# 082809 MTS

UPSTATE MEDICAL REHABILITATION

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LEOPARD, JOHN/WC

35643

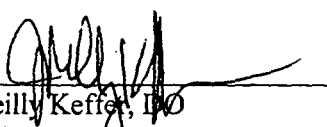
PROCEDURE NOTE

07/30/09

DIAGNOSIS: Persistent thoracic back pain with trigger points right lower thoracic paraspinals.

PROCEDURE: Informed consent was obtained. Trigger points were identified in the right lower thoracic paraspinal musculature at approximately T10/T11/T12. Trigger points were marked with a pen at T11 and T12 on the right. Skin was prepped with Betadine. Injectate included 1 cc of Depo-Medrol 80 mg combined with 4 cc of 1% lidocaine. The injectate was distributed equally among four injection sites with four different trigger points. The patient tolerated the procedure well. Fluoroscopy did help identify the level and ensure safe needle placement. The Betadine was cleansed off with alcohol. Two band aids were applied.

PLAN: The patient was refilled on his medications. We will see him back in follow up in the next few weeks for further evaluation and treatment recommendations.


J. Reilly Keffer, DO
JRK/mat T: 08/03/09
TR# 073009 MTS

UPSTATE MEDICAL REHABILITATION

1003 Grove Road, Suite E
Greenville, SC 29605
(864) 232-8417

David L. Shallcross, M.D.

J. Reilly Keffer, DO

Robert E. LeBlond, M.D.

LEOPARD, JOHN/WC

35643

OUTPATIENT FOLLOWUP 07/06/09

INTERVAL: One month.

BRIEF HISTORY: Mr. Leopard returns for a follow up of thoracic muscular sprain, superimposed on thoracic herniated disks, and probable mild compression fracture. Mr. Leopard has been going to physical therapy in Greenwood. He has been going three times a week for the last three weeks. He states that this has helped some with his range of motion, but his back pain is about the same. He did notice some improvement to the point where he could use his hunting bow this past weekend. He had a lot of pain afterwards, but he was able to perform the movements. He states that at this point the pain is extending from the midback into the right shoulder area and around the ribcage and he has noticed some periodic episodes of numbness down the right arm. He denies any weakness. He states that the therapists have been working quite diligently with him and do anticipate further benefit as he continues to attend his therapy sessions. He also has a TENS unit which gives him some relief, but discomfort at this point. The patient reports that he has been using tramadol and Zanaflex together and he states the combination makes him quite sleepy. He is not able to take this combination while at work. The Naproxen has been helpful. He uses this regularly. He does not get any GI upset from it and he continues on medication for acid reflux. Mr. Leopard reports that if he takes a tramadol alone he does not get quite as much sedation. The Zanaflex does make him quite sleepy.

PE: On physical examination today the patient is alert and oriented. He does well with transitional movements. His gait is steady. He has good posture. He has a lot of tenderness in the right thoracic facet region into the paraspinal musculature with some radiation up into the shoulder girdle and through the intercostal muscles on the right side. He has no visible edema and no muscle atrophy.

PLAN: Mr. Leopard may benefit from use of some Lidoderm patches over the sore spot in the thoracic area. He reports injection was mentioned at previous visit and at this point he is interested in scheduling a Cortisone injection into the sore area of the thoracic. He is most likely to benefit from a thoracic facet injection and will be scheduled with Dr. Shallcross in the next few weeks. He will attempt to use the tramadol separately from the Zanaflex and hope that he will get less sedation as he continues to do this. He can continue to work full duty. Prescription for Lidoderm patches is written and he will continue to work with the physical therapist. Follow up one month after injection.



Theresa Little, PA-C

TL/tsg T: 07/08/09

IR# 070609 MTS



David L. Shallcross, M.D.

DLS/tsg

UPSTATE MEDICAL REHABILITATION

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(864) 232-8417

David L. Shallcross, M.D.

J. Reilly Keffer, DO

Robert E. LeBlond, M.D.

LEOPARD, JOHN/WC

35643

OUTPATIENT EVALUATION

06/04/09

HPI: Mr. Leopard is a 38 y/o male being seen for evaluation of rehabilitation needs. He is a previously healthy individual who was injured in his capacity as a volunteer firefighter. He was entering a building from the top floor when he fell approximately six to eight feet landing on his hands twisting and falling backwards on 10/31/07. He hurt his mid back. He had an MRI scan showing bulging disks at several levels which did contact and at T11 actually flatten the spinal cord. He also developed a slight compression fracture at T11. He developed immediate pain between the shoulder blades. He started physical therapy but the physical therapy hurt and he had to discontinue. He has been on Naprosyn since that time which is of a little bit of benefit. Flexeril makes him sleepy. He continues to work as a volunteer firefighter. He can wear his gear but he cannot do the entries under stressful conditions. The patient had a prior herniated disk known at the cervical level. He had been awaiting surgery at the time of his back injury. He went ahead and had a cervical decompression and fusion by Dr. Lowe in Greenwood on 1/16/08. He did quite well with this and the neck is currently okay. He was out of work for about 12 weeks. His hands, neck, and arms are currently doing well and he has been back on his regular job since April of 2008. He works in maintenance at ATS which requires him to do plant maintenance on very large machines. He is doing his work without restrictions. He has no pain in the low back. He has no pain, numbness, or tingling in the legs. Gait is functional. He has no numbness. He walks without difficulty. He is bowel and bladder intact. He did find that a TENS unit was beneficial and heat also helps. The patient continues to volunteer as a firefighter and work his full time job and he also does yard work at home. He is in schooling now learning fire science.

PMH: As above, cervical herniated disk, S/P knee arthroscopy which did quite well, S/P left inguinal herniorrhaphy surgery which did quite well, depression which is stable, gastroesophageal reflux disease stable, and hypercholesterolemia.

ALLERGIES: Neosporin and Demerol.

MEDICATIONS: Naprosyn EC 500 mg once a day, Lexapro 20 mg per day, omeprazole 20 mg per day, Simcor 500/20 once a day, Flexeril 10 mg twice a day. He takes no over the counter medicines.

SH: The patient is married and has six children. He smokes less than a pack of cigarettes a day. He drinks about 12 beers a month. He has a high school education and one year of college. He has been working in maintenance for 18 years.

FH: Positive for hypercholesterolemia.

ROS: As above. One of his major problems is difficulty sleeping because of the back pain which is burning and at times sharp and other times dull.

PE: On examination the patient is alert, fluent, oriented and pleasant. He is a well developed, well muscled Caucasian man who appears his stated age in no acute distress. Posture and stature are normal. Gait is normal including toe walking, heel walking, and tandem walking. He can achieve a full squat and rise again without difficulty. He has full lumbar range of motion with no tenderness in the lumbar region. His cervical range of motion is normal. Shoulder range of motion is normal. Upper extremity range of motion, strength, sensation and DTRs are intact.

TR# 0603&060409 MAT

109

He has normal inspiratory excursion. Hair, nail and skin patterns are normal. He is very tender over the midline thoracic spine from the T5 to the T11 level. He is also tender in the right thoracic paraspinals with their insertion from T5 to T11. He has normal thoracic curvature. His lower extremity musculature is well developed with no atrophy or fasciculation. Sensation is intact. DTRs at the patellar tendon are quite brisk but not pathological. Achilles tendon reflex is normal. He has no pathologic reflexes. He has no spasticity or clonus.

IMP: The patient has muscular thoracic sprain superimposed on thoracic herniated disks and probable mild compression fracture. Treatment options are limited.

PLAN: Physical therapy would be recommended but I understand that timing and location are quite difficult since he lives in McCormick. He can continue working full duty. I recommend tramadol up to 50 mg four times a day. This may be a better option than the Naprosyn since he has some GI disturbance and he can begin Zanaflex 4 mg at night and possibly use this during the day if necessary. I recommend a TENS unit evaluation. Follow up in one month.

I authorize all follow-up care for this patient to be provided as "incident to the physician service".



David L. Shallcross, M.D.

DLS/mat T: 06/08/09

TR# 0603&060409 MAT



Neurology

105 VINE CREST CT. SUITE 1000 ♦ GREENWOOD, SC 29646 ♦ PH: 864-227-5240 ♦ FAX: 864-227-5239

WAYNE B. SIDA, M.D.

BRET J. WARNER, M.D.

PROGRESS NOTE

PATIENT: John Leopard

October 15, 2010

SS: 247-63-1193

REFERRED BY: Benjy Hill, MD

SUBJECTIVE:

John has been going to physical therapy. Pain varies. He has tried multiple modalities including physical therapy, TENS unit, lidoderm patches, and oral pain medications. Lidoderm patch caused a skin rash. He is seeing pain management in Greenville. He has been scheduled for a functional capacity evaluation. His employer is concerned about taking pain medications and working. I told him that this would have to be a defer to Dr. Shallcross with pain management and the results of his functional capacity evaluation. However, if he is on a stable dosage of pain medication without side effects, this should be no reason to restrict him. Clearly, if adjustments to his medication are made, he may need to be given a period of time to see if he develops any particular side effects. However, I do understand his employers concerns. His SSEP studies were stable with no evidence of cord conduction delay. We did discuss the findings on neuroimaging and both agreed not to pursue neurosurgical interventions at this point. I told him to call me if anything changes with his neurological symptoms. We talked about the future prognosis as well including the possibility of relapses.

OBJECTIVE:

Vital signs are stable and documented in the chart. Patient is alert and oriented. Language is normal. Eye movements are full. Pupils are equal. Face is symmetrical. There is no drift. No extinction. Visual fields are full to confrontation. Reflexes are symmetrical. There is no ataxia. Gait is normal. Slightly more brisk at the knees. 2 - right ankle and 2 + left ankle.

IMPRESSION:

T10-11 broad-based disk bulge with employs hypertrophy and ventral impression upon the distal cord. Posterior element hypertrophy contributes to produce moderate spinal canal stenosis. T11-12 broad-based disk bulge and employed hypertrophy with focal herniation to the left of midline producing anterolateral impression upon the distal cord without cord signal change. Previous anterior cervical discectomy and fusion at C6-7. Small T4-5 central disk protrusion with ventral impression upon the thecal sac and cord.

PLAN:

I did offer him neurosurgical assessment but he is not interested at this point. See comments above. Send me a copy of the functional capacity evaluation. Follow-up shortly.

///

PATIENT: John Leopard
PAGE 2

October 15, 2010

Wayne Sida MD

Wayne Sida, MD
Piedmont Health Group - Neurology

WBS/ 10/15/2010



Neurodiagnostics

EEG/EMG/SSEP/Autonomic Testing

105 VINE CREST CT., SUITE 1000 ♦ GREENWOOD, SC 29646 ♦ PHONE: 864-227-5240 ♦ FAX: 864-227-5239

WAYNE SIDA, M.D.

MEDICAL DIRECTORS

BRET WARNER, M.D.

Test Date: 9/9/2010

Patient:	John Leopard	DOB:	9/17/1970	Physician:	Wayne B. Sida, M.D.
Sex:	Male	Height:	cm	Ref Phys:	
ID#:	235030	Weight:	lbs.	Technician:	J Szortyka

Patient Chief Complaint, History, Exam:

39 year old male with T10-11 broad based disc bulge with ventral impression on the cord. T11-12 broad-based disc bulge endplate hypertrophy with focal herniation to the left midline producing anterolateral compression of the distal cord without cord signal change.

Introduction:

This is a posterior tibial nerve somatosensory evoked potential performed for the evaluation of cervical myelopathy. Unilateral limb stimulation was used. Patient cooperation was good. Sedation was used. Stimulus rate was 5.3 Hz. Craniospinal deformities were not noted.

Summary of Findings:

The obligate waveforms are present with normal latencies. The interpeak latencies are normal bilaterally.

Impression:

1. This is a normal bilateral tibial SSEP study.

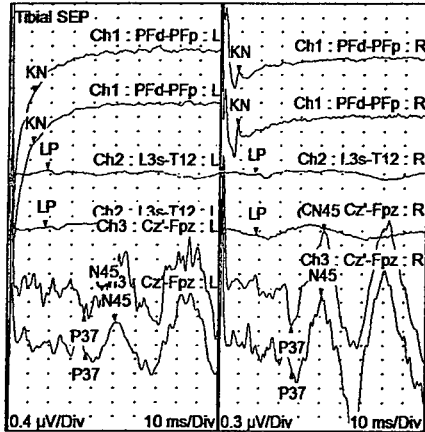
Electronically Signed By Wayne B. Sida, M.D. on October 2, 2010 at 1:11:43 PM

Wayne B. Sida, M.D.

Tibial SEP

Trial	P37 (ms)	LP (ms)	KN (ms)	P37-LP (ms)	LP-KN (ms)	P37-N45 (μV)
Norm	<41.7	<22.1		<20.5		
Trial1 - R	36.1	18.0	8.9	18.1	9.1	1.98
Trial2 - R	36.6	18.3	8.9	18.3	9.4	1.58
Trial3 - L	36.3	18.6	12.0	17.7	6.6	0.60
Trial4 - L	37.2	18.0	12.0	19.2	6.0	0.88

Waveforms:





Neurology

105 VINE CREST CT. SUITE 1000 ♦ GREENWOOD, SC 29646 ♦ PH: 864-227-5240 ♦ FAX: 864-227-5239

WAYNE B. SIDA, M.D.

BRET J. WARNER, M.D.

EMG NOTE

PATIENT: John Leopard

August 23, 2010

SS: 247631193

REFERRED BY:

NOTE:

John comes in for an EMG today. His pain level has diminished significantly and is near baseline. He remains ambulatory. Status post previous C6-7 ACDF. No evidence of upper cervicothoracic cord compression. However, T10-11 broad-based disk bulge with ventral impression upon the distal cord. T11-12 broad-based disk bulge and endplate hypertrophy with focal herniation to left midline producing anterolateral impression of the distal cord without cord signal change. SSEP studies are pending. I am going to send him to physical therapy. He continues to see Dr. Shallcross at pain medicine. As long as his pain remains under reasonable control, will continue conservative management. He does report some episodic tingling paresthesias in his toes on the right. Most of his problem seems to be at the level where his previous compression fractures located. However, no fragmentation or intrusion upon the canal by bone fragments or subluxation. Most of his distal cord/spinal canal abnormalities are related to disk disease.

Wayne Sida, MD

Piedmont Health Group - Neurology

WBS/ 08/23/2010



PIEDMONT HEALTH GROUP, L.L.C.

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Neurodiagnostics

EEG/EMG/SSEP/Autonomic Testing

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WAYNE SIDA, M.D.

MEDICAL DIRECTORS

BRET WARNER, M.D.

Test Date: 8/23/2010

Patient:	Johnnie Leopard	DOB:	9/17/1970	Physician:	Wayne B. Sida, M.D.
Sex:	Male	Height:	177 cm	Ref Phys:	Bartz, Mark
ID#:	235030	Weight:	225 lbs.	Technician:	Sida

Patient Chief Complaint, History, Exam:

Patient is a 39 year-old male who presents with hx of fall injury and multiple compression fractures/spinal. Had acute onset of pain especially in right lower back and leg recently that occurred spontaneously. No diabetes. Pain caused him to fall to ground.

Impression:

Normal electrodiagnostic study the right lower extremity. There is no electrodiagnostic evidence of nerve entrapment, generalized peripheral neuropathy, or lumbar radiculopathy.

EMG & NCV Findings:

All nerve conduction studies (as indicated in the following tables) were within normal limits.

H-reflex studies indicate that the Left Tibial H-Reflex has prolonged latency (36.03 ms). The Right Tibial H-Reflex has prolonged latency (35.21 ms). All H Reflex left vs. right side latency differences were within normal limits.

All examined muscles (as indicated in the following table) showed normal insertional activity and recruitment.

Wayne B. Sida, M.D.

Faxed 9/8/10
BU 8/24/10

Nerve Conduction Studies

Anti Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)
Right Sural Anti Sensory (Lat Mall)									
Calf		4.4	<4.8	8.8	>5.0	Calf	Lat Mall	4.4	14.0

Motor Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Peroneal Motor (Ext Dig Brev)											
Ankle		5.3	<6.6	5.5	>2	B Fib	Ankle	5.6	26.5	47.3	>42
B Fib		10.9		5.4							
Right Tibial Motor (Abd Hall Brev)											
Ankle		5.9	<6.6	5.7	>2	Knee	Ankle	10.1	43.0	42.6	>42
Knee		16.0		5.3	>2						

H Reflex Studies

NR	H-Lat (ms)	Lat Norm (ms)	L-R H-Lat (ms)	L-R Lat Norm	Leg Length (cm)
Left Tibial (Gastroc)					
	36.03	<0.0	0.82	<2.0	0.00
Right Tibial (Gastroc)					
	35.91	<0.0	0.82	<2.0	0.00

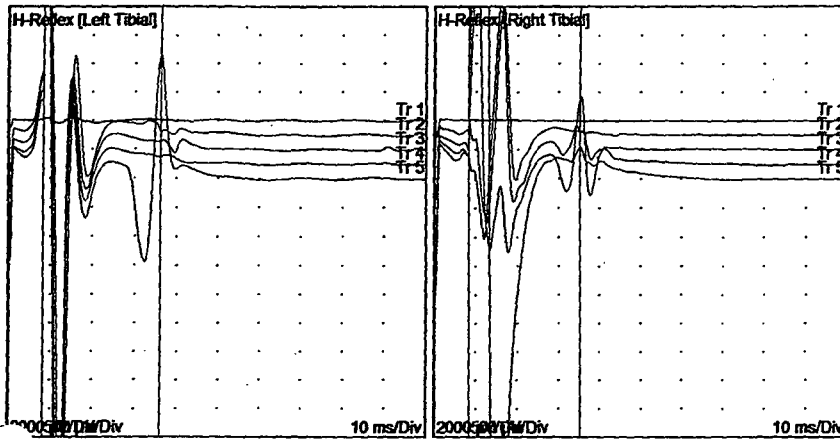
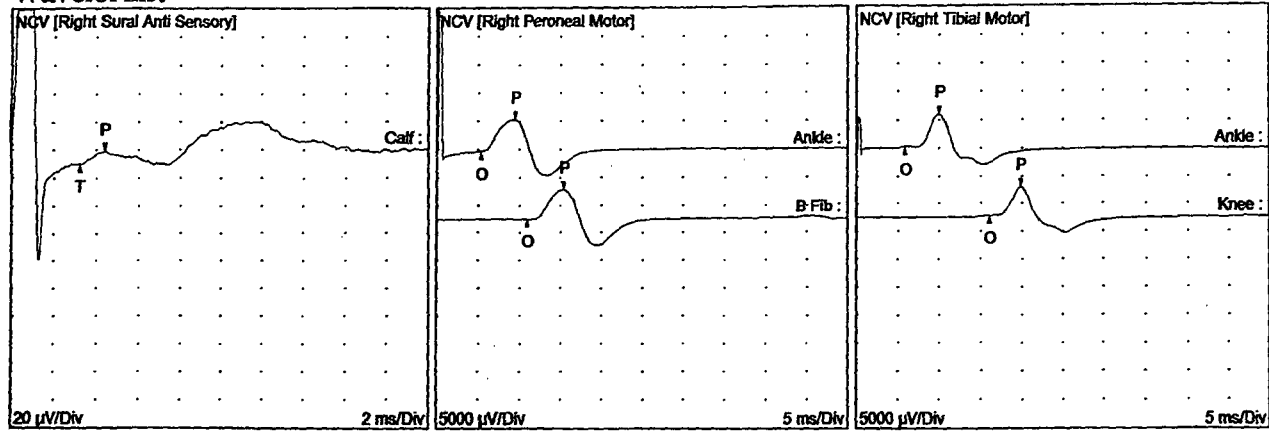
EMG

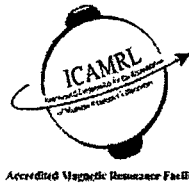
Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Fascics	CRD	Amp	Dur	Poly	Recrt	FF	Int Pat	Comment
Right	Peroneus Long	Sup Br Peron	L5-S1	Nml	0	0	0	Absent	Nml	Nml	0	Nml	Nml	Nml	
Right	MedGastroc	Tibial	S1-2	Nml	0	0	0	Absent	Nml	Nml	0	Nml	Nml	Nml	
Right	AntTibialis	Dp Br Peron	L4-5	Nml	0	0	0	Absent	Nml	Nml	0	Nml	Nml	Nml	
Right	VastusLat	Femoral	L2-4	Nml	0	0	0	Absent	Nml	Nml	0	Nml	Nml	Nml	

Paraspinal EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	CRD	Comments
Right	Lumbar paraspinals	Rami	L1-S1	Nml	Nml	Nml	Absent	

Waveforms:





**Piedmont Health Group L.L.C.
Diagnostic and Imaging Center
105 Vine Crest Court
Greenwood, SC 29646
Ph: (864)943-4800 Fax: (864)943-0939**

**Patient Name: Leopard, John B
Patient Acct #: 235030
Physician: Sida, Wayne**

**Date of Exam: 08/17/2010
Patient DOB: 09/17/1970**

Exam: MRI T-Spine Without Contrast

CLINICAL: 39-year-old male with acute onset back pain, urinary difficulty, lower extremity pain and leg weakness.

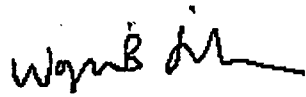
TECHNIQUE: Sagittal T1, T2, STIR, and selective axial T1 and T2 images of the thoracic spine were acquired in multiple planes without contrast. He has a history of thoracic compression fractures on a traumatic basis several years ago.

FINDINGS: Images were adequate for diagnostic purposes. Patient appears to be status post anterior cervical discectomy with fusion at C6-7. Multiple Schmorl's nodes are noted. Loss of ventral vertebral body height at T10 and T11 consistent with chronic compression fractures. Modest low some ventral vertebral body height at T8. Spinal cord appears to terminate normally at L1. Multilevel intervertebral disc desiccation noted. STIR images show no acute fracture lines. Type II endplate changes noted along the inferior endplate of T8 ventrally. Thoracic epidural fat planes and neural foramina are patent. No significant subluxations or listhesis noted. Spinal cord caliber and signal is normal. T10-11 broad-based disc bulge and endplate hypertrophy produces ventral impression upon the distal cord. Posterior element hypertrophy contributes to produce moderate spinal canal stenosis. Neural foramina are patent. T11-12 broad-based disc bulge and endplate hypertrophy with focal herniation to the left of midline producing anterolateral impression upon the distal cord without cord signal change. Posterior element hypertrophy present. Neural foramina are patent. Small focal, central disc protrusion at T4-5 producing deflection of the thecal sac.

IMPRESSION:

- 1. Multilevel Schmorl's nodes with chronic compression fractures noted at T10, T11, and possibly T8 of the anterior wedge type.**
- 2. T10-11 broad-based disc bulge and endplate hypertrophy with ventral impression upon the distal cord. Posterior element hypertrophy contributes to produce moderate spinal canal stenosis.**
- 3. T11-12 broad-based disc bulge and endplate hypertrophy with focal herniation to the left of midline producing anterolateral impression upon the distal cord without cord signal change.**
- 4. Incidental note is made of previous anterior cervical discectomy with fusion at C6-7. This would be better investigated by dedicated images of the cervical spine. Small T4-5 central disc**

protrusion with ventral impression upon the thecal sac and cord.

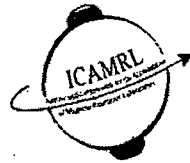


Wayne B. Sida, M. D.

*Certified in MRI & CT, American Society of Neuroimaging
Diplomate, American Board of Psychiatry & Neurology*

Signed: 2010-08-17 09:45:18.980000000

DD: 08/17/2010/DT: 08/17/2010



**Piedmont Health Group L.L.C.
Diagnostic and Imaging Center
105 Vine Crest Court
Greenwood, SC 29646
Ph: (864)943-4800 Fax: (864)943-0939**

**Patient Name: Leopard, John B
Patient Acct #: 235030
Physician: Sida, Wayne**

**Date of Exam: 08/17/2010
Patient DOB: 09/17/1970**

Exam: MRI C-Spine Without Contrast

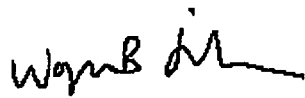
CLINICAL: 39-year-old male with bladder difficulty and leg weakness. Clinical concern for cervical myelopathy. Pathologically brisk reflexes. History of traumatic spinal injury.

TECHNIQUE: Sagittal T1, T2, and selective axial T1, fast spin echo T2, and 3-D T2 images of the cervical spine were obtained in multiple planes without contrast.

FINDINGS: Images are adequate for diagnostic purposes. Patient is status post anterior cervical discectomy with instrumented fusion at C6-7. Visualized portions of the posterior fossa are unremarkable. Spinal cord caliber and signal is normal in appearance. Schmorl's node along the inferior endplate of T3. Multilevel intervertebral disc desiccation with preservation of intervertebral disc space height. Vertebral body height and signal is normal. Instrumentation hardware appears stable. Vertebral artery flow voids are patent. Vertebral artery flow voids are patent. C3-4 uncinate hypertrophy with mild right and moderate bilateral neural foraminal stenosis. C5-6 mild broad based disc bulge eccentric to the right. C6-7 moderate bilateral neural foraminal stenosis. Ferromagnetic artifact. STIR images show no fracture lines or bone edema. Visualized portions of the upper thoracic spine are unremarkable. Thoracic epidural fat planes and neural foramina are patent.

IMPRESSION:

- 1. Patient is status post anterior cervical discectomy and fusion at C6-7.**
- 2. Multilevel cervical disc degenerative disease and spondylosis with varying degrees of neural foraminal stenosis as described above. No significant cord signal compromise or extrinsic cord compression noted.**



Wayne B. Sida, M. D.

***Certified in MRI & CT, American Society of Neuroimaging
Diplomate, American Board of Psychiatry & Neurology***

Signed: 2010-08-17 09:57:37.777000000

DD: 08/17/2010/DT: 08/17/2010

HISTORY

PATIENT: John Leopard

August 13, 2010

SS: 247631193

REFERRED BY:

HISTORY:

John is a 39-year-old white male referred here today for emergent consultation regarding potential spinal cord compression. He awoke this morning and developed a severe shooting pain in his back that caused him to fall to his knees. He has had trouble initiating urination. However, no frank incontinence. He has episodic numbness and pain in the right lower extremity. Of note, in October, 2007, while working as a fireman, he fell in a house fire and injured his back suffering wedge compression fractures at T10, T11, L1. He cut grass yesterday. He has been managed by the pain clinic in Greenville. He has since begun work in maintenance at Eaton electrical. He was seen by a neurosurgeon in the past. Thoracic neuroimaging in May of this year was performed for sudden onset of the midthoracic back pain. No compression. No acute findings. However images are of low resolution.

PAST MEDICAL HISTORY/FAMILY HISTORY/SOCIAL HISTORY/REVIEW OF SYSTEMS:

Past medical history, family history, social history, and review of systems are documented in the chart and reviewed with the patient today.

PHYSICAL EXAMINATION:

BP: 120/72. Height 177 cm. Weight 226 pounds. Respirations 18. Pulse 78. It appears to be in significant pain. Antalgic gait. General: Well developed well nourished individual. Integument: there is no skin rash. No evidence of lesions around the eyes or mouth. Extremities: pulses are symmetrical. No edema is noted. Heart is regular.

NEUROLOGICAL EXAMINATION:

Mental Status: patient is alert and oriented to person, place, time, and situation. There is normal language and attention. No extinction or neglect. No apraxia. Memory is normal. Visuospatial testing is normal. Fund of knowledge is normal.

Cranial Nerves: pupils are equal, round, and reactive to light. Visual fields are full to confrontation. Extraocular movements are intact without nystagmus. Disks are sharp bilaterally with normal retinal vasculature. Face moves symmetrically and there's normal sensation. Hearing is normal to voice and 512 Hertz tuning fork. Palate elevates symmetrically. Shoulder shrug and head turning maneuvers are normal. Tongue protrudes midline.

Motor: strength is 5 / 5 throughout with normal bulk and tone. There is no drift in the upper extremities. No extraneous movements are noted.

Sensory: intact to light touch, pinprick, vibration, proprioception, and cold.

PAGE 2

DTRs: 1+ uppers; 3+ at knees 2- right ankle and 2 + left ankle. Toes are downgoing bilaterally. No clonus.

Coordination: normal for finger to nose, heel to shin, and rapid alternating movements.

Gait: Antalgic. Tender percussion in lower thoracic/upper lumbar region.

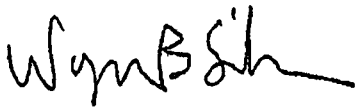
IMPRESSION:

No evidence of acute compression fracture. His main complaint is severe pain. He has a history of paroxysmal right lower extremity numbness and pain. This would be unexpected given the localization of his lower thoracic/upper lumbar spinal disease and prior compression fractures unless there is cauda equina compression. There is narrowing of the spinal canal around the conus medullaris and cauda equina. His reflexes remain brisk and this is suggestive of myelopathy. This could be pre-existing due to prior spinal contusion from his trauma. However, cannot exclude compression in the cervicothoracic cord. He is not experiencing significant pain in his neck or mid thoracic region presently. This leads me to believe most of his reflex changes are pre-existing although I have no comparison point.

PLAN:

1. Decadron taper. Avinza and valium.
2. Proceed with SSEP studies looking for residual of prior contusion or ongoing conus medullaris compression. At this point, based upon imaging alone, unless something changes on his neurological examination, I would like to pursue a more conservative approach without surgical intervention. I would like to take a look a little higher in his cervicothoracic cord because of his persistent brisk knee jerk reflexes. I will see him back shortly for an EMG and to review his response to our medications.

I would like to thank Dr. Bartz for allowing me to take care of this very pleasant gentleman.



Wayne Sida, MD

Piedmont Health Group - Neurology

WBS/ 08/13/2010



SPINAL SURGERY
Donald R. Johnson, II, MD
Steven C. Poletti, MD
R. Blake Dennis, MD

Danny Buder, PA-C
Justin Swain, PA-C
Amanda Thurber, PA-C

CONSERVATIVE SPINE CARE
Leonard E. Forrest, MD
John F. Johnson, MD
G. Robert Richardson III, MD

PAIN MANAGEMENT
Mark D. Netherton, MD
Blane Richardson, MD
Virginia Bleas, PA-C
Suzanne Livengood, PA-C

MAIN OFFICE
1106 Chuck Dawley Blvd., Suite 200
Mt. Pleasant, SC 29464

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Fax 884-0629
1-800-432-0274

1941 SAVAGE RD., STE. 100E
CHARLESTON, SC 29407
(843) 763-2720

March 28, 2011

Lena Meredith, Esquire
109 West Court Avenue
Greenwood, SC 29648

RE: John Leopard
Patient #319290

Dear Ms. Meredith:

With regards to Mr. Leopard, he has per my note of November 17, 2010 a 15-percent impairment rating with regards to his fractures. These fractures have worsened at the T11 level, and I would say that the 15-percent spine/whole person impairment rating that he was assigned in November 2010 is the result of a worsening of his condition as a consequence of his work-related injury.

If you have any further questions with regards to this, please do not hesitate to contact me.

Sincerely,

Steven C. Poletti, M.D.
SCP/dmp

Mar. 21. 2011 12:45PM
 South Carolina Workers' Compensation Commission
 1333 Main Street, Suite 500 • Post Office Box 1715
 Columbia, South Carolina 29202-1715
 (803) 737-5723
 www.wcc.sc.gov

NICHOLSON AND ANDERSON LAW FIRM

No. 1119 P. 2/2



Physician's Statement

Claimant's Name: John B. LeopardEmployer's Name: Greenwood County (Fireman)Physician's Name: Dr. Steven PolettiInsurance Carrier: SC Assoc of Counties SIF Companion TPAPractice/Clinic: Southeastern Spine InstituteSCWCC File No: 0724852Preparer's Name: Lena Y. MeredithPhone: (864) 229-7241

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: 10-30-2007Date of first office visit: 11-17-10Date of last visit: 11-17-10Diagnosis or nature of Injury or illness: T4 Fr w/multilevel deg disc diseaseBody part(s) injured: SpineBody part(s) affected: Spine

Date of Maximum Medical Improvement: _____

Based on the **AMA Guidelines**, the claimant has sustained a 15% 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

3-28-11

SOUTHEASTERN SPINE INSTITUTE

LEOPARD, JOHN

Patient # 319290

DOB: 09/17/1970

March 16, 2011

ADDENDUM:

This is an addendum to an independent medical evaluation from November 17, 2010. I have been asked specifically to review Mr. Leopard's MRI studies. Apparently Mr. Leopard was injured in 2007. He has had some improvement after his initial fall and fracture but subsequently through 2010 has worsened with regards to increasing pain into his back and legs.

I'm in receipt of his MRI scans from 2007 and from 2010. Specifically, there is evidence of compression injuries at the T11 level noted on the 2007 MRI. Specifically, there is no evidence of spinal cord compression or stenosis on the MRI or the MRI interpretation from 2007.

The nature of compression fractures is that they can progress. When looking at the MRI scan and the CT scan from 2010, there is noted to be 20 to 25 percent of anterior and central vertebral body height at the T11 level. This is consistent with a worsening of the degree of vertebral compression at the T11 level when compared specifically to the MRI from 2010.

In addition, the MRI scan from 2010 describes and shows disc bulging at the T10-11 level and that there is specifically posterior element hypertrophy with ventral impression upon the distal cord with moderate spinal canal stenosis and broad-based disc bulge and end plate hypertrophy at the T11-12 level with a focal disc herniation at T11-12 to the left of center. Specifically when the CT scan of 2007 is compared to the CT scan of 2010, it can be seen clearly that there is a worsening or increase in the degree of compression at the T11 level when specifically comparing the MRI scans from 2007 to 2010.

The nature of compression fractures is that they can continue to cause compression or have progressive collapse as the fractures heal. I do believe to a reasonable degree of medical certainty that as these fractures continued to compress or continued to collapse that they caused an increased amount of pressure against the spinal cord, which is most likely responsible for the increase in his symptoms and the symptoms that he has into his back and legs.

I continue to contend that he does not have a surgical option but should pursue nonoperative pain management options for control of pain and paresthesias. I hold the above opinions true to a reasonable degree of medical certainty.

Steven C. Poletti, M.D.

SCP/dmp

T- 3/21/11

Cc: Lena Meredith, Esquire

1106 Chuck Dawley Blvd., Ste. 200
1941 Savage Rd., Ste. 100-E

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Charleston, SC 29414

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(843) 763-2720

Fax: (843) 884-0629
Fax: (843) 769-6022

127

SOUTHEASTERN SPINE INSTITUTE

LEOPARD, JOHN

Patient # 319290

DOB: 09/17/1970

November 17, 2010

This 40-year-old man was injured in an accident when he was working as a firefighter entering the building from the top floor when he fell approximately 6-8 feet landing on his hands twisting and falling backwards. The date of the surgery was 10/31/07. He was noted to have a T11 compression fracture. He has continued with pain between his shoulder blades. He has been through physical therapy and has tried to attempt working as a firefighter. He has neck problems and apparently was noted to have neck problems prior to the time of his injury and subsequently underwent anterior cervical discectomy and fusion by Dr. Lowe in Greenwood on 1/16/08. He has continued to have pain into his mid-back and pain into his low back and pain into his hips and legs. He describes his pain as 6-8 on a digital analog scale. He describes virtually every activity as aggravating his pain. He has tried physical therapy, a TENS unit. He has had epidural injections x2. He has no current symptoms of incontinence or similar neurologic disturbance.

His exam demonstrates him to have a well-healed cervical scar. He has limited motion in his neck. He has intact reflexes. He has dysesthesia into the lower legs. He has positive straight leg raising. He has limitation of motion with flexion and extension of his low back. There are no upper or lower extremity long tract signs. He has diagnostic imaging studies demonstrating postoperative changes from the anterior cervical discectomy and fusion at the C6-7 level. He has x-rays and scans demonstrating the presence of a T11 fracture with a mild thoracic scoliosis as well. He has posterior disc protrusion and osteophytes at the T10-11 and T11-12 levels and has the MRI scan of the mid-back with chronic Schmorl's nodes and chronic compression fractures noted at the T10-11 and T8 levels.

He has postoperative imaging studies to involve MRI of the cervical spine showing normal postoperative changes post discectomy and interbody fusion at C6-7.

Diagnoses:

1. Thoracic (T11) fracture with multilevel degenerative disease aggravated by fall.
2. Status post anterior cervical discectomy and fusion at C6-7.
3. Back and bilateral leg pain.

(Continued)

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128

SOUTHEASTERN SPINE INSTITUTE

LEOPARD, JOHN

Patient # 319290

DOB: 09/17/1970

November 17, 2010

Page 2

Comment: This man does have multilevel degenerative disease in the mid-back. He has been through pain management and is followed by Dr. Sida in the clinic for which he has had what sounds like nonoperative care for pain management. He actually could consider further evaluation on his mid-back, but I would say to a reasonable degree of medical certainty that he has multilevel wedge deformity or compression injuries which most likely would cause an increase or fracture as a consequence of his fall. The cervical fusion may have been aggravated or necessitated by injury sustained in the fall but certainly he does not have any kind of absolute correlation between his fall and the onset of his neck and arm symptoms. With regards to his fractures I would ascribe him a 15% impairment rating. He can work but not exertionally. He could require a follow up with pain management but I would not recommend an operation. I have seen this man for the purposes of an independent medical evaluation and would be glad to see him back anytime.

Steven C. Poletti, M.D.SCP/vg
T- 1/3/11

Cc: Lena Meredith, Esquire

1106 Chuck Dawley Blvd., Ste. 200
1941 Savage Rd., Ste. 100-EMt. Pleasant, SC 29464
Charleston, SC 29414(843) 849-1551
(843) 763-2720Fax: (843) 884-0629
Fax: (843) 769-6022

129

Pain Management Associates

PatientID: 88551JL
Patient Name: JOHN B LEOPARD
Date of Birth: 09/17/1970
Physician Requesting Consult:
Date of Service: March 15, 2011

PHYSICIAN REQUESTING CONSULT: Dr. Lena Meradith
CHIEF COMPLAINT: The patient presents with lumbar pain.

INFO/RECORDS REVIEWED & SCANNED INTO CHART:

CURRENT ALLERGY LIST:
NEOSPORIN

CURRENT MEDICATION LIST:
TRAMADOL 50 MG, 4-5 times a day
ZANAFLEX ORAL TABLET 4 MG, 3-4 times a day
LORTAB 10/500 MG, 1-2 times a day
RELAFEN ORAL TABLET 750 MG, 1-2 times a day
LEXAPRO ORAL TABLET 20 MG, 1 time a day

PAST MEDICAL HISTORY:
MEDICAL: No history of significant medical diseases.
SURGICAL: Right knee arthroscopy., hernia, c6-c7 fusion

FAMILY HISTORY:

SOCIAL HISTORY:
MARITAL STATUS: Patient is married.
ALCOHOL: Does not give any significant history of alcohol usage.
TOBACCO USE: Currently smokes 1 PPD, has smoked for 20 to 25 years.
ILLCIT DRUG USE: No history of illicit drug use or prescription misuse.

REVIEW OF SYSTEMS:
GI: Has frequent heartburn.
MUSCULOSKELETAL: Has joint pain, muscular pain.
NEUROLOGICAL: Has generalized muscle weakness, loss of sensation.
PSYCHIATRIC: Has sleep disturbances, depressive symptoms.
ENDOCRINE: Has a decreased libido.

PHYSICAL EXAM:
CONSTITUTIONAL:
GENERAL APPEARANCE: White male, well nourished body habitus, appears stated age, appropriately groomed. In no acute distress.
GENERAL EXAM:
ORIENTATION/MOOD/AFFECT: Oriented to person, place, time and general circumstances. Mood and affect appropriate.

Ryan A. Wetzel, MD LIC# 2033017 DEA FW1996593

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1005 Grove Rd*Greenville, SC 29605*Phone:(864) 242-6447*Fax: (864)242-6517

Pain Management Associates

PatientID: 88551JL

Patient Name: JOHN B LEOPARD

Date of Birth: 09/17/1970

Physician Requesting Consult:

Date of Service: March 15, 2011

SKIN: Warm, dry.

HEAD/FACE: The head is normocephalic. There are no maxillofacial abnormalities. Normal facial appearance.

EYES: Lids are normal without ptosis, edema. Conjunctivae are normal and without inflammation, injection, hemorrhages or exudates. Pupils are equal, round. EOMs full and conjugate.

EARS/NOSE/THROAT: Teeth are in good repair, gums are normal. Oral mucosa is pink.

PAIN BEHAVIORS: Behaviors are within expected context of disease. Facial appearance is relaxed. Normal verbalization. **Mobility and range of motion are generally reduced.** Appropriate social interaction.

MUSCULOSKELETAL EXAM:

HEAD/NECK (POSTERIOR), SHOULDER GIRDLE: There are well healed scars consistent with previous surgeries listed in HPI/PMH. **Generalized mild tenderness over the neck and shoulder girdle.** Head and neck in neutral position. Actively touches chin to chest, extension mildly restricted. Normal stability. Normal strength and tone.

SPINE, RIBS, PELVIS: **Mild edema in the right thoracic/rib area. Moderate tenderness in the right paraspinal area.** No kyphosis, lordosis, or scoliosis. Thoracic rotation mildly restricted bilaterally. Normal stability. Normal strength and tone.

LEFT UPPER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No muscle or joint tenderness to palpation. No crepitation.

MUSCLE STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone of the major groups is normal. Normal muscle bulk (no atrophy). No fasciculations.

RIGHT UPPER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No muscle or joint tenderness to palpation. No crepitation.

MUSCLE STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone of the major groups is normal. Normal muscle bulk (no atrophy). No fasciculations.

LEFT LOWER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No tenderness. No crepitation.

JOINT STABILITY: No instability of the hip. No evidence of medial instability of the knee. No ankle instability.

STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone is normal. Normal muscle bulk (no atrophy). No fasciculations.

RIGHT LOWER EXTREMITY:

INSPECTION: No erythema. No ecchymosis. No edema.

PALPATION: No tenderness. No crepitation.

JOINT STABILITY: No instability of the hip. No evidence of medial instability of the knee. No ankle instability.

STRENGTH, TONE, ATROPHY: Muscle strength of the major groups is 5/5. Tone is

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normal. Normal muscle bulk (no atrophy). No fasciculations.
MUSCLE SPASMS: **Right middle paraspinal muscle tenderness.** No CVA tenderness. Negative straight leg raising.

SENSATION:

NERVE ROOTS: Sensation to touch and pressure intact. Sensation to pinprick (sharp/dull) intact.

RANGE OF MOTION: Normal in the major joints. **The neck is restricted in flexion and extension.**

POSTURE: **Altered due to dorsal spine position.**

GAIT/STATION: Gait intact. Does not use mobility aids.

IMAGING STUDIES:

PLAN: SEE DICTATION..PER DR. REDDICK. KD

Electronically Signed by: Sybil Reddick, M.D. on Monday, May 16, 2011

Ryan A. Wetzel, MD LIC# 2033017 DEA FW1996593

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Page 3 of 3

132

PAIN MANAGEMENT ASSOCIATES

115 Academy Avenue
Greenwood, SC 29646

Phone: 864-855-1633

Fax: 864-855-1323

PATIENT'S NAME: John B. Leopard
DATE OF BIRTH: 09/17/1970
MRN: 88551JL
DATE OF EVALUATION: 03/15/2011

INDEPENDENT MEDICAL EVALUATION

HISTORY OF PRESENT ILLNESS:

This patient is seen and evaluated today, secondary to ongoing disability and pain as it relates to his thoracic compression fracture and back pain. This examinee was seen and evaluated on today's date, March 15, 2011, at the above address. The examinee's evaluation started at approximately 10:30 a.m. and ended at 11:30 a.m. The examinee came to the office unaccompanied. This is an Independent Medical Evaluation. I introduced myself to this patient. I advised the patient that I was seeing him for an Independent Medical Evaluation and that all information gained would be used in the assessment and would be presented in my report. The examinee was told that I would not be a treating physician and a doctor/patient relationship would not be established. The examination process was explained and the patient understood.

Prior to this evaluation, multiple medical records were available for review. The records evaluated included:

- Two reports from Self Regional Healthcare Emergency Department (10/30/2007, 08/09/2010).
- MRI of the lumbar spine (05/01/2010) and CT of the thoracic spine (05/01/2010).
- Progress notes from Dr. Daniel Divilbliss at Montgomery Center for Family Medicine (10/31/2007-12/21/2007).
- CT of the thoracic spine (12/11/2007) and MRI of the thoracic spine (12/19/2007).
- Physical therapy progress notes from Optimum Life Center of Self Regional Healthcare (11/07/2007-01/15/2008).
- Multiple reports from Dr. Philip Hodge at Southeastern Neurosurgery and Spine Institute (02/19/2008-02/23/2009).
- Progress notes from Dr. David Shallcross at Upstate Medical Rehabilitation (06/04/2009-02/02/2011).
- Physical therapy notes from Select Physical Therapy (06/12/2009-11/18/2009, 01/13/2011).
- Progress notes from Dr. Mark Bartz (08/13/2010).
- Multiple reports from Dr. Wayne Sida at Piedmont Neurology Associates (08/13/2010-10/15/2010).
- A functional capacity evaluation Matrix ZBS (*could not verify*) Physical Therapy (01/14/2011).

Continued . . .

John B. Leopard

03/15/2011

PAGE 2

The patient indicates he was injured October 30, 2007, when he fell through the second story of a burning house. He was working as a volunteer fireman at the time of injury. He was evaluated at the Self Regional Healthcare Emergency Department. X-ray of the spine demonstrated mild osteoarthritis affecting the lower cervical and lower thoracic levels with no acute skeletal abnormality noted. He was seen by Dr. Divilbliss the following day on October 31, 2007. He was treated for contusion and paraspinous spasm of the back. He underwent therapy and was progressing with improvement in all areas, except in mid back pain. He was returned to work light duty and CT of the thoracic spine was done December 11, 2007. The study did not demonstrate the occult fracture, but there was noted possibility of disc protrusion at multiple levels of the thoracic spine (T10-T11, T11-T12). MRI of the thoracic spine was ordered and completed December 19, 2007. The study showed impingement on the anterior aspect of the cord at multiple levels. The patient was referred for neurosurgical evaluation by Dr. Sunber Lal.

The patient was discharged from Self Regional Physical Therapy on January 15, 2008. His therapy was placed on hold because of continued pain and limitation of therapy secondary to pain. The patient was seen by Dr. Hodge who noted mildly increased reflexes, but no other symptoms of myelopathy. He did not feel surgery was warranted. He recommended pain management. He was evaluated by Dr. Hodge May 12, 2008, and he stated that he felt the injury was likely a soft tissue injury. The patient had reached MMI and was able to return to work without restriction.

On August 13, 2010, he reports he developed a severe, shooting pain in his back, causing him to fall to his knees. He states he stood up to get ready for work and felt the typical pain that he experiences in his mid back. He turned to the right to take a step with sudden onset of severe pain in the low back. He states he had previously had pain from the mid back radiating to the lateral aspect of his right leg. He has had some pain into the left lower extremity, but not as much as the right. He states that in addition to the mid back, he felt pain in the low back, which has persisted. He was evaluated that same day by Dr. Sida at Piedmont Health Group - Neurology, after referral from Dr. Bartz. Dr. Sida began a Decadron taper and prescribed Avenza and Valium.

MRI on August 17, 2010, demonstrated broad-based disc bulge at T10-T11 with ventral impression on the distal cord. Posterior element hypertrophy contributes to reduced moderate spinal canal stenosis. At T11-T12, broad-based disc bulge with focal herniation to the left of midline producing anterolateral impression upon the distal cord without cord signal change. Previous anterior cervical discectomy and fusion at C6-C7. Also noted, a small T4-T5 central disc protrusion with ventral impression on the thecal sac and cord. SSEP studies were stable with no evidence of cord conduction delay. unclear - possibly "SCVEMP" - please confirm) studies were within normal limits. There was no surgical intervention recommended.

The patient continued care at Upstate Medical Rehabilitation with Dr. David Shallcross. The patient was released and returned to work with restrictions after completing a functional capacity evaluation. Presently, the patient complains of mid back pain that radiates down the right side to the lower back and then into the right leg. He describes it as an aching, sharp, shooting pain that is typically 7/10 with use of medications. He states too much bending, sitting, standing, or twisting exacerbates his pain. Medication helps alleviate his pain. He reports no relief with physical therapy, exercise, or injections. He reports moderate relief of symptoms with massage, TENS unit, and

Continued . . .

134

John B. Leopard

03/15/2011

PAGE 4

General:

The patient is a white male, well nourished body habitus, appears stated age, appropriate groomed, in no acute distress. The patient is oriented to person, place, time, and general circumstances. Mood and affect appear appropriate. The patient answers questions appropriate. It is felt the history is reliable.

HEENT:

The patient is normocephalic with normal hair distribution. His face is symmetrical with no maxillofacial abnormalities noted. Eyes are clear. The lids are normal without ptosis or edema. Extraocular muscles are intact. Ear, nose, and throat are intact.

Neck:

Supple. There are no carotid bruits. There are well-healed scars consistent with previous surgery, as listed in HPI and Past Medical History. There is generalized mild tenderness to palpation of the neck and shoulder girdle. The head and neck are in neutral position. He is able to actively touch his chin to his chest. Extension is mildly restricted. There is normal stability noted. There is normal strength and tone noted in the posterior and anterior musculature.

Chest:

Clear inspiratory and expiratory excursion is intact.

Cardiac:

Heart rate and rhythm are regular.

Abdomen:

Soft, nondistended. Bowel sounds are present.

Spine:

There was mild edema noted in the right thoracic rib area. There is elevation of the right hemipelvis with some obliquity of the right hemipelvis noted. Moderate tenderness in the right paraspinal area at the T10-T11 level. There is no kyphosis, lordosis, or scoliosis. Thoracic rotation is restricted bilaterally with rotation to the right 20 degrees and to the left 30 degrees. Lumbar range is mildly reduced in flexion plane. There is tenderness to palpation of the right SI joint.

Extremities:

There was no edema, erythema, or ecchymosis noted in the upper or lower extremities. There is no muscle or joint tenderness to palpation. There is no evidence of atrophy or muscle fasciculation in the upper or lower extremities. He has 4/5 muscle strength noted in the right hip, abductors, extensors, and right flexors. The remainder of the muscle testing of the upper and lower extremities is 5/5. Gait intact. The patient does not use mobility or assistive devices.

ASSESSMENT/PLAN:

1. Thoracic compression fractures at T10-T11, L1 (chronic).
2. Thoracic pain.
3. Right SI joint dysfunction.
4. Lumbosacral radicular pain.

It is my opinion to a reasonable degree of medical certainty that the additional symptoms described are related to the original injury. I noted on my exam evidence of

Continued . . .

John B. Leopard;

03/15/2011

PAGE 3

medication. The patient is not currently working. The patient's complete history and physical, as well as medication survey has been reviewed by me and included in the chart.

ALLERGIES:**NEOSPORIN.****CURRENT MEDICATIONS:**

Zanaflex 4 mg 3-4 times a day, tramadol 50 mg 4-5 times a day, Lortab 10/500 taken 1-2 times per day, Relafen 750 mg 1-2 times per day, Lexapro 20 mg once a day.

PAST SURGICAL HISTORY:

C6-C7 fusion, right knee surgery, hernia repair.

FAMILY HISTORY:

Noncontributory. Chronic health problems, GERD.

SOCIAL HISTORY:

The patient smokes 1 pack of cigarettes per day and denies use of alcohol.

REVIEW OF SYSTEMS BY HISTORY:

General:	Denies fever, chills, weight loss/gain, fatigue, weakness.
Skin:	Denies rash, pruritus, lesions, bruising.
Head/EENT:	The patient denies abnormal discharge from the eyes, ears, nose.
Cardiovascular:	Denies palpitations, chest pain, syncope, dyspnea on exertion, orthopnea, peripheral edema, PND.
Respiratory:	Denies shortness of breath, dyspnea, cough, hemoptysis, wheezing, sputum.
Gastrointestinal:	Positive for heartburn. Denies constipation, diarrhea, change in bowel habits, nausea, vomiting, abdominal pain, dysphagia.
Neuropsychiatric:	Positive for problems with sleeping, depression. Denies syncope, seizures, weakness, memory/mood problems, drug/alcohol-related problems.
Neuromuscular:	As noted in HPI.
Endocrine/Hematologic:	Positive for decreased sex drive. The patient denies temperature intolerance, changes in hair/skin texture, bleeding tendency, easy bruising, lymph node enlargement, increase thirst, hunger, or weight gain/loss.

PHYSICAL EXAMINATION:

Ht: 5' 10" Wt: 220 lbs. BP: 154/78 Pulse: 70 Temp: Afebrile.

Continued . . .

136

John B. Leopard:

03/15/2011

PAGE 5

SI joint dysfunction on the right. There was previous documentation of a leg length discrepancy with the right longer, associated with anterior rotation of the ileum. Given the description of the onset of pain, I think these findings are most likely the source of increased pain, August 13, 2010. The question is how does the thoracic injury relate to these findings. There was no documentation noted indicating any derangement in the pelvis or sacrum, but I think it is reasonable to conclude that these changes occurred as a results of the fall that lead to the thoracic compression fractures and pain. Current treatment regimen is appropriate, but I would add treatment for the SI joint, pelvic tilt, and resultant functional leg length discrepancy. This should include strengthening, spinal stabilization exercises, lower extremity and spinal stretches, and soft tissue mobilization. It is also my opinion, based on my examination and review of the most recent functional capacity evaluation of January 14, 2011, that this patient is unable to perform the duties of maintenance and/or volunteer firefighter jobs.

This Independent Medical Evaluation includes both objective and subjective findings. I follow the applicable professional and ethical guidelines. These opinions are based on the facts as related to both the medical records and to the examination and to the historical examination of the examinee. I declare under penalties of perjury that the information contained within this document was prepared and is the work product of this undersigned physiatrist. It is true to the best of my knowledge and information.

Sybil Reddick, MD
Physical Medicine and Rehabilitation

SR:ats46
Voice file: 0330-335

Transcription dictated but not read in order to expedite records.

STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM GREENWOOD COUNTY
South Carolina Workers' Compensation Commission

Appellate Panel

NOV 26 2012

SC Court of Appeals

Case No. 0724852

John B. Leopard, ... Appellant,

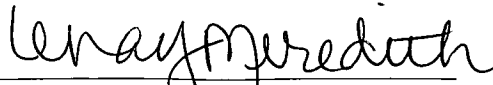
v.

Greenwood County and S.C. Association of Counties, SIF, ... Respondents.

PROOF OF SERVICE

I certify that I have served the Record on Appeal on Greenwood County and S.C. Association of Counties SIF by depositing a copy of it in the United States Mail, postage prepaid, on November 26, 2012, addressed to their attorney of record, Richard B. Kale, Jr., Esquire, Willson Jones Carter & Baxley, PA, 872 S Pleasantburg Dr, Greenville, SC 29607.

November 26, 2012



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